1 # MEDICAID AUDIT AMENDMENTS

2 2015 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: Lyle W. Hillyard**

5 House Sponsor: Edward H. Redd

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7 **LONG TITLE**

8 **General Description:**

9 This bill establishes Medicaid audit standards for the Medicaid program administered

10 by the Department of Health, and for the Office of Inspector General of Medicaid

11 Services.

12 **Highlighted Provisions:**

13 This bill:

14 ▸ defines terms;

15 ▸ requires the Department of Health to adopt administrative rules, in consultation with

16 providers, for Medicaid audit and investigation procedures;

17 ▸ establishes certain audit and investigation standards for audits and investigations

18 conducted by the Medicaid program within the Department of Health and by the

19 Office of Inspector General of Medicaid Services;

20 ▸ makes technical amendments to the Medicaid audit functions of the Office of

21 Internal Audit and Program Integrity within the Department of Health; and

22 ▸ makes technical amendments.

23 **Money Appropriated in this Bill:**

24 None

25 **Other Special Clauses:**

26 None

27 **Utah Code Sections Affected:**

28 AMENDS:

29 **26-18-602**, as enacted by Laws of Utah 2011, Chapter 362

30 **26-18-603**, as enacted by Laws of Utah 2011, Chapter 362
31 **26-18-604**, as last amended by Laws of Utah 2013, Chapter 167
32 **26-18-605**, as enacted by Laws of Utah 2011, Chapter 362
33 **63A-13-102**, as renumbered and amended by Laws of Utah 2013, Chapter 12
34 **63A-13-204**, as last amended by Laws of Utah 2013, Chapter 359 and renumbered and
35 amended by Laws of Utah 2013, Chapter 12
36 ENACTS:
37 **26-18-20**, Utah Code Annotated 1953
38

39 *Be it enacted by the Legislature of the state of Utah:*
40 Section 1. Section **26-18-20** is enacted to read:
41 **26-18-20. Review of claims -- Audit and investigation procedures.**
42 (1) (a) The department shall adopt administrative rules in accordance with Title 63G,
43 Chapter 3, Utah Administrative Rulemaking Act, and in consultation with providers and health
44 care professionals subject to audit and investigation under the state Medicaid program, to
45 establish procedures for audits and investigations that are fair and consistent with the duties of
46 the department as the single state agency responsible for the administration of the Medicaid
47 program under Section 26-18-3 and Title XIX of the Social Security Act.
48 (b) If the providers and health care professionals do not agree with the rules proposed
49 or adopted by the department under Subsection (1)(a), the providers or health care
50 professionals may:
51 (i) request a hearing for the proposed administrative rule or seek any other remedies
52 under the provisions of Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and
53 (ii) request a review of the rule by the Legislature's Administrative Rules Review
54 Committee created in Section 63G-3-501.
55 (2) The department shall:
56 (a) notify and educate providers and health care professionals subject to audit and
57 investigation under the Medicaid program of the providers' and health care professionals'

58 responsibilities and rights under the administrative rules adopted by the department under the
59 provisions of this section;
60 (b) ensure that the department, or any entity that contracts with the department to
61 conduct audits:
62 (i) has on staff or contracts with a medical or dental professional who is experienced in
63 the treatment, billing, and coding procedures used by the type of provider being audited; and
64 (ii) uses the services of the appropriate professional described in Subsection (3)(b)(i) if
65 the provider who is the subject of the audit disputes the findings of the audit;
66 (c) ensure that a finding of overpayment or underpayment to a provider is not based on
67 extrapolation, as defined in Section 63A-13-102, unless:
68 (i) there is a determination that the level of payment error involving the provider
69 exceeds a 10% error rate:
70 (A) for a sample of claims for a particular service code; and
71 (B) over a three year period of time;
72 (ii) documented education intervention has failed to correct the level of payment error;
73 and
74 (iii) the value of the claims for the provider, in aggregate, exceeds $200,000 in
75 reimbursement for a particular service code on an annual basis; and
76 (d) require that any entity with which the office contracts, for the purpose of
77 conducting an audit of a service provider, shall be paid on a flat fee basis for identifying both
78 overpayments and underpayments.
79 (3) (a) If the department, or a contractor on behalf of the department:
80 (i) intends to implement the use of extrapolation as a method of auditing claims, the
81 department shall, prior to adopting the extrapolation method of auditing, report its intent to use
82 extrapolation to the Social Services Appropriations Subcommittee; and
83 (ii) determines Subsections (2)(c)(i) through (iii) are applicable to a provider, the
84 department or the contractor may use extrapolation only for the service code associated with
85 the findings under Subsections (2)(c)(i) through (iii).

86 (b) (i) If extrapolation is used under this section, a provider may, at the provider's
87 option, appeal the results of the audit based on:
88 (A) each individual claim; or
89 (B) the extrapolation sample.
90 (ii) Nothing in this section limits a provider's right to appeal the audit under Title 63G,
91 Administrative Code, Title 63G, Chapter 4, Administrative Procedures Act, the Medicaid
92 program and its manual or rules, or other laws or rules that may provide remedies to providers.
93 Section 2. Section **26-18-602** is amended to read:
94 **26-18-602. Definitions.**
95 As used in this part:
96 (1) "Abuse" means:
97 (a) an action or practice that:
98 (i) is inconsistent with sound fiscal, business, or medical practices; and
99 (ii) results, or may result, in unnecessary Medicaid related costs or other medical or
100 hospital assistance costs; or
101 (b) reckless or negligent upcoding.
102 (2) "Auditor's Office" means the Office of Internal Audit [~~and Program Integrity~~],
103 within the department.
104 (3) "Fraud" means intentional or knowing:
105 (a) deception, misrepresentation, or upcoding in relation to Medicaid funds, costs,
106 claims, reimbursement, or practice; or
107 (b) deception or misrepresentation in relation to medical or hospital assistance funds,
108 costs, claims, reimbursement, or practice.
109 (4) "Medical or hospital assistance" is as defined in Section 26-18-2.
110 (5) "Upcoding" means assigning an inaccurate billing code for a service that is payable
111 or reimbursable by Medicaid funds, if the correct billing code for the service, taking into
112 account reasonable opinions derived from official published coding definitions, would result in
113 a lower Medicaid payment or reimbursement.

114 (6) "Waste" means overutilization of resources or inappropriate payment.

115 Section 3. Section **26-18-603** is amended to read:

116 **26-18-603. Adjudicative proceedings related to Medicaid funds.**

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

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

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

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

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

129 (a) the director of the Office of Internal Audit [~~and Program Integrity~~], or the director's
130 designee; and

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

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

136 Section 4. Section **26-18-604** is amended to read:

137 **26-18-604. Division duties -- Reporting.**

138 (1) The division shall:

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

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

142 (ii) payment for goods or services by resubmitting a claim for which:
143 (A) payment has been disallowed on the grounds that payment would be a violation of
144 federal or state law, administrative rule, or the state plan; and
145 (B) the decision to disallow the payment has become final;
146 (iii) payment for goods or services provided after a recipient's death, including payment
147 for pharmaceuticals or long-term care; or
148 (iv) payment for transporting an unborn infant;
149 (b) consult with the Centers for Medicaid and Medicare Services, other states, and the
150 Office of Inspector General [~~for~~] of Medicaid Services[~~, if one is created by statute,~~] to
151 determine and implement best practices for discovering and eliminating fraud, waste, and
152 abuse of Medicaid funds and medical or hospital assistance funds;
153 (c) actively seek repayment from providers for improperly used or paid:
154 (i) Medicaid funds; and
155 (ii) medical or hospital assistance funds;
156 (d) coordinate, track, and keep records of all division efforts to obtain repayment of the
157 funds described in Subsection (1)(c), and the results of those efforts;
158 (e) keep Medicaid pharmaceutical costs as low as possible by actively seeking to obtain
159 pharmaceuticals at the lowest price possible, including, on a quarterly basis for the
160 pharmaceuticals that represent the highest 45% of state Medicaid expenditures for
161 pharmaceuticals and on an annual basis for the remaining pharmaceuticals:
162 (i) tracking changes in the price of pharmaceuticals;
163 (ii) checking the availability and price of generic drugs;
164 (iii) reviewing and updating the state's maximum allowable cost list; and
165 (iv) comparing pharmaceutical costs of the state Medicaid program to available
166 pharmacy price lists; and
167 (f) provide training, on an annual basis, to the employees of the division who make
168 decisions on billing codes, or who are in the best position to observe and identify upcoding, in
169 order to avoid and detect upcoding.

170 (2) Each year, the division shall report the following to the Social Services
171 Appropriations Subcommittee:
172 (a) incidents of improperly used or paid Medicaid funds and medical or hospital
173 assistance funds;
174 (b) division efforts to obtain repayment from providers of the funds described in
175 Subsection (2)(a);
176 (c) all repayments made of funds described in Subsection (2)(a), including the total
177 amount recovered; and
178 (d) the division's compliance with the recommendations made in the December 2010
179 Performance Audit of Utah Medicaid Provider Cost Control published by the Office of
180 Legislative Auditor General.
181 Section 5. Section **26-18-605** is amended to read:
182 **26-18-605. Utah Office of Internal Audit.**
183 The Utah Office of Internal Audit [~~and Program Integrity~~]:
184 (1) may not be placed within the division;
185 (2) shall be placed directly under, and report directly to, the executive director of the
186 Department of Health; and
187 (3) shall have full access to all records of the division.
188 Section 6. Section **63A-13-102** is amended to read:
189 **63A-13-102. Definitions.**
190 As used in this chapter:
191 (1) "Abuse" means:
192 (a) an action or practice that:
193 (i) is inconsistent with sound fiscal, business, or medical practices; and
194 (ii) results, or may result, in unnecessary Medicaid related costs; or
195 (b) reckless or negligent upcoding.
196 (2) "Claimant" means a person that:
197 (a) provides a service; and

198 (b) submits a claim for Medicaid reimbursement for the service.
199 (3) "Department" means the Department of Health, created in Section 26-1-4.
200 (4) "Division" means the Division of Health Care Financing, created in Section
201 26-18-2.1.
202 (5) "Extrapolation" means a method of using a mathematical formula that takes the
203 audit results from a small sample of Medicaid claims and projects those results over a much
204 larger group of Medicaid claims.
205 [~~(5)~~] (6) "Fraud" means intentional or knowing:
206 (a) deception, misrepresentation, or upcoding in relation to Medicaid funds, costs, a
207 claim, reimbursement, or services; or
208 (b) a violation of a provision of Sections 26-20-3 through 26-20-7.
209 [~~(6)~~] (7) "Fraud unit" means the Medicaid Fraud Control Unit of the attorney general's
210 office.
211 [~~(7)~~] (8) "Health care professional" means a person licensed under:
212 (a) Title 58, Chapter 5a, Podiatric Physician Licensing Act;
213 (b) Title 58, Chapter 16a, Utah Optometry Practice Act;
214 (c) Title 58, Chapter 17b, Pharmacy Practice Act;
215 (d) Title 58, Chapter 24b, Physical Therapy Practice Act;
216 (e) Title 58, Chapter 31b, Nurse Practice Act;
217 (f) Title 58, Chapter 40, Recreational Therapy Practice Act;
218 (g) Title 58, Chapter 41, Speech-Language Pathology and Audiology Licensing Act;
219 (h) Title 58, Chapter 42a, Occupational Therapy Practice Act;
220 (i) Title 58, Chapter 44a, Nurse Midwife Practice Act;
221 (j) Title 58, Chapter 49, Dietitian Certification Act;
222 (k) Title 58, Chapter 60, Mental Health Professional Practice Act;
223 (l) Title 58, Chapter 67, Utah Medical Practice Act;
224 (m) Title 58, Chapter 68, Utah Osteopathic Medical Practice Act;
225 (n) Title 58, Chapter 69, Dentist and Dental Hygienist Practice Act;

226 (o) Title 58, Chapter 70a, Physician Assistant Act; and
227 (p) Title 58, Chapter 73, Chiropractic Physician Practice Act.
228 [(8)] (9) "Inspector general" means the inspector general of the office, appointed under
229 Section 63A-13-201.
230 [(9)] (10) "Office" means the Office of Inspector General of Medicaid Services, created
231 in Section 63A-13-201.
232 [(10)] (11) "Provider" means a person that provides:
233 (a) medical assistance, including supplies or services, in exchange, directly or
234 indirectly, for Medicaid funds; or
235 (b) billing or recordkeeping services relating to Medicaid funds.
236 [(11)] (12) "Upcoding" means assigning an inaccurate billing code for a service that is
237 payable or reimbursable by Medicaid funds, if the correct billing code for the service, taking
238 into account reasonable opinions derived from official published coding definitions, would
239 result in a lower Medicaid payment or reimbursement.
240 [(12)] (13) "Waste" means overutilization of resources or inappropriate payment.
241 Section 7. Section **63A-13-204** is amended to read:
242 **63A-13-204. Selection and review of claims.**
243 (1) (a) The office shall periodically select and review a representative sample of claims
244 submitted for reimbursement under the state Medicaid program to determine whether fraud,
245 waste, or abuse occurred.
246 (b) The office shall limit its review for waste and abuse under Subsection (1)(a) to 36
247 months prior to the date of the inception of the investigation or 72 months if there is a credible
248 allegation of fraud. In the event the office or the fraud unit determines that there is fraud as
249 defined in [Subsection] Section 63A-13-102[(5)], then the statute of limitations defined in
250 Subsection 26-20-15(1) shall apply.
251 (2) The office may directly contact the recipient of record for a Medicaid reimbursed
252 service to determine whether the service for which reimbursement was claimed was actually
253 provided to the recipient of record.

254 (3) The office shall:

255 (a) generate statistics from the sample described in Subsection (1) to determine the

256 type of fraud, waste, or abuse that is most advantageous to focus on in future audits or

257 investigations[.];

258 (b) ensure that the office, or any entity that contracts with the office to conduct audits:

259 (i) has on staff or contracts with a medical or dental professional who is experienced in

260 the treatment, billing, and coding procedures used by the type of provider being audited; and

261 (ii) uses the services of the appropriate professional described in Subsection (3)(b)(i) if

262 the provider who is the subject of the audit disputes the findings of the audit;

263 (c) ensure that a finding of overpayment or underpayment to a provider is not based on

264 extrapolation, unless:

265 (i) there is a determination that the level of payment error involving the provider

266 exceeds a 10% error rate:

267 (A) for a sample of claims for a particular service code; and

268 (B) over a three year period of time;

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

270 and

271 (iii) the value of the claims for the provider, in aggregate, exceeds $200,000 in

272 reimbursement for a particular service code on an annual basis; and

273 (d) require that any entity with which the office contracts, for the purpose of

274 conducting an audit of a service provider, shall be paid on a flat fee basis for identifying both

275 overpayments and underpayments.

276 (4) (a) If the office, or a contractor on behalf of the department:

277 (i) intends to implement the use of extrapolation as a method of auditing claims, the

278 department shall, prior to adopting the extrapolation method of auditing, report its intent to use

279 extrapolation to:

280 (A) the Social Services Appropriations Subcommittee; and

281 (B) the Executive Appropriations Committee pursuant to Section 63A-13-502; and

282 (ii) determines Subsections (2)(c)(i) through (iii) are applicable to a provider, the office
283 or the contractor may use extrapolation only for the service code associated with the findings
284 under Subsections (2)(c)(i) through (iii).
285 (b) (i) If extrapolation is used under this section, a provider may, at the provider's
286 option, appeal the results of the audit based on:
287 (A) each individual claim; or
288 (B) the extrapolation sample.
289 (ii) Nothing in this section limits a provider's right to appeal the audit under Title 63G,
290 Administrative Code, Title 63G, Chapter 4, Administrative Procedures Act, the Medicaid
291 program and its manual or rules, or other laws or rules that may provide remedies to providers.