Senator Lyle W. Hillyard proposes the following substitute bill:

1 # MEDICAID AUDIT AMENDMENTS

2 2015 GENERAL SESSION

3 STATE OF UTAH

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

5 House Sponsor: Edward H. Redd

6

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, has on staff a medical or dental professional who is experienced in the
62 treatment, billing, and coding procedures used by the type of provider being audited;
63 (c) ensure that a finding of overpayment or underpayment to a provider is not based on
64 extrapolation, unless:
65 (i) there is a determination that the level of payment error involving the provider
66 exceeds a 10% error rate:
67 (A) for a sample of claims for a particular service code; and
68 (B) over a three year period of time;
69 (ii) documented education intervention has failed to correct the level of payment error;
70 and
71 (iii) the value of the claims for the provider, in aggregate, exceeds $200,000 in
72 reimbursement for a particular service code on an annual basis; and
73 (d) require that any entity with which the office contracts, for the purpose of
74 conducting an audit of a service provider, shall be paid on a flat fee basis for identifying both
75 overpayments and underpayments.
76 (3) If the department, or a contractor on behalf of the department:
77 (a) intends to implement the use of extrapolation as a method of auditing claims, the
78 department shall, prior to adopting the extrapolation method of auditing, report its intent to use
79 extrapolation to the Social Services Appropriations Subcommittee; and
80 (b) determines Subsections (2)(c)(i) through (iii) are applicable to a provider, the
81 department or the contractor may use extrapolation only for the service code associated with
82 the findings under Subsections (2)(c)(i) through (iii).
83 Section 2. Section **26-18-602** is amended to read:
84 **26-18-602. Definitions.**
85 As used in this part:
86 (1) "Abuse" means:
87 (a) an action or practice that:

88 (i) is inconsistent with sound fiscal, business, or medical practices; and
89 (ii) results, or may result, in unnecessary Medicaid related costs or other medical or
90 hospital assistance costs; or
91 (b) reckless or negligent upcoding.
92 (2) "Auditor's Office" means the Office of Internal Audit [~~and Program Integrity~~],
93 within the department.
94 (3) "Fraud" means intentional or knowing:
95 (a) deception, misrepresentation, or upcoding in relation to Medicaid funds, costs,
96 claims, reimbursement, or practice; or
97 (b) deception or misrepresentation in relation to medical or hospital assistance funds,
98 costs, claims, reimbursement, or practice.
99 (4) "Medical or hospital assistance" is as defined in Section 26-18-2.
100 (5) "Upcoding" means assigning an inaccurate billing code for a service that is payable
101 or reimbursable by Medicaid funds, if the correct billing code for the service, taking into
102 account reasonable opinions derived from official published coding definitions, would result in
103 a lower Medicaid payment or reimbursement.
104 (6) "Waste" means overutilization of resources or inappropriate payment.
105 Section 3. Section **26-18-603** is amended to read:
106 **26-18-603. Adjudicative proceedings related to Medicaid funds.**
107 (1) If a proceeding of the department, under Title 63G, Chapter 4, Administrative
108 Procedures Act, relates in any way to recovery of Medicaid funds:
109 (a) the presiding officer shall be designated by the executive director of the department
110 and report directly to the executive director or, in the discretion of the executive director, report
111 directly to the director of the Office of Internal Audit [~~and Program Integrity~~]; and
112 (b) the decision of the presiding officer is the recommended decision to the executive
113 director of the department or a designee of the executive director who is not in the division.
114 (2) Subsection (1) does not apply to hearings conducted by the Department of
115 Workforce Services relating to medical assistance eligibility determinations.
116 (3) If a proceeding of the department, under Title 63G, Chapter 4, Administrative
117 Procedures Act, relates in any way to Medicaid or Medicaid funds, the following may attend
118 and present evidence or testimony at the proceeding:

119 (a) the director of the Office of Internal Audit [~~and Program Integrity~~], or the director's
120 designee; and
121 (b) the inspector general of Medicaid services[~~, if an Office of Inspector General of~~
122 ~~Medicaid Services is created by statute,~~] or the inspector general's designee.
123 (4) In relation to a proceeding of the department under Title 63G, Chapter 4,
124 Administrative Procedures Act, a person may not, outside of the actual proceeding, attempt to
125 influence the decision of the presiding officer.
126 Section 4. Section **26-18-604** is amended to read:
127 **26-18-604. Division duties -- Reporting.**
128 (1) The division shall:
129 (a) develop and implement procedures relating to Medicaid funds and medical or
130 hospital assistance funds to ensure that providers do not receive:
131 (i) duplicate payments for the same goods or services;
132 (ii) payment for goods or services by resubmitting a claim for which:
133 (A) payment has been disallowed on the grounds that payment would be a violation of
134 federal or state law, administrative rule, or the state plan; and
135 (B) the decision to disallow the payment has become final;
136 (iii) payment for goods or services provided after a recipient's death, including payment
137 for pharmaceuticals or long-term care; or
138 (iv) payment for transporting an unborn infant;
139 (b) consult with the Centers for Medicaid and Medicare Services, other states, and the
140 Office of Inspector General [~~for~~] <u>of</u> Medicaid Services[~~, if one is created by statute,~~] to
141 determine and implement best practices for discovering and eliminating fraud, waste, and
142 abuse of Medicaid funds and medical or hospital assistance funds;
143 (c) actively seek repayment from providers for improperly used or paid:
144 (i) Medicaid funds; and
145 (ii) medical or hospital assistance funds;
146 (d) coordinate, track, and keep records of all division efforts to obtain repayment of the
147 funds described in Subsection (1)(c), and the results of those efforts;
148 (e) keep Medicaid pharmaceutical costs as low as possible by actively seeking to obtain
149 pharmaceuticals at the lowest price possible, including, on a quarterly basis for the

150 pharmaceuticals that represent the highest 45% of state Medicaid expenditures for
151 pharmaceuticals and on an annual basis for the remaining pharmaceuticals:
152 (i) tracking changes in the price of pharmaceuticals;
153 (ii) checking the availability and price of generic drugs;
154 (iii) reviewing and updating the state's maximum allowable cost list; and
155 (iv) comparing pharmaceutical costs of the state Medicaid program to available
156 pharmacy price lists; and
157 (f) provide training, on an annual basis, to the employees of the division who make
158 decisions on billing codes, or who are in the best position to observe and identify upcoding, in
159 order to avoid and detect upcoding.
160 (2) Each year, the division shall report the following to the Social Services
161 Appropriations Subcommittee:
162 (a) incidents of improperly used or paid Medicaid funds and medical or hospital
163 assistance funds;
164 (b) division efforts to obtain repayment from providers of the funds described in
165 Subsection (2)(a);
166 (c) all repayments made of funds described in Subsection (2)(a), including the total
167 amount recovered; and
168 (d) the division's compliance with the recommendations made in the December 2010
169 Performance Audit of Utah Medicaid Provider Cost Control published by the Office of
170 Legislative Auditor General.
171 Section 5. Section **26-18-605** is amended to read:
172 **26-18-605. Utah Office of Internal Audit.**
173 The Utah Office of Internal Audit [~~and Program Integrity~~]:
174 (1) may not be placed within the division;
175 (2) shall be placed directly under, and report directly to, the executive director of the
176 Department of Health; and
177 (3) shall have full access to all records of the division.
178 Section 6. Section **63A-13-102** is amended to read:
179 **63A-13-102. Definitions.**
180 As used in this chapter:

181 (1) "Abuse" means:
182 (a) an action or practice that:
183 (i) is inconsistent with sound fiscal, business, or medical practices; and
184 (ii) results, or may result, in unnecessary Medicaid related costs; or
185 (b) reckless or negligent upcoding.
186 (2) "Claimant" means a person that:
187 (a) provides a service; and
188 (b) submits a claim for Medicaid reimbursement for the service.
189 (3) "Department" means the Department of Health, created in Section 26-1-4.
190 (4) "Division" means the Division of Health Care Financing, created in Section
191 26-18-2.1.
192 (5) "Extrapolation" means a method of using a mathematical formula that takes the
193 audit results from a small sample of Medicaid claims and projects those results over a much
194 larger group of Medicaid claims.
195 [~~(5)~~] (6) "Fraud" means intentional or knowing:
196 (a) deception, misrepresentation, or upcoding in relation to Medicaid funds, costs, a
197 claim, reimbursement, or services; or
198 (b) a violation of a provision of Sections 26-20-3 through 26-20-7.
199 [~~(6)~~] (7) "Fraud unit" means the Medicaid Fraud Control Unit of the attorney general's
200 office.
201 [~~(7)~~] (8) "Health care professional" means a person licensed under:
202 (a) Title 58, Chapter 5a, Podiatric Physician Licensing Act;
203 (b) Title 58, Chapter 16a, Utah Optometry Practice Act;
204 (c) Title 58, Chapter 17b, Pharmacy Practice Act;
205 (d) Title 58, Chapter 24b, Physical Therapy Practice Act;
206 (e) Title 58, Chapter 31b, Nurse Practice Act;
207 (f) Title 58, Chapter 40, Recreational Therapy Practice Act;
208 (g) Title 58, Chapter 41, Speech-Language Pathology and Audiology Licensing Act;
209 (h) Title 58, Chapter 42a, Occupational Therapy Practice Act;
210 (i) Title 58, Chapter 44a, Nurse Midwife Practice Act;
211 (j) Title 58, Chapter 49, Dietitian Certification Act;

212 (k) Title 58, Chapter 60, Mental Health Professional Practice Act;
213 (l) Title 58, Chapter 67, Utah Medical Practice Act;
214 (m) Title 58, Chapter 68, Utah Osteopathic Medical Practice Act;
215 (n) Title 58, Chapter 69, Dentist and Dental Hygienist Practice Act;
216 (o) Title 58, Chapter 70a, Physician Assistant Act; and
217 (p) Title 58, Chapter 73, Chiropractic Physician Practice Act.
218 [~~(8)~~] (9) "Inspector general" means the inspector general of the office, appointed under
219 Section 63A-13-201.
220 [~~(9)~~] (10) "Office" means the Office of Inspector General of Medicaid Services, created
221 in Section 63A-13-201.
222 [~~(10)~~] (11) "Provider" means a person that provides:
223 (a) medical assistance, including supplies or services, in exchange, directly or
224 indirectly, for Medicaid funds; or
225 (b) billing or recordkeeping services relating to Medicaid funds.
226 [~~(11)~~] (12) "Upcoding" means assigning an inaccurate billing code for a service that is
227 payable or reimbursable by Medicaid funds, if the correct billing code for the service, taking
228 into account reasonable opinions derived from official published coding definitions, would
229 result in a lower Medicaid payment or reimbursement.
230 [~~(12)~~] (13) "Waste" means overutilization of resources or inappropriate payment.
231 Section 7. Section **63A-13-204** is amended to read:
232 **63A-13-204. Selection and review of claims.**
233 (1) (a) The office shall periodically select and review a representative sample of claims
234 submitted for reimbursement under the state Medicaid program to determine whether fraud,
235 waste, or abuse occurred.
236 (b) The office shall limit its review for waste and abuse under Subsection (1)(a) to 36
237 months prior to the date of the inception of the investigation or 72 months if there is a credible
238 allegation of fraud. In the event the office or the fraud unit determines that there is fraud as
239 defined in [~~Subsection~~] Section 63A-13-102[~~(5)~~], then the statute of limitations defined in
240 Subsection 26-20-15(1) shall apply.
241 (2) The office may directly contact the recipient of record for a Medicaid reimbursed
242 service to determine whether the service for which reimbursement was claimed was actually

243 provided to the recipient of record.
244 (3) The office shall:
245 (a) generate statistics from the sample described in Subsection (1) to determine the
246 type of fraud, waste, or abuse that is most advantageous to focus on in future audits or
247 investigations[.];
248 (b) ensure that the office, or any entity that contracts with the office to conduct audits,
249 has on staff a medical or dental professional who is experienced in the treatment, billing, and
250 coding procedures used by the type of provider being audited;
251 (c) ensure that a finding of overpayment or underpayment to a provider is not based on
252 extrapolation, unless:
253 (i) there is a determination that the level of payment error involving the provider
254 exceeds a 10% error rate:
255 (A) for a sample of claims for a particular service code; and
256 (B) over a three year period of time;
257 (ii) documented education intervention has failed to correct the level of payment error;
258 and
259 (iii) the value of the claims for the provider, in aggregate, exceeds $200,000 in
260 reimbursement for a particular service code on an annual basis; and
261 (d) require that any entity with which the office contracts, for the purpose of
262 conducting an audit of a service provider, shall be paid on a flat fee basis for identifying both
263 overpayments and underpayments.
264 (4) If the office, or a contractor on behalf of the department:
265 (a) intends to implement the use of extrapolation as a method of auditing claims, the
266 department shall, prior to adopting the extrapolation method of auditing, report its intent to use
267 extrapolation to:
268 (i) the Social Services Appropriations Subcommittee; and
269 (ii) the Executive Appropriations Committee pursuant to Section 63A-13-502; and
270 (b) determines Subsections (2)(c)(i) through (iii) are applicable to a provider, the office
271 or the contractor may use extrapolation only for the service code associated with the findings
272 under Subsections (2)(c)(i) through (iii).