H-1743.3

SUBSTITUTE HOUSE BILL 1314

State of Washington 65th Legislature 2017 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Caldier, Jinkins, DeBolt, Cody, Rodne, Griffey, Harris, Haler, and Appleton)

READ FIRST TIME 02/17/17.

AN ACT Relating to health care authority auditing practices; and adding a new section to chapter 74.09 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** A new section is added to chapter 74.09 RCW to read as follows:

(1) Audits of the records of health care providers performed under this chapter are subject to the following:

(a) The authority must provide at least thirty calendar days' notice before scheduling any on-site audit, unless there is evidence of danger to public health and safety or fraudulent activities;

(b) The authority must make a good faith effort to establish a mutually agreed upon time and date for the on-site audit;

(c) The authority must allow providers, at their request, to submit records requested as a result of an audit in electronic format, including compact disc, digital versatile disc, or other electronic formats deemed appropriate by the authority, or by facsimile transmission;

(d) The authority shall make reasonable efforts to avoid reviewing claims that are currently being audited by the authority, that have already been audited by the authority, or that are currently being audited by another entity;

(e) A finding of overpayment to a provider in a program operated or administered by the authority may not be based on extrapolation unless there is a determination of sustained high level of payment error involving the provider or when documented educational intervention has failed to correct the level of payment error. Any finding that is based upon extrapolation, and the related sampling, must be established to be statistically fair and reasonable in order to be valid. The sampling methodology used must be validated by a statistician or person with equivalent experience as having a confidence level of ninety-five percent or greater;

(f) The authority must 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 shall, at a minimum, include the following: (i) The reason for the adverse determination; (ii) the specific criteria on which the adverse determination was based; (iii) an explanation of the provider's appeal rights; and (iv) if applicable, the appropriate procedure to submit a claims adjustment in accordance with subsection (3) of this section;

(g) The authority may not recoup overpayments until all informal and formal appeals processes have been completed;

(h) The authority must offer a provider with an adverse determination the option of repaying the amount owed according to a negotiated repayment plan of up to twelve months;

(i) The authority must produce a preliminary report or draft audit findings within one hundred twenty days from the receipt of all requested information as identified in writing by the authority; and

(j) In the event that the authority seeks to recoup funds from a provider who is no longer a contractor with the medical assistance program, the authority must provide a description of the claim, including the patient name, date of service, and procedure. A provider is not required to obtain a court order to receive such information.

(2) Any contractor that conducts audits of the medical assistance program on behalf of the authority must comply with the requirements in this subsection and must:

(a) In any appeal by a health care provider, employ or contract with a medical or dental professional who practices within the same specialty, is board certified, and experienced in the treatment,

billing, and coding procedures used by the provider being audited to make findings and determinations;

(b) Compile, on an annual basis, metrics specified by the authority. The authority shall publish the metrics on its web site. The metrics must, at a minimum, include:

(i) The number and type of claims reviewed;

(ii) The number of records requested;

(iii) The number of overpayments and underpayments identified by the contractor;

(iv) The aggregate dollar amount associated with identified overpayments and underpayments;

(v) The duration of audits from initiation until time of completion;

(vi) The number of adverse determinations and the overturn rates of those determinations at each stage of the informal and formal appeal process;

(vii) The number of informal and formal appeals filed by providers categorized by disposition status;

(viii) The contractor's compensation structure and dollar amount of compensation; and

(ix) A copy of the authority's contract with the contractor.

(3) The authority shall develop and implement a procedure by which an improper payment identified by an audit may be resubmitted as a claims adjustment.

(4) The authority shall provide educational and training programs annually for providers. The training topics must include a summary of audit results, a description of common issues, problems and mistakes identified through audits and reviews, and opportunities for improvement.

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