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HOUSE BILL 1314

State of Washington 65th Legislature 2017 Regular Session

By Representatives Caldier, Jinkins, DeBolt, Cody, Rodne, Griffey, Harris, Haler, and Appleton

Read first time 01/17/17. Referred to Committee on Health Care & Wellness.

AN ACT Relating to health care authority auditing practices; reenacting and amending RCW 74.09.215; 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 and its contractors may not perform an audit of a health care provider within three years of the federal government conducting an audit of that health care provider. This prohibition applies whether the federal government conducts the audit directly or through a contractor, including the authority acting as a contractor;

(b) The authority and its contractors must provide at least thirty business days' notice before scheduling any on-site audit and make a good faith effort to establish a mutually agreed-upon time and date for the on-site audit;

(c) The authority and its contractors 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 and its contractors may not review claims:

(i) That are more than three years from the date of their initial payment;

(ii) Processed or paid through a capitated medicaid managed care program; or

(iii) That are currently being audited by the authority or one of its contractors, that have already been audited by the authority or one of its contractors, or that are currently being audited by another entity;

(e) The authority and its contractors may not recover payments in a medical necessity review in which the provider has obtained prior authorization for the service and the service was performed as authorized;

(f)(i) If the authority or a contractor performs an audit using an algorithm to conduct probability sampling, extrapolation, or other means that project an error, the authority may not use the same algorithm that was the basis of a previous audit performed by the federal government, directly or through a contractor;

(ii) 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 and 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;

(g) Technical deficiencies may not be the basis for finding an overpayment if the health care provider can substantiate through documentation that the claim for services complies with all of the elements of an allowable cost;

(h) Clerical errors, including recordkeeping, typographical errors, scrivener's errors, or computer errors, discovered in a record or document produced for an audit do not constitute a willful violation of medical assistance standards, unless proof of intent to commit fraud or otherwise violate program rules is established;

(i) Once an initial audit review phase has been completed, the authority and its contractors shall notify the health care provider who was the subject of the audit of the findings within ten days of completion. An initial audit review phase must be considered complete once the auditing entity has concluded its analysis of audit data and decided to either issue a report with findings of noncompliance or cease further review activity and determine the health care provider to be compliant with program standards;

(j) The authority and its contractors must produce a preliminary report within forty-five days of receiving all requested materials and a final written report concluding an audit within sixty days of completion of the initial review phase;

(k) The authority and its contractors 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;

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

(m) The authority and its contractors must offer a provider with an adverse determination the option of repaying the amount owed according to a reasonable repayment plan; and

(n) In the event that the authority or a contractor seeks to recoup funds from a provider who is no longer a contractor with the medical assistance program, the authority or contractor 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:

(a) 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 establish audit methodology consistent with established practice guidelines, standards of care, and state issued medical assistance program provider guides;

(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, in conjunction with its contractors, 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.

(5) For the purposes of this section:

(a) "Contractor" means a medicaid managed care contractor selected by the authority to perform audits for the purpose of ensuring medicaid program integrity in accordance with the provisions of 42 C.F.R. 455 et seq.

(b) "Technical deficiency" means an omission in documentation by a health care provider that does not affect direct patient care of, or receipt of services by, the recipient, or affects any elements of an allowable cost. In order for cost to be allowable, the medical cost must be: (i) Covered by the state plan and waivers; (ii) supported by the medical records indicating that the service was provided and consistent with the medical order or condition; and (iii) paid at the rate allowed by the state plan. "Technical

deficiency" does not include fraud, a pattern of abusive billing or noncompliance, or a gross or flagrant violation.

Sec. 2. RCW 74.09.215 and 2013 2nd sp.s. c 4 s 1902, 2013 2nd sp.s. c 4 s 997, and 2013 2nd sp.s. c 4 s 995 are each reenacted and amended to read as follows:

The medicaid fraud penalty account is created in the state treasury. All receipts from civil penalties collected under RCW 74.09.210, all receipts received under judgments or settlements that originated under a filing under the federal false claims act, and all receipts received under judgments or settlements that originated under the state medicaid fraud false claims act, chapter 74.66 RCW, must be deposited into the account. Moneys in the account may be spent only after appropriation and must be used only for medicaid services, fraud detection and prevention activities, recovery of improper payments, for other medicaid fraud enforcement activities, and the prescription monitoring program established in chapter 70.225 RCW. No moneys in the account may be disbursed to the health care authority. For the 2013-2015 fiscal biennium, moneys in the account may be spent on inpatient and outpatient rebasing and conversion to the tenth version of the international classification of diseases. For the 2011-2013 fiscal biennium, moneys in the account may be spent on inpatient and outpatient rebasing.

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