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AMENDMENTS TO LB315

Introduced by Health and Human Services.

1. Strike the original sections and insert the following new sections:

Section 1. Section 68-974, Revised Statutes Cumulative Supplement, 2014, is amended to read:

68-974 (1) The department shall contract with one or more recovery audit contractors to promote the integrity of the medical assistance program and to assist with cost-containment efforts and recovery audits. The contract or contracts shall include services for (a) cost-avoidance through identification of third-party liability, (b) cost recovery of third-party liability through postpayment reimbursement, (c) casualty recovery of payments by identifying and recovering costs for claims that were the result of an accident or neglect and payable by a casualty insurer, and (d) reviews of claims submitted by providers of services or other individuals furnishing items and services for which payment has been made to determine whether providers have been underpaid or overpaid, and to take actions to recover any overpayments identified or make payment for any underpayment identified.

(2) Notwithstanding any other provision of law, all recovery audit contractors retained by the department when conducting a recovery audit shall:

(a) Review claims within two years from the date of the payment;

(b) Send a determination letter concluding an audit within sixty days after receipt of all requested material from a provider;

(c) In any records request to a provider, furnish information sufficient for the provider to identify the patient, procedure, or location;

(d) Develop and implement with the department a procedure in which

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an improper payment identified by an audit is permitted to be rebilled as a corrected claim;

(e) Utilize a licensed health care professional from the area of practice being audited to establish relevant audit methodology consistent with established practice guidelines, standards of care, and state-issued medicaid provider handbooks;

(f) Provide a written notification and explanation of an adverse determination that includes the reason for the adverse determination, the medical criteria on which the adverse determination was based, an explanation of the provider's appeal rights, and, if applicable, an explanation of the appropriate procedure to rebill in accordance with subdivision (2)(d) of this section; and

(g) Schedule any onsite audits with advance notice of not less than ten business days and make a good faith effort to establish a mutually agreed upon time and date for the onsite audit.

(3) The department shall exclude the following from the scope of review of recovery audit contractors: (a) Claims processed or paid through a capitated medicaid managed care program; (b) medical necessity reviews in which the provider has obtained prior authorization for the service and in which the authorized service was provided; and (c) any claims that are currently being audited or that have already been audited by the recovery audit contractor or by another entity.

(4 ~~2~~) The department shall contract with one or more persons to support a health insurance premium assistance payment program.

(5 ~~3~~) The department may enter into any other contracts deemed to increase the efforts to promote the integrity of the medical assistance program.

(6 ~~4~~) Contracts entered into under the authority of this section may be on a contingent fee basis. Contracts entered into on a contingent fee basis shall provide that contingent fee payments are based upon amounts recovered, not amounts identified~~, and that contingent fee payments are~~

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~~not to be paid on amounts subsequently repaid due to determinations made in appeal proceedings~~. Whether the contract is a contingent fee contract or otherwise, the contractor shall not recover overpayments by the department until all appeals have been completed unless there is a credible allegation of fraudulent activity by the provider, the contractor has referred the claims to the department for investigation, and an investigation has commenced. In that event, the contractor may recover overpayment prior to the conclusion of the appeals process. In any contract between the department and a recovery audit contractor, the payment or fee provided for identification of overpayments shall be the same provided for identification of underpayments. Contracts shall be in compliance with federal law and regulations when pertinent, including a limit on contingent fees of no more than twelve and one-half percent of amounts recovered, and initial contracts shall be entered into as soon as practicable under such federal law and regulations.

(7 ~~5~~) All amounts recovered and savings generated as a result of this section shall be returned to the medical assistance program.

(8) Records requests made by a recovery audit contractor in any one-hundred-eighty-day period shall be limited to not more than five percent of the number of claims filed by the provider for the specific service being reviewed, not to exceed two hundred records. The contractor shall allow a provider no less than forty-five days to respond to and comply with a record request. If the contractor can demonstrate a significant provider error rate relative to an audit of records, the contractor may make a request to the department to initiate an additional records request regarding the subject under review for the purpose of further review and validation. The contractor shall not make the request until the time period for the appeals process has expired and the provider given the opportunity to contest to the department the second records request.

(9) On an annual basis, the department shall require the recovery

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audit contractor to compile and publish on the department's Internet web site metrics related to the performance of each recovery audit contractor. Such metrics shall include: (a) The number and type of issues reviewed; (b) the number of medical records requested; (c) the number of overpayments and the aggregate dollar amounts associated with the overpayments identified by the contractor; (d) the number of underpayments and the aggregate dollar amounts associated with the identified underpayments; (e) the duration of audits from initiation to time of completion; (f) the number of adverse determinations and the overturn rating of those determinations in the appeal process; (g) the number of appeals filed by providers and the disposition status of such appeals; (h) the contractor’s compensation structure and dollar amount of compensation; and (i) a copy of the department’s contract with the recovery audit contractor.

(10) The recovery audit contractor, in conjunction with the department, shall perform educational and training programs annually for providers that encompass a summary of audit results, description of common issues, problems, and mistakes identified through audits and reviews, and a discussion of opportunities for improvement in provider performance with respect to claims, billing, and documentation.

(11) Providers shall be allowed to submit records requested as a result of an audit in electronic format which shall include either compact disc or digital versatile disc or via facsimile transmission, at the request of the provider.

(12)(a) A provider shall have the right to appeal a determination made by the recovery audit contractor.

(b) The contractor shall establish an informal consultation process. Within thirty days after receipt of notification of an adverse determination from the contractor, the provider may request an informal consultation with the contractor and the Medicaid Program Integrity Unit of the Division of Medicaid and Long-Term Care of the department to

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discuss and attempt to resolve the findings or portion of such findings in the adverse determination letter. The request shall be made to the contractor. The consultation shall occur within thirty days after the provider's request for informal consultation.

(c) Within thirty days after an informal consultation, or within thirty days after notification of a final decision or an adverse determination if no informal consultation is requested, a provider may request an administrative appeal of the final decision or adverse determination as set forth in the Administrative Procedure Act.

(13 ~~6~~) The department shall by December 1 of each year ~~, 2012,~~ report to the Legislature the status of the contracts, including the parties, the programs and issues addressed, the estimated cost recovery, and the savings accrued as a result of the contracts. Such report shall be filed electronically.

(14 ~~7~~) For purposes of this section:

(a) Adverse determination means any decision rendered by the recovery audit contractor that results in a payment to a provider for a claim for service being reduced or rescinded;

(b ~~a~~) Person means bodies politic and corporate, societies, communities, the public generally, individuals, partnerships, limited liability companies, joint-stock companies, and associations; and

(c ~~b~~) Recovery audit contractor means private entities with which the department contracts to audit claims for medical assistance, identify underpayments and overpayments, and recoup overpayments.

Sec. 2. Original section 68-974, Revised Statutes Cumulative Supplement, 2014, is repealed.