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LEGISLATURE OF NEBRASKA

ONE HUNDRED FOURTH LEGISLATURE

FIRST SESSION

LEGISLATIVE BILL 315

Introduced by Howard, 9; Kolterman, 24.

Read first time January 15, 2015

Committee: Health and Human Services

A BILL FOR AN ACT relating to the Medical Assistance Act; to amend section 68-974, Revised Statutes Cumulative Supplement, 2014; to change and add provisions relating to recovery audit contractors; to harmonize provisions; and to repeal the original section.

Be it enacted by the people of the State of Nebraska,

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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 three years after the date of initial payment;

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

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

(d) Develop and implement a process to ensure that providers receive or retain an appropriate reimbursement amount for claims, within the three-year period set forth in subdivision (2)(a) of this section, in which the contractor determines that services or products delivered have been improperly billed but were reasonably necessary;

(e) Utilize a licensed health care professional from the area of

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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 reimbursement determined 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; and (b) medical necessity reviews in which the provider has obtained prior authorization for the service. If an adverse determination is made regarding the billing for a procedure or service that has been consistently utilized by providers for more than five years immediately prior to the audit, no retroactive payment may be enforced.

(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 not to be paid on amounts subsequently repaid due to determinations made in appeal proceedings~~. Whether the contract is a contingent fee contract

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or otherwise, the contractor shall not recover overpayments by the department until all informal and formal appeals have been completed unless the contractor has a good faith reason to suspect fraudulent activity by the provider, 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 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 informal 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 audit contractor to compile and publish on the department's Internet web site metrics related to the performance of each recovery audit

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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 underpayments identified by the contractor; (d) the aggregate dollar amounts associated with identified overpayments and 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 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. If a provider is required to reproduce records manually because no electronic format is available or because the contractor requests a nonelectronic format, the contractor shall make reasonable efforts to reimburse the provider for the cost of reproducing the records.

(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 appeals process. Following receipt of an initial findings letter by the contractor, the provider and contractor may engage in an informal discussion and consultation relating to the reasons for the letter. Within forty-five days after receipt of a notification of an adverse determination from the contractor, a provider may request an informal hearing of such findings,

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or portion of such findings, with the contractor and the Medicaid Program Integrity Unit of the Division of Medicaid and Long-Term Care of the department by submitting such request in writing to the contractor. The informal hearing shall occur within thirty days after the provider's request. The contractor and the unit shall issue a final decision related to the informal appeal to the provider within thirty days after the final determination of the appeal.

(c) Within thirty days after issuance of a final decision or determination pursuant to an informal appeal, a provider may request an administrative appeal of the final decision as set forth in the Administrative Procedure Act.

(d) If the department or the hearing officer in a formal appeal finds that the recovery audit contractor's determination was unreasonable or frivolous, the contractor shall reimburse the provider for the provider's costs associated with the appeal.

(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

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Supplement, 2014, is repealed.