# DEPARTMENT OF HEALTH & SOCIAL SERVICES

## PROPOSED CHANGES TO REGULATIONS
### MEDICAID- AUDIT & REVIEW.

- **7 AAC 105.230. Medicaid Provider and Recipient Participation- Requirements for Provider Records;**

- **7 AAC 120.430. Medicaid Coverage; Prescription Drugs and Medical Supplies; Durable Medical Equipment; Transportation Services- Authorized Escort.**

- **7 AAC 160. Medicaid Program; General Provisions.**
  - **7 AAC 160.110. Fiscal Audit.**
  - **7 AAC 160.115. Duty of a provider to identify and repay self-identified overpayments.**
  - **7 AAC 160.120. Use of statistical sampling.**
  - **7 AAC 160.130. Appeal.**
  - **7 AAC 160.140. Quality assurance program.**

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**PUBLIC REVIEW DRAFT**
***June 26, 2017***

**COMMENT PERIOD ENDS: September 22, 2017**

Please see the public notice for details about how to comment on these proposed changes.

**Notes to reader:**

1. Except as discussed in note 2, new text that amends an existing regulation is **bolded and underlined**.

2. If the lead-in line above the text of each section of the regulations states that a new section, subsection, paragraph, or subparagraph is being added, or that an existing section, subsection, paragraph, or subparagraph is being repealed and readopted (replaced), *the new or replaced text is not bolded or underlined*.

3. [ALL-CAPS TEXT WITHIN BRACKETS] indicates text that is to be deleted.

4. When the word "including" is used, Alaska Statutes provide that it means "including, but not limited to."

5. Only the text that is being changed within a section of the current regulations is included in this draft. Refer to the text of that whole section, published in the current Alaska Administrative Code, to determine how a proposed change relates within the context of the whole section and the whole chapter.

## Title 7 Health and Social Services.

## Chapter 105. Medicaid Provider and Recipient Participation.

## Sec 230. Requirements for provider records.

**7 AAC 105.230. Requirements for provider records.**

7 AAC 105.230(a) is amended to read:

(a) A provider shall

**(1)** maintain accurate financial, clinical, and other records necessary to support the services for which the provider requests payment;[. THE PROVIDER SHALL]

**(2)** ensure that the provider's staff, billing agent, or other entity responsible for the maintenance of the provider's financial, clinical, and other records meets the requirements of this section**;**

**(3) not submit a claim to the department for payment for services unless the provider's records are kept and maintained in accordance with this section.**

7 AAC 105.230(d)(5) is amended to read:

(5) [STOP AND START TIMES ] for time-based billing codes**, stop and start**

**times must be detailed in the record or timesheet; a provider may only bill for a unit of service if the actual direct service time spent is in excess of 50 percent of the time value of the procedure code billed; for a 15 minute code, a minimum of 8 minutes of direct services must be provided; direct service time associated with a particular procedure code shall be accumulated by the direct service provider for each date of service when determining the appropriate number of units that may be billed; the use of pre-populated clinical notes or timesheets is not permissible to document actual stop and start times; a provider shall not bill for services without proper time in and time out documentation; the use of documentation that does not specify both time in and time out will result in an overpayment; the following table identifies the appropriate number of units to bill using a 15 minute time based code**; and

| Units | Number of Minutes of Direct Service Time |
|---|---|
| 1 | >8 minutes through 22 minutes |
| 2 | >23 minutes through 37 minutes |
| 3 | >38 minutes through 52 minutes |
| 4 | >52 minutes through 67 minutes |
| 5 | >68 minutes through 82 minutes |
| 6 | >83 minutes through 97 minutes |
| 7 | >98 minutes through 112 minutes |
| 8 | >113 minutes through 127 minutes |
| The pattern remains the same for direct service times in excess of 2 hours | |

7 AAC 105.230(d)(6) is amended to read:

(6) annotated case notes identifying each service or supply delivered; the case notes must be dated and either signed or initialed by the individual who provided each service**; for electronic records, an electronic signature that complies with the requirements of AS 09.80, the Uniform Electronic Transactions Act satisfies the signature requirement under**

**this section; the individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information being attested to**;

7 AAC 105.230(d) is amended by adding a new paragraph to read:

(7) records that are maintained contemporaneously with the service provided; for purposes of this chapter, contemporaneous records are those records documented in accordance with the provider's professional licensing standards, or within 72 hours from the end of date of service; a provider shall not bill for services for which records were not kept contemporaneously.

7 AAC 105.230(f) is amended to read:

(f) A provider who maintains all or part of the provider's records in an electronic format shall ensure that the data required to be maintained by this section is **available and** [READILY] accessible **if requested** [AS REQUIRED] under 7 AAC 105.240(a). **All systems and software products must comply with the Health Insurance Portability and Accountability Act, and include protections against unauthorized modification and identify the creator and date of origination and modification.**

7 AAC 105.230 is amended by adding a new subsection to read:

(g) A provider of personal care services billing for time-based codes shall document the care provided to a recipient through the use of a timesheet, dated April 2017, adopted by reference. No claim shall be submitted for services unless the timesheet is completed in compliance with the timesheet instructions, dated April 2017, adopted by reference. Failure to comply with the timesheet instructions adopted by reference will result in an overpayment.

7 AAC 105.230 is amended by adding a new subsection to read:

(h) An electronic visit verification system approved by the department satisfies the timesheet requirement under (g) of this section.

7 AAC 105.230 is amended by adding a new subsection to read:

(i) A provider shall not submit a claim to the department for a service if a provider does not maintain records in compliance with this chapter.

(Eff. 2/1/2010, Register 193; am___/___/____, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

An editor's note is added following 7 AAC 105.230:

**Editor's note:** The timesheet and the timesheet instructions adopted by reference in 7 AAC 105.230 may be obtained from the Department of Health and Social Services, Division of Senior and Disabilities Services, P.O. Box 110680, Juneau, Alaska, 99811-0680 and are posted on the Department of Health and Social Services, Division of Senior and Disabilities Services Internet website at http://dhss.alaska.gov/dsds .

## Chapter 120. Medicaid Coverage; Prescription Drugs and Medical Supplies; Durable Medical Equipment; Transportation Services.

### Sec 430. Authorized escort.

**7 AAC 120.430. Authorized escort.**

7 AAC 120.430(d) is repealed and readopted to read:

(d) A provider shall not submit a claim to the department for an additional or a higher accommodation rate when the recipient and authorized escort(s) stay in the same room , or when more than one escorts stay in the same room unless the department determines that the circumstances warrant a higher rate as indicated in the prior authorization.

7 AAC 120.430 is amended by adding a new subsection to read:

(e) A provider shall not submit a claim to the department for more than one room for the recipient and escort(s), or for more than one escort, unless the department determines that circumstances warrant separate accommodations, as indicated in the prior authorization.

(Eff. 2/1/2010, Register 193; am___/___/____, Register____)

**Authority:** AS 47.05.010 AS 47.07.030 AS 47.07.040

## Chapter 160. Medicaid Program; General Provisions.

### Sec 110. Fiscal audit.

**7 AAC 160.110. Fiscal audit.**

7 AAC 160.110(a) is amended to read:

(a) The department or its designee shall conduct fiscal audits of Medicaid providers **and all subcontractors or grantees. A provider that bills the department is responsible for ensuring all records kept by employees, contractors or grantees are maintained in accordance with 7 AAC 105.230 and are made available when requested by the department**.

7 AAC 160.110(b) is amended to read:

(b) For purposes of this section, a fiscal audit may include a desk audit, a field audit, or both, to determine the provider's compliance with the requirements of 42 U.S.C. 1396, AS 47.05, AS 47.07, 42 C.F.R. Part 430 - 42 C.F.R. Part 498, **and** 7 AAC 105 - 7 AAC 160 [, AND THE PROVIDER'S CURRENT PROVIDER AGREEMENT MADE UNDER 7 AAC 105.220].

The introductory language of 7 AAC 160.110(d) is amended to read:

(d) Except as provided in (e) of this section, the department or its designee**,** will give a provider 30 days' advance notice of an audit to be conducted under this section. The notice will

**…**

7 AAC 160.110(e) is amended to read:

(e) The department or its designee may request **and receive immediate access to** records and perform an audit of those records without advance notice if the department or its designee has reason to believe, based on **some evidence** [RELIABLE EVIDENCE], that the provider is engaging in a course of conduct or performing an act in violation of the requirements specified in (b) of this section. Notwithstanding the provisions of 7 AAC 105.240, the provider shall produce the requested records for an immediate audit under this subsection at the provider's place of business or other location as specified by the department or its designee. **For purposes of this subsection, immediate access to records means the records must be made available on the same business day as the request.**

7 AAC 160.110(f) is amended to read:

(f) Following the department's or its designee's audit of a provider's records, the department or its designee will give the provider the written preliminary findings of the audit. The preliminary findings will identify claim-line inaccuracies [, BUT WILL NOT IDENTIFY ANY OVERPAYMENT AMOUNTS]. The provider has 30 days after the date of the letter informing the provider of the preliminary findings to submit additional documentation or respond to the preliminary findings.

7 AAC 160.110(h) is repealed and readopted to read:

(h) If the department finds in the final audit report under (g) of this section that the provider has not complied with the requirements specified in (b) of this section,

(1) the department will

(A) recoup or require repayment of any identified overpayment amount from the provider;

(B) require that the provider pay interest on identified overpayments; interest on overpayments shall be calculated in accordance with AS 47.05.200(b);

(2) in addition to (1) of this subsection, the department may take one or more of the following actions;

(A) impose sanctions against the provider under 7 AAC 105.400 – 7 AAC 105.490;

(B) initiate other administrative or civil actions;

(C) refer the matter to another state, federal, or local agency.

(Eff. 2/1/2010, Register 193; am 10/1/2011, Register 199; am___/___/____, Register____)

**Authority:** AS 47.05.010 AS 47.07.030 AS 47.07.074

AS 47.05.200 AS 47.07.040

7 AAC 160 is amended by adding a new section to read:

**7 AAC 160.115. Duty of a provider to identify and repay self-identified overpayments.**

(a) An enrolled provider who bills the department for services rendered during a calendar year shall conduct a review or audit of a statistically valid sample of claims submitted to the department for reimbursement once every two years, unless the provider is being audited under AS 47.05.200(a). The universe of claims from which the random sample is drawn shall be all claims billed with dates of service within the calendar year for the provider identified at the taxpayer identification level. A statistically valid random sample of claims shall be utilized for self-audit under this section. As part of the self-review, a provider shall establish appropriate corrective actions for any deficiencies identified, and will return the overpayment identified as a result of the extrapolation.

(b) A biennial review or audit conducted under this section shall be conducted no earlier than one year following the end of the calendar year to allow for timely filing of all claims.

(c) The provider may use any widely accepted statistical software such as RAT-STATS, developed by the Department of Health and Human Services, Office of Inspector General to assist in sample size determination, sample selection, and extrapolation of any identified overpayment amount.

(d) If overpayments are identified by a provider either through the biennial audit or review, or during the normal course of business, the provider shall report the overpayment to the department no later than 10 business days after identification of the overpayment. Overpayments must be returned in accordance with 42 U.S.C. 1320(d).

(e) All providers who were reimbursed greater than $30,000 for services during the year shall submit a report to the department detailing the claims audited or reviewed together with the results of that review or audit. Providers reimbursed less than $30,000 are not required to submit their report to the department but must have the report available for review by the department. The report must be made in writing, include an attestation on a form prescribed by the department, and be submitted to Department of Health and Social Services, Medicaid Program Integrity; PO Box 240249, Anchorage, AK 99524, or electronically to QAPIProgramIntegrity@alaska.gov. If a provider billed the Medicaid program less than $10,000 during the reporting period, the attestation shall be considered the report required under this chapter. The reimbursement values referenced are based upon the 1099 forms issued by the department to the provider by calendar year.

(f) Providers shall retain audit documents and reports created as a result of the review for at least seven calendar years following completion.

(g) A repayment agreement between the provider and the department shall be entered into within 30 days of the identification of the overpayment. The agreement may authorize repayment through any one of the following means:

(1) a lump sum payable within two months of the date of the discovery of the overpayment;

(2) a payment plan not to exceed two years in length; the payment plan may be extended beyond two years at the discretion of the department;

(3) by offsetting future billings by the provider; if a provider chooses to offset future billings, the amount offset must be repaid within two years from the date of the agreement.

(h) If a provider defaults on a repayment in (g) of this section, the department may

require immediate payment of the total amount due. If a provider defaults on paying the total amount, the provider entity and its owners are subject to sanction up to and including termination from the Medicaid program in accordance with 7 AAC 105.410.

(i) The department reserves the right to review the results of a provider conducted self-review for accuracy. Failure to comply with this subsection will result in sanction up to and including termination from the Medicaid program in accordance with 7 AAC 105.410.

(Eff.___/___/____, Register____)

**Authority:** AS 47.05.010 AS 47.05.235 AS 47.07.040
AS 47.05.200 AS 47.07.030 AS 47.07.074

**Editor's note:** For information regarding the conduct of a self-audit, please refer to CMS self-audit toolkit; Conducting a Self-Audit: A guide for Physicians and other health Care Professionals" February, 2016. The toolkit may be obtained at the following website: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/audit-toolkit.html.

The attestation referenced in 7 AAC 160.115(e) may be obtained at the following website: http://dhss.alaska.gov/Commissioner/Pages/ProgramIntegrity/default.aspx.

## Chapter 160. Medicaid Program; General Provisions.

### Sec 120. Use of statistical sampling.

**7 AAC 160.120. Use of statistical sampling.**

7 AAC 160.120 is amended to read:

**A provider, or the** [THE] department or its designee**,** may use statistically valid sampling methodologies to

(1) select Medicaid claims for review or audit; and

(2) calculate overpayment amounts to providers that are subject to a **provider self review, a** fiscal audit under 7 AAC 160.110**,** or a quality assurance program review under 7 AAC 160.140.

(Eff. 2/1/2010, Register 193; am___/___/____, Register____)

**Authority:** AS 47.05.010 AS 47.07.030 AS 47.07.040

## Chapter 160. Medicaid Program; General Provisions.

### Sec 130. Appeal.

**7 AAC 160.130. Appeal.**

7 AAC 160.130(a) is amended to read:

(a) A provider may appeal the findings of a final audit conducted under 7 AAC 160.110 and determinations of overpayment amount under the audit. **The department may offer a reconsideration of the audit findings prior to a formal appeal. If the department offers reconsideration, a provider may request a formal appeal under this section.**

7 AAC 160.130(c) is amended to read:

(c) The commissioner will review the **proposed decision issued by the Office of Administrative Hearings** [INFORMATION] and materials submitted under (b) of this section [AND CONSIDER THE FOLLOWING FACTORS] in reaching a decision on an appeal under this section[:

(1) THE PROVIDER'S ERROR RATE IN THE AUDIT;

(2) WHETHER THE PROVIDER HAS A PRIOR HISTORY OF SIMILAR

AUDIT FINDINGS AND WHETHER THE PREVIOUS FINDINGS WERE CORRECTED;

(3) WHETHER THE PROVIDER RECEIVED NOTICE OF NONCOMPLIANCE PREVIOUSLY AND WHETHER THE PROVIDER RECEIVED TRAINING REGARDING THE NONCOMPLIANCE;

(4) WHETHER THE PROVIDER SUBMITTED FALSE OR FRAUDULENT INFORMATION, OR OMITTED MATERIAL INFORMATION, ON THE MEDICAID CLAIMS TO THE DEPARTMENT;

(5) WHETHER THE FINDINGS OF THE AUDIT INDICATE THAT THE PROVIDER POSES A HEALTH OR SAFETY RISK TO RECIPIENTS].

7 AAC 160.130 is amended by adding a new subsection to read:

(e) Appeals received pursuant to this section will be referred to the Department of Administration Office of Administrative Hearings. The Office of Administrative Hearings will conduct a hearing in which the department must prove by a preponderance of the evidence that overpayments were properly identified and that the amount is correctly calculated. At the conclusion of the Office of Administrative Hearings proceedings, the Administrative Law Judge will submit in writing his or her recommendation to the commissioner.

(Eff. 2/1/2010, Register 193; am___/___/____, Register____)

**Authority:** AS 47.05.010 AS 47.05.200 AS 47.07.040

**Chapter 160. Medicaid Program; General Provisions.**

**Sec 140. Quality assurance program.**

**7 AAC 160.140. Quality assurance program.**

7 AAC 160.140(a) is amended to read:

(a) The department**, through each division responsible for the administration of the Medicaid program,** will establish a quality assurance program to ensure provider compliance with AS 47.05, AS 47.07, and 7 AAC 105 - 7 AAC 160.

7 AAC 160.140(b) is amended to read:

(b) Under the quality assurance program, the department will conduct[ RANDOM] program reviews[ OF A SAMPLING] of providers[ ON AN ANNUAL BASIS]. **If the department proposes adverse action as a result of the review, the department will issue a written report of the findings to the provider.** [AFTER EACH REVIEW, THE DEPARTMENT WILL ISSUE A WRITTEN REPORT OF FINDINGS AS TO WHETHER THE PROVIDER WAS IN COMPLIANCE WITH THE PROVISIONS OF AS 47.05, AS 47.07, AND 7 AAC 105 – 7 AAC 160.]

7 AAC 160.140(c)(3) is amended to read:

(3) require that the provider be **subject to a financial audit** [AUDITED] if there is a reasonable basis to conclude that the provider has received payments in excess of what is authorized under the Medicaid program;

7 AAC 160.140(c)(6)(B) is repealed:

(B) repealed ___/___/___ . (Eff. 2/1/2010, Register 193; am 10/1/2011, Register 199; am___/___/____, Register____)

**Authority:** AS 47.05.010 AS 47.07.040