

DEPARTMENT OF HEALTH & SOCIAL SERVICES



PROPOSED CHANGES TO REGULATIONS

7 AAC 105. Medicaid Provider and Recipient Participation.

- 7 AAC 105.230. Requirements for provider records.

7 AAC 160. Medicaid Program; General Provisions.

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



PUBLIC REVIEW DRAFT

August 14, 2019

COMMENT PERIOD ENDS: October 2, 2019

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paragraph, or subparagraph is being added, or that an existing section, subsection, paragraph, or subparagraph is being repealed and readopted (replaced), *the new or replaced text is not bolded or underlined*.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.****7 AAC 105.230. Requirements for provider records.**

7 AAC 105.230(a)(3) is amended to read:

(a) A provider

...

(3) may not submit a claim to the department for **payment** [PAVMENT] 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:

(d) A provider shall maintain a clinical record, including a record of therapeutic services, in accordance with professional standards applicable to the provider, for each recipient. The clinical record must include

...

(5) **start** [STOP] and **stop** [START] times for time-based billing codes;

(A) 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;

(B) 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;

(C) a provider may not use pre-populated clinical notes or time-sheets to document actual **start** [STOP] and **stop** [START] times;

(D) a provider may not bill for services without proper time-in and time-out documentation;

(E) the use of documentation that does not specify both time in and time out will result in an overpayment;

(F) the following table identifies the appropriate number of units to bill using a 15-minute time-based code:

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	≥ 53 [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.	

(G) documentation of start and stop times is not required for evaluation and management codes; however, documentation must be maintained in

accordance with professional guidance as adopted by reference in 7 AAC**160.900(a);**

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

(6) annotated case notes identifying each service or supply delivered;

(A) the case notes must be dated and either signed or initialed by the individual who provided each service;

(B) for electronic records, an electronic signature that complies with the requirements of AS 09.80 (Uniform Electronic Transactions Act) satisfies the signature requirement under this section; the individual whose name is on the electronic signature and the provider bear the responsibility for the authenticity of the information being attested to; and

7 AAC 105.230(d)(7) is amended 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 **14 days** [72 HOURS] from the end of the date of service; [, WHICHEVER IS LONGER] a provider may not bill for services for which records were not kept contemporaneously.

(Eff. 2/1/2010, Register 193; am 6/7/2018, Register 226; am ____/____/____, Register ____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

Chapter 160. Medicaid Program; General Provisions.**7 AAC 160.115. Duty of a provider to identify and repay self-identified overpayments.**

7 AAC 160.115(d) is amended to read:

(d) If a provider identifies overpayments through the biennial review or audit, during the normal course of business, or both, the provider shall report each overpayment to the department not later than 10 business days after identification of that overpayment. In this subsection, "business day" means a day other than Saturday, Sunday, or a legal holiday under AS 44.12.010.

Each overpayment shall be submitted to the Department of Health and Social Services, Office of the Commissioner, Medicaid Program Integrity.

7 AAC 160.115(e) is amended to read:

(e) A provider who was reimbursed

(1) \$30,000 or greater 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; [A PROVIDER WHO WAS REIMBURSED]

(2) \$10,000 or greater but less than \$30,000 is not required to submit the report to the department but must have the report available for review by the department; [A PROVIDER WHO WAS REIMBURSED]

(3) less than \$10,000 is not required to produce a report but shall have an [A] attestation form on file and available for review by the department [THE REPORT SHALL BE MADE IN WRITING, INCLUDE AN ATTESTATION ON A FORM PRESCRIBED BY THE DEPARTMENT, AND BE SUBMITTED, IF REQUIRED, TO THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES, OFFICE OF THE COMMISSIONER, MEDICAID

PROGRAM INTEGRITY. THE REIMBURSEMENT VALUES REFERENCED ARE BASED UPON THE REIMBURSEMENT VALUES REPORTED IN EACH UNITED STATES INTERNAL REVENUE SERVICE FORM 1099 THAT THE DEPARTMENT ISSUES TO THE PROVIDER BY CALENDAR YEAR].

7 AAC 160.115(f) is repealed and readopted to read:

(f) The reimbursement values referenced in (e) of this section are based upon the reimbursement values reported in each United States Internal Revenue Service form 1099 that the department issues to the provider by calendar year [A PROVIDER SHALL RETAIN AUDIT DOCUMENTS AND REPORTS CREATED AS A RESULT OF THE REVIEW FOR AT LEAST SEVEN CALENDAR YEARS FOLLOWING COMPLETION].

7 AAC 160.115(g) is repealed and readopted to read:

(g) Under this section, the report shall be made in writing, include an attestation on a form prescribed by the department, and be submitted, if required, to the Department of Health and Social Services, Office of the Commissioner, Medicaid Program Integrity. The report shall include

- (1) the method used to sample the claims;
- (2) the sampled claims Medicaid assigned transaction control number (TCN);
- (3) the outcome of the individual claim audit;
- (4) the identified amount of overpayment back to the department; and
- (5) a corrective action plan [NOT LATER THAN 30 DAYS AFTER

IDENTIFICATION OF THE OVERPAYMENT, THE PROVIDER SHALL ENTER INTO A

REPAYMENT AGREEMENT WITH THE DEPARTMENT. THE AGREEMENT MAY AUTHORIZE REPAYMENT THROUGH ANYONE OF THE FOLLOWING MEANS:

- (1) A LUMP SUM PAYABLE NOT LATER THAN TWO MONTHS AFTER THE DATE OF THE DISCOVERY OF THE OVERPAYMENT;
- (2) A PAYMENT PLAN NOT TO EXCEED TWO YEARS IN LENGTH; THE DEPARTMENT MAY EXTEND THE PAYMENT PLAN BEYOND TWO YEARS;
- (3) BY OFFSETTING FUTURE BILLINGS BY THE PROVIDER; IF A PROVIDER CHOOSES TO OFFSET FUTURE BILLINGS, THE AMOUNT OFFSET MUST BE REPAYED NOT LATER THAN TWO YEARS FROM THE DATE OF THE AGREEMENT].

7 AAC 160.115(h) is repealed and readopted to read:

(h) A provider shall retain audit documents and reports created as a result of the review for at least seven calendar years following completion [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 IS SUBJECT TO SANCTIONS UNDER 7 AAC 105.400 - 7 AAC 105.490. SANCTIONS MAY INCLUDE TERMINATION FROM THE MEDICAID PROGRAM IN ACCORDANCE WITH 7 AAC 105.410].

7 AAC 160.115(i) is repealed and readopted to read:

(i) Not later than 30 days after identification of the overpayment, the provider shall enter into a repayment agreement with the department. The department may, in the agreement, authorize repayment through one of the following means:

(1) a lump sum payable not later than two months after the date of the discovery of the overpayment;

(2) a payment plan not to exceed two years in length; the department may extend the payment plan beyond two years;

(3) by offsetting future billings by the provider; if a provider chooses to offset future billings, the amount offset must be repaid not later than two years from the date of the agreement [THE DEPARTMENT MAY REVIEW THE RESULTS OF A PROVIDER-CONDUCTED SELF-REVIEW FOR ACCURACY. IF THE PROVIDER DOES NOT PROVIDE AN OPPORTUNITY FOR DEPARTMENT REVIEW UNDER THIS SUBSECTION OR OBSTRUCTS THE REVIEW, OR IF THE DEPARTMENT DETERMINES THAT THE PROVIDER'S SELF-REVIEW IS INACCURATE, THE PROVIDER IS SUBJECT TO SANCTIONS UNDER 7 AAC 105.400 - 7 AAC 105.490. SANCTIONS MAY INCLUDE TERMINATION FROM THE MEDICAID PROGRAM IN ACCORDANCE WITH 7 AAC 105.410].

7 AAC 160.115 is amended by adding new subsections to read:

(j) If a provider defaults on a repayment in (i) 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 is subject to sanctions under 7 AAC 105.400 - 7 AAC 105.490. Sanctions may include termination from the Medicaid program in accordance with 7 AAC 105.410.

(k) Under this section, an overpayment is identified when the provider has through the exercise of reasonable diligence, determined that the provider has received an overpayment and quantified the amount of the overpayment.

(l) The department may review the results of a provider-conducted self-review for accuracy. If the provider does not provide an opportunity for department review under this subsection or obstructs the review, or if the department determines that the provider's self-review is inaccurate, the provider is subject to sanctions under 7 AAC 105.400 - 7 AAC 105.490. Sanctions may include termination from the Medicaid program in accordance with 7 AAC 105.410.

(Eff. 6/7/2018, Register 226; am ____/____/____, 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