Medicaid Provider Audit and Record Keeping

Proposed Regulations - Public Comment
Department of Health and Social Services

	Summary of Comments	Department Responses
1.	**7 AAC 160.115(d)** Do all overpayments need to be processed through Medicaid Program Integrity or can we still use the normal void and adjust process through Conduent for overpayments identified in the normal course of business? Can a checklist be published? The original information released on the provider self-audit was vague and up for individual interpretation. What is the standard for accuracy for the self - audits Under 7 AAC 160.115, will the state provide an audit checklist of the elements that should be reviewed? Under 7 AAC 160.115 states, "…..provider….shall conduct, once every two years, a review or audit of a statistically valid random sample of claims….unless the provider is being audited under AS.47.05.200" What specifically does "unless the provider is being audited under AS.47.05.200" mean we see it problematic to know what timeframe to do the self-audit if the state annual audits are conducted on retrospective timeframes greater than 2 years post date of service.	1. **7 AAC 160.115(d)** DHSS is proposing to amend this section to clarify only overpayments made through self audits are required to be returned through Program integrity. Yes a list of what should be contained in the self audit is included in the regulations and contains: (1) the method used to sample of 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. The standards for accuracy are the requirements contained in regulation and professional guidance such as the CPT coding manual Yes, a suggested list of criteria will be provided as an FAQ on the Medicaid Program Integrity website. Audited under AS 47.05.200 means an audit conducted by the department's contract auditors, currently Myers and Stauffer, LC. Typically the audits conducted under AS 47.05.200 are older than 2 years. It would be an unusual circumstance for this provision of the regulation to apply.

In reference to 7 AAC 160.115: In some cases, the fact that an overpayment exists may be identified through the self-audit, but the provider may not be able to identify the exact amount of the overpayment. How should this situation be handled in the submission of the self-audit findings	The overpayment must be disclosed in the self-audit. Medicaid Program Integrity will work with the provider to help determine the overpayment amount
Does the self audit requirement apply to SNF/LTC facilities?	Yes.
The process currently requires an estimate using a statistic calculator that is cumbersome to utilize and the defined audit is vague.	DHSS receive comments 2 comments expressing concern regarding the use of a statistical calculator
7 AAC 160.115(d) requires a report of each overpayment to the department no later than 10 business days after identification. It often takes longer than 10 business days to identify, research and confirm a suspected overpayment is actually an overpayment. We would propose as an alternative a 30 day reporting window. Subsequent timelines proposed elsewhere in the regulations would need to be adjusted accordingly.	DHSS received 2 similar comments Response follows: 7 AAC 160.115(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. For purposes of this section, "quantified" means express the amount or quantity of the overpayment which can only be done after confirming the overpayment.
We realize 160.115 applies to a wide range of service types, making it difficult for the state to define the criteria for which any given claim is audited against. However, it would be helpful if the rule established some boundaries on the number of criteria applied to any given claim. When you consider the potential criteria that could be used for an inpatient encounter, it becomes overwhelming. An example for setting boundaries could be requiring that providers must audit against no less than two and no greater than five criteria.	DHSS will publish on the Program Integrity website a generic (not provider type specific) sample list of criteria that should be reviewed when conducting a self -audit
We are very concerned with the administrative burden the self-audit requirement will create for larger organizations that are already dedicating a great deal of resources to be in compliance with CMS rules. In particular, the Federal requirements to have an effective Compliance Program, which include ongoing auditing and monitoring with a requirement to repay all identified overpayments from Federal health care programs (including Medicaid) within 60 days. The Medicaid self-audit requirement is duplicative and will	The department agrees that CMS requires effective compliance programs. The self-audit requirement is contained in statute (AS 47.05.235). That statute does not contain exemptions based on provider type or compliance requirements.

only add to the cost of health care in Alaska. We ask you to consider allowing organizations that fall under the Federal requirements for a compliance program to submit evidence of an effective compliance program, in lieu of a separate audit for Medicaid	
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.* This time frame seems unreasonable as it seems unlikely the State could agree on repayment arrangements within 30 days. The Affordable Care Act established the 60-day rule in the Social Security Act. We recommend the State adopt the same criteria here and replace the section above with the following language: the provider will return each overpayment to the Department within 60 days after identification of the overpayment unless the provider enters into an alternative repayment arrangement with the Department.	DHSS proposes to change the language in 7 AAC 160.115(i) to read: Not later than 60 days after identification of the overpayment, the provider shall make repayment to the department unless the provider has entered into a repayment agreement with the department.
Page 4, in reference to regarding the scope of the audit with reads: (e) A provider who was reimbursed Requesting clarification on definition of provider. Is it individual provider number or group provider number?	It is the provider who received reimbursement and IRS form 1099 from Medicaid.
Page 5, in reference to regarding the scope of the audit with reads: (1) the method used to sample the claims; (2) the sampled claims Medicaid assigned transaction control nu (3) the outcome of the individual claim audit: (4) the identified amount of overpayment back to the departmen Requesting clarification on the audit criteria to include "all aspects of the claim regarding billing and documentation". Clarification that it will be dependent on defined standards adopted by Medicaid (start and stop time, signature within 14 days, etc.).	Audit criteria checklist will be provided on the Medicaid Program Integrity website
.7 AAC 160.115(a). The Department has not proposed substantive changes to this paragraph. However, we suggest several changes to make the biennial self-audit requirements less burdensome on providers. All our	

recommended changes are entirely consistent with the governing statute, AS 47.05.235. Specifically, we recommend: a. That providers be allowed to use a non-random sample if it is statistically valid. Requiring a random sample effectively requires providers to utilize complicated software programs like RAT-STATs, which is burdensome especially on smaller providers. b. That providers be allowed to audit a period other than a full calendar year. There are times when a full year audit will not be the most appropriate choice, for example, when regulations or a provider's systems or software are changed midyear. Allowing providers to audit a shorter time period will also reduce the cost of the audit. c. That providers be allowed to conduct separate audits of discrete service lines and to stratify the sample to reflect the relative volume and value of claims, different service locations, or other relevant factors.	A. The use of a non-random sampling techniques could easily result in a biased sample. A biased sample may result in questionable outcomes and defeats the purpose of a bi-annual self-audit. B. The use of a full calendar year helps to ensure consistency in self-auditing amongst providers and aligns with audits conducted under AS 47.05.200. C. The use of stratified random sample is acceptable. A provider may stratify the random sample to reflect the relative volume and value of claims. Provider may choose to audit at the Medicaid provider ID level or the tax ID level. However, if a provider chooses at the Medicaid Provider ID level, all provider ID's are required to conduct the self-audit every two years. Medicaid self-audit regulations require one audit of randomly selected claims every two years. As part of your internal compliance program, you may conduct audits using any methodologies at your discretion.
7 AAC 160.115(g). The Department proposes new language to specify what information must be included in a provider's overpayment report. In general, we think this information is helpful. However, we anticipate it will be difficult for many providers to produce a thoughtful corrective action plan within the 10-day reporting period required by the regulation and the governing statute, as would be required by (g)(5). We recommend that the requirement for a corrective action plan be removed from this section. Instead, a corrective action plan could be due with, or as part of, the provider's repayment agreement under 7 AAC 160.115(i).	Under 7 AAC 160.115(k) an overpayment is identified when the provider has exercised through reasonable diligence determined the provider has received an overpayment and quantified the amount of the overpayment. For purposes of this section, the amount of the overpayment has not be determined until the self-audit is complete and the total amount of overpayment has been quantified.

7 AAC 160.115(i). The department proposes to retain the 30-day deadline for providers to enter into a repayment agreement with the Department. Many providers will need more time to determine what repayment schedule they can manage, and a 30-day deadline does not allow time for meaningful discussion and negotiation between the provider and the Department. The statute requires a repayment agreement, but it does not impose a deadline. We recommend allowing at least 60 days, and preferably up to 6 months, for providers to enter into a repayment agreement. As discussed above, we also recommend that any required corrective action plan be due at the same time as the repayment agreement, and not when the overpayment report is due	1. The new language reads 7 AAC 160.115(i) Not later than 60 days after identification of the overpayment, the provider shall make repayment to the department unless the provider has entered into a repayment agreement with the department.
7AAC 105.230	
Please accept this letter of support for changes to 72 Hour Documentation rule to 14 days.	The department received over 30 comments in of support for the change from 72 hours to 14 days from the end of the date of service for documentation to be considered contemporaneous. no changes are anticipated from these comments
Personally, most of my documentation is done within 24 hours of the provision of service. With the advent of electronic health records and the ease of use for a program, most documentation takes less than 15 minutes to complete a concise and thorough note. Documentation done after 72 hours is not as accurate nor detailed. The sooner the documentation is completed, the better the memory or what was done or completed. This protects both the patient and the provider. Anything past 4 days usually has at least some fictionalization.	The Department received 2 comments indicating they thought 14 days was too long to complete documentation.
Additionally concerns may arise when providers have emergency case loads or have emergencies themselves. Extenuating circumstances for documentation should also be noted as reasons to extend further timeliness.	Comments were received from 2 parties expressing concerns that emergencies or extenuating circumstances may cause a delay in documentation.
My questions is related to the term "direct service provider". Does refer to an individual or an agency who provides the service?	The term “direct service provider” means an individual who renders the service billed

In 7 AAC 105.230(d)(5) what are the differences between (C) start/stop time and (D) time-in/time-out? What constitutes "proper time-in and time-out documentation."? Are all provider types required to record both	The department received this question two times: the response is: For purposes of this section, time-in and time-out are synonymous with start and stop time.
Eliminating the requirement to document start and stop times for Evaluation and Management codes. Most importantly, this change now has Alaska Medicaid in alignment with the Medicare coding guidelines' requirement for documenting start and stop times. This will result in less administrative burden on facilities to establish systems to capture and confirm that times are being documented	DHSS received 4 comments indicating appreciation for removing start and stop time requirement for Evaluation and Management codes
Physical therapists utilize a variety of time-based and service-based codes each session. Most procedures and modalities provided by the therapist during the course of treatment do not occur during a single segment of time, i.e. one start and one stop time. Chapter 7 section 105.230(d)(5) of the Alaska Admin Code states that "stop and start times fortime-based billing codes" must be included in the clinical record. Later in the same subsection, the code states that "a provider may not bill for services without proper time-in and time-out documentation." These two statements appear to require two different things. **APTQI urges DHSS to clarify that the clinician is required to only document time-in and time-out per session, not per timed code**.	DHSS received 2 similar comments regarding documentation of start and stop times for therapy codes. The response is: Existing regulations already require documentation of start and stop times for time based codes .For purposes of this section, time-in and time-out are synonymous with start and stop time.
The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.ASMA is disappointed by the lack of outreach on the re-write of 7 AAC 105.230(d)(7) prior to public notice of the proposed regulation. The lack of outreach and dialog is how we arrived at the current situation. While the proposed regulation, utilizing 14 days from end of the service, is far more workable than the original 72 hours it still creates situations that could be problematic for some physicians. Specially, those in single practices or in rare circumstances where a	The vast majority of public comments received supports the 14 day time period change. The use of "timely manner" is indefinite.

physician is waiting on additional information or perhaps comes in from a subsistence hunt to assist in an emergency event returning shortly after would likely have difficulty meeting this requirement. ASMA acknowledges 14 days should be enough time for the vast majority of providers to complete the records and would expect physicians in general to comply much earlier under the current national policy of "timely manner." Nevertheless, the new regulation acts to overturn current national policy and doesn't allow any justifications for going over 14 days regardless of situation.	
I would like to request that the definition of time-based codes be either expanded or list of code sequences be identified with clarification or elimination of the therapy codes.	If a procedure code is billed on a unit of time (15 minutes, 30 minutes, 45 minutes etc.) it is considered a time-based code.
I would like to request the definition of pre-populated clinical notes. Is a computerized generated stamp inserted into the note by the provider a sufficient method or does the provider physically need to document in the note a start and stop time?	A computer generated time stamp is different than prepopulated time in /time out.
On the section pertaining to the 72-hour rule I would like to add or clarify the wording to include Provider's Professional Licensing Standards held in accordance with the State Licensing Statutes.	We are adopting a uniform standard applicable to all non-facility provider types. Since facility documentation standards are already defined in regulation, we are providing for an exception for facilities in regulations as defined in 7 AAC 12.990.
And in the portion that references"from end of the date of service" to clarify the end of day being 11:59pm.	We agree the end of the date of service is 11:59pm
We believe the Department should continue to allow a longer documentation period when consistent with a provider's licensing requirements; for example, consistent with Alaska's hospital licensing regulation 7 AAC 12.770(e), hospital documentation should be deemed timely for Medicaid purposes if completed within 30 days after a patient's discharge.	DHSS agrees Since facility documentation standards are already defined in regulation, we are providing for an exception for facilities in regulations as defined in 7 AAC 12.990.
. . **7 AAC 105.230(d)(5).** We appreciate and support exempting evaluation and management codes from the start-and-stop time documentation requirements for	We believe, by exempting evaluation and management (e/m) codes CPT series

	timebased billing codes, as proposed by paragraph (G). However, other services should also be exempt. For example, start-and-stop time documentation should not be required for services furnished in hospitals, where intensive services are furnished by extremely busy providers who should not be distracted by the need to precisely document when a service started and stopped. Indeed, in our view start-and-stop time documentation should be required, if at all, only for time-based services the Department considers especially subject to abuse due to the nature of the service or the setting in which they are furnished, for example, unsupervised PCA services furnished in a recipient's home At the very least, we recommend the regulation be revised to allow the Department to exempt additional services in its discretion. Finally, we recommend that start-and-stop time documentation only be required for services that are actually reimbursed in units of time, as opposed to those for which the duration of a service is one factor in selecting the appropriate billing code.	"99XXX" we are requiring start and stop times for services that are actually reimbursed in units of time as opposed to those for a duration of service is one factor in selecting the appropriate billing code.
	The 72-hour Documentation requirement to do my billing is going to be difficult especially when I am already stretched with other duties. 30 day documentation requirement would be more ideal for small privately owned Bed & Breakfast Hotels.	Thank you for your comment. Please note this regulation is for documenting the services provided. A provider currently has 1 year to submit a claim for reimbursement from the date of service