

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Bureau of Health Services Financing**

Recovery Audit Contractor Program (LAC 50:I.Chapter 85)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:I.Chapter 85 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Patient Protection and Affordable Care Act (PPACA), U.S. Public Law 111-148, and 111-152 directed states to establish a Recovery Audit Contractor (RAC) program to audit payments to Medicaid providers. Act 568 of the 2014 Regular Session of the Louisiana Legislature directed the Department of Health and Hospitals to implement a Recovery Audit Contractor program. In compliance with the Patient Protection and Affordable Care Act (PPACA) and Act 568, the department adopts provisions to establish the RAC program.

This action is being taken to avoid federal sanctions. It is anticipated that the implementation of this Emergency Rule

will have no programmatic costs to the Medicaid Program for state fiscal year 2014-2015.

Effective November 20, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions establishing the Recovery Audit Contractor program.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part I. Administration
Subpart 9. Recovery

Chapter 85. Recovery Audit Contractor

§8501. General Provisions

A. Pursuant to the provisions of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148, 111-152, and Act 562 of the Regular Session of the Louisiana Legislature, the Medicaid Program adopts provisions to establish a Recovery Audit Contractor (RAC) program.

B. These provisions do not prohibit or restrict any other audit functions that may be performed by the department or its contractors. This rule shall only apply to Medicaid RACs as they are defined in applicable federal law.

C. This rule shall apply to RAC audits that begin on or after November 20, 2014, regardless of dates of claims reviewed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§8503. Definitions

Adverse Determination-any decision rendered by the recovery audit contractor that results in a payment to a provider for a claim or service being reduced either partially or completely.

Department-Department of Health and Hospitals (DHH) or any of its sections, bureaus, offices, or its contracted designee.

Provider-any healthcare entity enrolled with the department as a provider in the Medicaid program.

Recovery Audit Contractor(RAC)-a Medicaid recovery audit contractor selected by the department to perform audits for the purpose of ensuring Medicaid program integrity in accordance with the provisions of 42 CFR 17 455 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§8505. Contractor Functions

A. Notwithstanding any law to the contrary, the RAC shall perform all of the following functions.

1. The RAC shall ensure it is reviewing claims within three years of the date of its initial payment. For

purposes of this requirement, the three year look back period shall commence from the beginning date of the relevant audit.

2. The RAC shall send a determination letter concluding an audit within 60 days of receipt of all requested materials from a provider.

3. For any records which are requested from a provider, the RAC shall ensure proper identification of which records it is seeking. Information shall include, but is not limited to:

- a. recipient name;
- b. claim number;
- c. medical record number (if known); and
- d. date(s) of service.

B. Pursuant to applicable statute, the RAC program's scope of review shall exclude the following:

1. all claims processed or paid within 90 days of implementation of any Medicaid managed care program that relates to said claims. This shall not preclude review of claims not related to any Medicaid managed care program implementation;

2. claims processed or paid through a capitated Medicaid managed care program. This scope restriction shall not prohibit any audits of per member per month payments from the department to any capitated Medicaid managed care plan utilizing such claims; and

3. medical necessity reviews in which the provider has obtained prior authorization for the service.

C. The RAC shall refer claims it suspects to be fraudulent directly to the department for investigation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§8507. Reimbursement and Recoupment

A. The department has in place, and shall retain, a process to ensure that providers receive or retain the appropriate reimbursement amount for claims within any look back period in which the RAC determines that services delivered have been improperly billed, but reasonable and necessary. It shall be the provider's responsibility to provide documentation to support and justify any recalculation.

B. The RAC and the department shall not recoup any overpayments identified by the RAC until all informal and formal appeals processes have been completed. For purposes of this Section, a final decision by the Division of Administrative Law shall be the conclusion of all formal appeals processes. This does not prohibit the provider from seeking judicial review and any remedies afforded thereunder.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§8509. Provider Notification

A. The RAC shall provide a detailed explanation in writing to a provider for any adverse determination as defined by state statute. This notification shall include, but not be limited to the following:

1. the reason(s) for the adverse determination;
2. the specific medical criteria on which the determination was based, if applicable;
3. an explanation of any provider appeal rights; and
4. an explanation of the appropriate reimbursement determined in accordance with §8507, if applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§8511. Records Requests

A. The RAC shall limit records requests to not more than 1 percent of the number of claims filed by the provider for the specific service being reviewed in the previous state fiscal year during a 90 day period. The 1 percent shall be further

limited to 200 records. For purposes of this Chapter, each specific service identified for review within the requested time period will be considered a separate and distinct audit.

B. The provider shall have 45 calendar days to comply with any records request unless an extension is mutually agreed upon. The 45 days shall begin on the date of receipt of any request.

1. *Date of Receipt*-two business days from the date of the request as confirmed by the post office date stamp.

C. If the RAC demonstrates a significant provider error rate relative to an audit of records, the RAC may make a request to the department to initiate an additional records request relative to the issue being reviewed for the purposes of further review and validation.

1. The provider shall be given an opportunity to provide written objections to the secretary or his/her designee of any subsequent records request. Decisions by the secretary or his/her designee in this area are final and not subject to further appeal or review.

2. This shall not be an adverse determination subject to the Administrative Procedures Act process.

3. A significant provider error rate shall be defined as 25 percent.

4. The RAC shall not make any requests allowed above until the time period for the informal appeals process has expired.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§8513. Audits and Records Submission

A. The RAC shall utilize provider self-audits only if mutually agreed to by the provider and the RAC.

B. If the provider is determined to be a low-risk provider, the RAC shall schedule any on-site audits with advance notice of not less than 10 business days. The RAC shall make a reasonable good-faith effort to establish a mutually agreed upon date and time, and shall document such efforts.

C. In association with an audit, providers shall be allowed to submit records in electronic format for their convenience. If the RAC requires a provider to produce records in any non-electronic format, the RAC shall make reasonable efforts to reimburse the provider for the reasonable cost of medical records reproduction consistent with 42 CFR 476.78.

1. The cost for medical record production shall be at the current federal rate at the time of reimbursement to the provider. This rate may be updated periodically, but in no

circumstance shall it exceed the rate applicable under Louisiana statutes for public records requests.

2. Any costs associated with medical record production may be applied by the RAC as a credit against any overpayment or as a reduction against any underpayment. A tender of this amount shall be deemed a reasonable effort.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§8515. Appeals Process

A. A provider shall have a right to an informal and formal appeals process for adverse determinations made by the RAC.

B. The informal appeals process shall be conducted as follows.

1. Beginning on the date of issuance of any initial findings letter by the RAC, there shall be an informal discussion and consultation period. During this period the provider and RAC may communicate regarding any audit determinations.

2. Within 45 calendar days of receipt of written notification of an adverse determination from the RAC, a provider shall have the right to request an informal hearing

relative to such determination. The department's Program Integrity Section shall be involved in this hearing. Any such request shall be in writing and the date of receipt shall be deemed to be two days after the date of the adverse determination letter.

3. The informal hearing shall occur within 30 days of receipt of the provider's request.

4. At the informal hearing the provider shall have the right to present information orally and in writing, the right to present documents, and the right to have the department and the RAC address any inquiry the provider may make concerning the reason for the adverse determination. A provider may be represented by an attorney or authorized representative, but any such individual must provide written notice of representation along with the request for informal hearing.

5. The RAC and the Program Integrity Section shall issue a final written decision related to the informal hearing within 15 calendar days of the hearing closure.

C. Within 30 days of issuance of an adverse determination of the RAC, if an informal hearing is not requested or there is a determination pursuant to an informal hearing, a provider may request an administrative appeal of the final decision by requesting a hearing before the Division of Administrative Law. A copy of any request for an administrative appeal shall be

filed contemporaneously with the Program Integrity Section. The date of issuance of a final decision or determination pursuant to an informal hearing shall be two days from the date of such decision or determination.

D. The department shall report on its website the number of adverse determinations overturned on informal or formal appeals at the end of the month for the previous month.

E. If the department or the Division of Administrative Law hearing officer finds that the RAC determination was unreasonable, frivolous or without merit, then the RAC shall reimburse the provider for its reasonable costs associated with the appeals process. Reasonable costs include, but are not limited to, cost of reasonable attorney's costs and other reasonable expenses incurred to appeal the RAC's determination. The fact that a decision has been overturned or partially overturned via the appeals process shall not mean the determination was without merit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§8517. Penalties and Sanctions

A. If the department determines that the RAC inappropriately denied a claim(s), the department may impose a

penalty or sanction. A claim has been inappropriately denied when the:

1. adverse determination is not substantiated by applicable department policy or guidance and the RAC fails to utilize guidance provided by the department; or

2. RAC fails to follow any programmatic or statutory rules.

B. If more than 25 percent of the RAC's adverse determinations are overturned on informal or formal appeal, the department may impose a monetary penalty up to 10 percent of the cost of the claims to be awarded to the providers of the claims inappropriately determined, or a monetary penalty up to 5 percent of the RAC's total collections to the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030,

Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary