R-39 Rev. 08/2012
(Title page)

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State of Connecticut
REGULATION
of

NAME OF AGENCY
Department of Social Services

Concerning

SUBJECT MATTER OF REGULATION
Provider Audit Requirements

Section 1. The Regulations of Connecticut State Agencies are amended by adding sections 17b-99(d)-1 to 17b-99(d)-6, inclusive, as follows:

(NEW) **Sec. 17b-99(d)-1. Scope**

Sections 17b-99(d)-1 to 17b-99(d)-6, inclusive, of the Regulations of Connecticut State Agencies set forth the department's general requirements for auditing providers pursuant to section 17b-99 of the Connecticut General Statutes. Individual providers may also have to adhere to additional requirements set forth in other state and federal statutes and regulations. The provisions of sections 17b-99(d)-1 to 17b-99(d)-6, inclusive, of the Regulations of Connecticut State Agencies apply in addition to, and not in lieu of, such other requirements.

(NEW) **Sec. 17b-99(d)-2. Definitions**

As used in sections 17b-99(d)-1 to 17b-99(d)-6, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Audit" means the department's general, periodic review of a provider's claims to determine whether any underpayments or overpayments occurred in accordance with subsection (d) of section 17b-99 of the Connecticut General Statutes. "Audit" does not include any of the department's other targeted investigations or reviews;

(2) "Claim" means a provider's request or demand, whether under a contract or otherwise, for money, property or payment to a contractor, grantee, recipient or the department if the department provides any portion of the money, property or payment that is requested or demanded, or if the department will reimburse such contractor, grantee or other recipient for any portion of the money, property or payment that is requested or demanded;

(3) "Clerical error" means a provider's recordkeeping, typographical, scrivener's or computer error that is unintentional, discrete, isolated, and due to the provider's unwitting mistake or inadvertence;

(4) "Client" means a person who the department has determined is eligible for goods or services pursuant to a department program;

(5) "Commissioner" means the Commissioner of Social Services;

(6) "Commissioner's designee" means a person who is impartial and is not an employee of the Department of Social Services Office of Quality Assurance or an employee of an entity with which the Commissioner contracts for the purpose of conducting an audit of a service provider;

(7) "Common ownership" means a circumstance where the same individual, individuals, entity, or entities directly or indirectly own 5 percent or more total ownership of two entities. Common ownership includes, but is not limited to, parent corporations, direct and indirect subsidiaries, and brother or sister corporations;

(8) "Control" means a circumstance where an individual, individuals, entity, or entities have power over or direct the behavior, action, or function of another individual, individuals, entity, or entities;

(9) "Department" means the Department of Social Services or its agent;

(10) "Document" or "record" means any data created by the provider in the ordinary course of business by or before the date of the submission of a claim to the department that concerns the claim or concerns the goods or services that were the subject of the claim. "Document" or "record" does not include any data created by the provider after the date of the submission of a claim, unless the department, in its discretion, finds such document or record reliable for the purpose of the department's audit;

(11) "Department program" means a program operated or administered by the department pursuant to chapters 319s, 319t, 319v, 319y or 319ff of the Connecticut General Statutes, except a program for which rates are established pursuant to section 17b-340 of the Connecticut General Statutes;

(12) "Exit conference" means a meeting, as required by section 17b-99(d)(6) of the Connecticut General Statutes, between a provider and the department to discuss the department's preliminary written report of its audit of the provider;

(13) "Extrapolation" means the determination of an unknown value by projecting the results of the review of a sample to the universe from which the sample was drawn;

(14) "Goods or services" means care or items that a provider furnishes to a client in accordance with all federal and state laws, policies and procedures, all provider enrollment agreement terms and all provider enrollment and, if applicable, reenrollment application terms;

(15) "Medical necessity" or "medically necessary" has the same meaning as in section 17b-259b of the Connecticut General Statutes, as amended from time to time;

(16) "Overpayment" means the amount of financial liability that the department determines is due to the department. An overpayment may be a singular amount, the sum of an aggregate of amounts, or an amount calculated through the use of extrapolation. Any finding of an overpayment that is based upon an extrapolation shall be made in accordance with section 17b-99(d)(3) of the Connecticut General Statutes;

(17) "Paid claim" means a claim that the department has paid;

(18) "Payment" means any money or property, whether under a contract or otherwise, that the department pays to a provider, contractor, grantee or other recipient;

(19) "Provider" means a person, public agency, private agency or proprietary agency that is licensed, certified or otherwise approved by the commissioner to supply services authorized by the programs set forth in chapters 319s, 319t, 319v, 319y or 319ff of the Connecticut General Statutes, except for programs for which rates are established pursuant to section 17b-340 of the Connecticut General Statutes, and includes any person acting on his or her own behalf or on behalf of an entity to furnish goods or services under department programs;

(20) "Provider enrollment agreement" means a signed, written, contractual agreement between the department and a provider for enrollment as a provider in a program administered by the department;

(21) "Provider enrollment application" or "provider reenrollment application" means an application form that the department uses to obtain provider information including, but not limited to, name, address, licensure or certification information, service protocols and other information required by the department, together with all other information and documents required by the department, to assess provider eligibility for participation in department programs;

(22) "Related party" means a person or organization related through an ability to control, ownership, family relationship or business association, and includes a person related through marriage;

(23) "Sample design" means the method used to select the sample unit;

(24) "Sample selection" means the number of sample units to be reviewed during the audit;

(25) "Sample unit" means one paid claim or a different unit of measurement when a different unit is deemed necessary by the department and indicated in writing in the department's final written report;

(26) "Sampling universe" means all of a provider's sample units from which the sample selection will be drawn;

(27) "Third party" means any individual, private or public organization, or entity that is or may be liable to pay all or part of the medical costs of injury, disease, or disability for a client pursuant to 42 CFR 433.136; and

(28) "Underpayment" means the amount of financial liability that the department determines is due from the department. An underpayment may be a singular amount, the sum of an aggregate of amounts, or an amount calculated through the use of extrapolation. Any finding of an underpayment that is based upon an extrapolation shall be made in accordance with section 17b-99(d)(3) of the Connecticut General Statutes.

(NEW) **Sec. 17b-99(d)-3. Sampling Methodology**

(a) The department may perform an audit by reviewing every claim or paid claim or by reviewing a sample selection or some combination thereof. Audits may consist of the review of a sample selection and extrapolation of the underpayment or overpayment from the sample. Any finding of an underpayment or overpayment that is based upon an extrapolation shall be made in accordance with section 17b-99(d)(3) of the Connecticut General Statutes.

(b) When the department performs an audit by reviewing a sample selection, the department shall review a sample selection that has been selected by using methods generally accepted by the professional auditing or accounting community for selecting statistically valid samples including, but not limited to, the methods set forth in subdivisions (1) to (8), inclusive, of this subsection. The department may select a sample selection by taking the following steps:

(1) Identifying the provider;

(2) identifying the time period to be audited;

(3) identifying the item of goods or services or type of claim to be audited;

(4) identifying the sampling universe;

(5) identifying the sample unit;

(6) defining the sample design;

(7) defining the sample selection; and

(8) obtaining the sample selection to proceed with the audit.

(c) When the department performs an audit by reviewing a sample selection, the department may calculate underpayments and overpayments by extrapolation methods generally accepted by the professional auditing or accounting community including, but not limited to, calculating the error rate based upon value of the underpayments and overpayments in the sample and projecting that error rate to the sampling universe. Any finding of an underpayment or overpayment that is based upon an extrapolation shall be made in accordance with section 17b-99(d)(3) of the Connecticut General Statutes.

(d) The department shall state in writing in the preliminary written report and final written report the sampling methodology and extrapolation methodology for the audit.

(NEW) **Sec. 17b-99(d)-4. Conduct of the Audit Process**

(a) The department may audit any provider in any department program.

(b) The department shall determine, in its discretion, which providers and periods of time to audit. In determining which providers to audit, the department may give consideration to the history of a provider's compliance.

(c) The department shall determine, in its discretion, the frequency of audits for any particular provider.

(d) The department shall, as required by subdivision (1) of subsection (d) of section 17b-99 of the Connecticut General Statutes, give providers timely written notice of audits.

(e) The department shall determine whether to perform an audit by reviewing every paid claim or by reviewing a sample of paid claims or some combination thereof. If the department decides to review a sample of paid claims, it shall select a sample pursuant to section 17b-99(d)-3 of the Regulations of Connecticut State Agencies.

(f) During an audit, the department may review and consider any document, record or other information from the provider or any other source that the department has reasonable cause to believe is relevant and reliable to the scope of the audit.

(g) During an audit, the department may review the sample selection to determine whether:

(1) The provider provided goods or services to a client;

(2) the billings properly reflected the type and amount of goods or services provided;

(3) the goods or services were medically necessary;

(4) the provider maintained original documentation that thoroughly, fully and accurately evidences the goods or services provided and the medical necessity of such goods or services;

(5) the provider adhered to all applicable state and federal laws, policies and procedures;

(6) the provider properly billed all available third parties and, if applicable, received appropriate denials, prior to the provider seeking payment from the department;

(7) the provider adhered to all applicable standards for licensure governing the goods or services provided;

(8) the provider adhered to all of the terms and conditions of its provider enrollment agreement with the department;

(9) the provider adhered to all of the statements and disclosures in its provider enrollment application and, if applicable, provider reenrollment application with the department;

(10) the provider accurately reported all allowable costs and any data or information associated with the goods or services provided;

(11) the provider accurately and completely reported, allocated or disallowed any related party transactions or costs not related to department programs where required;

(12) all information concerning the costs of the providers' subcontractors, to the extent the subcontractors' costs are paid for by the department, is accurate and complete;

(13) all information maintained by the provider or utilized by the provider to support claims is accurate and complete;

(14) the provider gave accurate and complete information to the department during the course of an audit; and

(15) other documents or items deemed relevant and necessary by the department are needed in order to complete the audit.

(h) A clerical error may be considered as the basis for an overpayment or underpayment.

(i) A provider shall have thirty days to provide documentation in connection with any discrepancy discovered and brought to the attention of the provider in the course of the audit. Upon a provider's request, the department may permit a provider more than thirty days to provide such documentation.

(j) Not later than sixty days after the department determines that the preliminary fieldwork, review and analysis of the audit has concluded, the department shall produce a preliminary written report concerning the audit and provide said report to the audited provider.

(k) After the department has provided the preliminary written report required by subsection (j) of this section to the provider, the department shall hold an exit conference with said provider for the purpose of discussing the preliminary written report. The provider may present evidence at the exit conference to refute findings in the preliminary report.

(l) The department, or any entity with which the department contracts for the purpose of conducting an audit of a service provider, shall send the provider a final written report not later than sixty days after the date of the exit conference, unless the department, or any entity with which the department contracts for the purpose of conducting an audit of a service provider, agrees to a later date or there are other referrals or investigations pending concerning the provider.

(m) The department may identify underpayments or overpayments based upon an audit of a provider's claims and may calculate underpayments or overpayments based upon extrapolation. Any finding of an underpayment or overpayment that is based upon an extrapolation shall be made in accordance with section 17b-99(d)(3) of the Connecticut General Statutes.

(NEW) **Sec. 17b-99(d)-5. Review of Provider's Items of Aggrievement in Final Audit Report**

(a) A provider aggrieved by a decision contained in a final written report issued pursuant to subsection (l) of section 17b-99(d)-4 of the Regulations of Connecticut State Agencies may, not later than thirty days after the receipt of the final written report, request, in writing, a review of all items of aggrievement. The scope of the review shall not include or consider facts or circumstances outside the audit and the final written report.

(b) The provider's request for review shall be made in writing and, at a minimum, set forth a detailed written description of each specific item of aggrievement including:

(1) The specific decision or decisions for which review is sought;

(2) any facts that were misapprehended or overlooked by the audit decision thereby causing aggrievement; and

(3) any state or federal laws, operational policies or procedures, any provider enrollment agreement terms, or statements or disclosures in the provider enrollment application and, if applicable, provider reenrollment application, that were misapprehended or overlooked by the audit decision thereby causing aggrievement.

(c) In the discretion of the commissioner's designee presiding over the review, the commissioner's designee may conduct the review by using some or all of the following methods:

(1) Making informal inquiries to the provider or the department;

(2) accepting written statements from the provider, the department, and other persons or entities;

(3) holding an informal conference with the provider and the department for fact finding purposes or for accepting oral statements from the provider and department or from persons or entities other than the provider and the department;

(4) hearing witness testimony or receiving other evidence for fact finding purposes after giving appropriate notice thereof to the provider and the department, but only if, in the discretion of the commissioner's designee, witness testimony or receipt of other evidence is necessary to understand the facts during the review of the audit; and

(5) obtaining such other information as the commissioner's designee may in his or her discretion find necessary.

(d) Following review, the commissioner's designee shall issue a final written decision that:

(1) States what, if any, facts were misapprehended or overlooked by the audit decision thereby causing aggrievement; or

(2) states what, if any, state or federal laws, operational policies or procedures, provider enrollment agreement terms, or statements or disclosures in the provider enrollment application, and if applicable, provider reenrollment application were misapprehended or overlooked by the audit decision thereby causing aggrievement; and

(3) directs the department regarding what, if any, action should be taken including, but not limited to, changing the audit decision or not changing the audit decision.

(NEW) **Sec. 17b-99(d)-6. Recovery of Overpayments**

(a) The conclusion of an audit occurs, and recoupment liability begins, on the date that the department issues the final written report to the provider.

(b) After the department concludes an audit conducted pursuant to sections 17b-99(d)-1 through 17b-99(d)-5, inclusive, of the Regulations of Connecticut State Agencies, any amount which the department's audit finds was an overpayment shall be payable to the department and any amount which the department's audit finds was an underpayment shall be payable to the provider.

(c) The department may bring a civil action against a provider to recover any overpayment not returned to the department.

(d) The department may recoup overpayments from current and future payment due the provider, which may include recoupment of overpayments made for prior years. The department shall recoup such overpayments as soon as possible.

(e) If the provider requests a review of a decision in the final written report pursuant to section 17b-99(d)-5 of the Regulations of Connecticut State Agencies, such a request for review and the pendency of such a review shall not automatically stay any recoupment of overpayment identified in the final written report. A provider may request a stay of any such recoupment, and the department may grant or deny such request in the department's discretion.

(f) Whenever the department identifies an overpayment made to a provider, the department may:

(1) Recoup the amount of such overpayment from payments to the provider regardless of any intervening change in ownership of the provider; and

(2) offset against the indebtedness any liability of the department to another provider which is owned or controlled by the same person or persons who owned or controlled the first provider at the time the indebtedness to the department was incurred.

A. In the case of the same person or persons owning or controlling two or more providers but separately incorporating them, whether the person or persons own or control such corporations shall be an issue of fact the department shall decide.

B. Where the department finds common ownership or control, the provisions of this section shall apply notwithstanding the form of business organization utilized by such persons including, but not limited to, separate corporations and limited partnerships.

C. The department's finding of control does not necessarily require evidence of actual past exercise of control, but rather requires only the potential or ability to directly or indirectly exercise influence or control.

(g) Where the department finds common ownership or control prior to the final written report being issued, the department shall include such finding in the final written report.

(h) The department shall not be limited to the provisions of this section as the means of recovery of such overpayments. The means of recovery of such overpayments set forth in this section are in addition to, and not in lieu of, any other provision, means, or remedy the department may have to recover such overpayments.

Statement of Purpose

These regulations implement the provisions of subsection (d) of section 17b-99 of the Connecticut General Statutes. The regulations describe sampling methodologies the department may use, how the department may conduct audits, how providers may obtain review of provider's items of aggrievement in a final audit report, and how the department may recover overpayments found by audit. The regulations set forth how the department may initiate audits, proceed with and conclude audits, and what the department may review during an audit. The regulations provide that the department will recover overpayments as soon as possible from all providers by allowing the department to use any means or remedy it may have, including, but not limited to, recoupment of current or future payments from providers who were subject to audit or from other providers owned or controlled by the same person or persons who own or control the providers subject to audit without delay due to requests for review by the provider, unless in the discretion of the Commissioner a stay of recoupment is authorized.