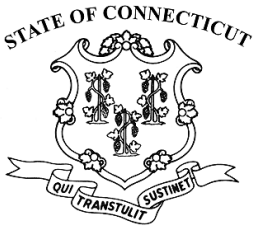

Senate Bill No. 243

Public Act No. 18-76

AN ACT CONCERNING AUDITS OF MEDICAL ASSISTANCE PROVIDERS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivision (2) of subsection (d) of section 17b-99 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(2) Not less than thirty days prior to the commencement of any such audit, the commissioner, or any entity with which the commissioner contracts to conduct an audit of a participating provider, shall provide written notification of the audit to such provider and the statistically valid sampling and extrapolation methodology to be used in conducting such audit, unless the commissioner, or any entity with which the commissioner contracts to conduct an audit of a participating provider makes a good faith determination that (A) the health or safety of a recipient of services is at risk; or (B) the provider is engaging in vendor fraud. At the commencement of the audit, the commissioner, or any entity with which the commissioner contracts to conduct an audit of a participating provider, shall disclose (i) the name and contact information of the assigned auditor or auditors, (ii) the audit location, including notice of whether such audit shall be conducted on-site or through record submission, **[**and**]** (iii) the manner

by which information requested shall be submitted, and (iv) the types of information to be reviewed in the audit. No audit shall include claims paid more than thirty-six months from the date claims are selected for the audit. The commissioner shall not apply an agency policy, guideline, bulletin or manual provision or other criteria, including, but not limited to, updated medical payment codes, to make determinations in an audit unless the policy, guideline, bulletin or manual provision or other criteria, together with the effective date, was promulgated and distributed to a provider prior to provision of a service included in a claim being audited. The commissioner shall accept a scanned copy of documentation supporting a claim when the original documentation is unavailable.

Sec. 2. Subdivision (5) of subsection (d) of section 17b-99 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(5) In conducting any audit pursuant to this subsection, the commissioner, or any entity with which the commissioner contracts to conduct such audit, shall accept (A) as sufficient proof of a written order: A photocopy, facsimile image, an electronically maintained document or original pen and ink document, and (B) as sufficient proof of delivery of a covered item or service: A receipt signed by the recipient of medical assistance or a nursing facility representative or, in the case of delivery of a covered item or service by a shipping or delivery service, a supplier's detailed shipping invoice and the delivery service tracking information substantiating delivery. The commissioner, or any entity with which the commissioner contracts to conduct such audit, may seek additional documentation in circumstances including, but not limited to: (i) The proof provided is insufficiently legible, (ii) the proof provided is contradicted by other sources of information reviewed in the audit, or (iii) the commissioner, or any entity with which the commissioner contracts to conduct such

audit, makes a good faith determination that the provider may be engaging in vendor fraud. A provider, in complying with the requirements of any such audit, shall be allowed not less than thirty days to provide documentation in connection with any discrepancy discovered and brought to the attention of such provider in the course of any such audit. Such documentation may include evidence that errors concerning payment and billing resulted from a provider's transition to a new payment or billing service or accounting system. The commissioner shall not calculate an overpayment based on extrapolation or attempt to recover such extrapolated overpayment when the provider presents credible evidence that an error by the commissioner, or any entity with which the commissioner contracts to conduct an audit pursuant to this subsection, caused the overpayment, provided the commissioner may recover the amount of the original overpayment.

Sec. 3. Subdivision (11) of subsection (d) of section 17b-99 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(11) The commissioner shall provide free training to providers on how to enter claims to avoid errors and shall post information on the department's Internet web site concerning the auditing process, standard audit procedures and methods to avoid clerical errors. The commissioner shall establish and publish on the department's Internet web site audit protocols to assist the Medicaid provider community in developing programs to improve compliance with Medicaid requirements under state and federal laws and regulations, provided audit protocols may not be relied upon to create a substantive or procedural right or benefit enforceable at law or in equity by any person, including a corporation. The commissioner shall establish audit protocols for specific providers or categories of service, including, but not limited to: (A) Licensed home health agencies, (B)

drug and alcohol treatment centers, (C) durable medical equipment, (D) hospital outpatient services, (E) physician and nursing services, (F) dental services, (G) behavioral health services, (H) pharmaceutical services, (I) emergency and nonemergency medical transportation services, and (J) homemaker companion services. The commissioner shall ensure that the Department of Social Services, or any entity with which the commissioner contracts to conduct an audit pursuant to this subsection, has on staff or consults with, as needed, a medical or dental professional who is experienced in the use and review of electronic medical records, and the treatment, billing and coding procedures used by the provider being audited. The commissioner shall ensure that an auditor reviews any electronic medical record associated with a patient chart included in the audit.

Approved June 1, 2018