2013 SENATE HUMAN SERVICES

SB 2114

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2114
1/21/13
Recording Job Number: 17424

☐ Conference Committee

Committee Clerk Signature: Kari Hunt

Explanation or reason for introduction of bill/resolution:

Relating to sanctions against a provider who provides services under a provider agreement with medical assistance.

Minutes: You may make reference to "attached testimony."

Chairman Lee opens hearing on SB 2114.

Jon Alm, with the Department of Human Services, is first up to testify in support of SB 2114.

See attached testimony #1.

Chairman Lee opens the floor for questions from the committee.

(0:8:13) Chairman Lee questions section in testimony on page 4 where it states section 28-32-46 and then references where the Bill reads 28-32-42 and then below it 28-32-46. Just wants to make sure the correct numbers are in the Bill.

Mr. Alm states that the sections stated in the proposed law are correct and clarifies 28-32-42 and 28-32-46 as it relates to his testimony.

(0:9:25) Senator Dever questions how big the problem is and if there are similar procedures either through the department or other agencies.

Mr. Alm states that over the last year (2012) there are about a handful of providers that this might apply. He explains the process and that ultimately the last resort for the department is termination of the provider.

Chairman Lee follows with a brief history of the fraud and abuse issue.

(0:12:12) Senator Dever feels that allowing for this might otherwise pursue criminal sanctions.

Mr. Alm states that criminal sanctions are still available and are referred to the federal prosecutor's office or the state's attorney's office. This is the only option right and he is not aware of any cases that are being taken up by the authorities.

(0:14:10) Senator Anderson asks if the criminal sanctions get turned over to the Office of Inspector General rather than try to do it locally.

Mr. Alm states that the investigation does get turned over to the OIG to review and process.

(0:14:36) Chairman Lee inquires about a fiscal note.

Mr. Alm states that there is no fiscal note attached and he doesn't believe there will be a cost to the department.

No further questions from the committee for Mr. Alm.

No further testimony in favor or opposition.

Chairman Lee closes the hearing on SB 2114.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2114
1/21/13
Recording Job Number: 17430

☐ Conference Committee

Committee Clerk Signature: Kari Lerch

Explanation or reason for introduction of bill/resolution:

Relating to sanctions against a provider who provides services under a provider agreement with medical assistance.

Minutes: You may make reference to "attached testimony."

Committee action on SB 2114:

Senator Anderson moves Do Pass.

Senator Axness seconds.

No further committee discussion.

Roll call vote: 5-0, Do Pass.

Senator Anderson carries Bill to the floor.

Date: 1/21/13
Roll Call Vote #: 1

2013 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2114

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☑ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Sen. Anderson Seconded By Sen. Axness

Senators	Yes	No	Senator	Yes	No
Chariman Judy Lee	✓		Senator Tyler Axness	✓	
Vice Chairman Oley Larsen	✓				
Senator Dick Dever	✓				
Senator Howard Anderson, Jr.	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment Sen. Anderson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2114: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2114 was placed on the Eleventh order on the calendar.

2013 HOUSE HUMAN SERVICES

SB 2114

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SB 2114
March 19, 2013
Job #20136

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

Relating to sanctions against a provider who provides services under a provider agreement with medical assistance

Minutes: *See Testimony #1*

Chairman Weisz opened the hearing on SB 2114.

Jonathan Alm: Attorney for the DHS testified in support of the bill. (See Testimony #1)

7:37
Rep. Porter: What is the appeal process for a provider who wants to appeal?

Alm: The provider has a right to ask us to review the decision of being sanctioned. Then we would have an employee go through all the information that was provided to us. If it is overturned we would notify the provider and if not it would go to the appeals supervisor in the department. The appeals supervisor has to by this law draft a findings of fact conclusion of the law and order. That gets signed and sent to the provider. Provider has a right to appeal to the district court and then they could go on to the supreme court for appeal if they don't like the decision.

Rep. Porter: There isn't a less costly way then district court?

Alm: On page 2, line 18; it talks about how you can ask for a review from someone other than the individual involved. It also talks about an informal conference. There is no outside mediation from a third party.

Rep. Porter: Did you discuss that as you were putting this together to see what would minimize the impact back on the overburdened district court?

Alm: It was discussed and also on how often we would implement this. It would have been implemented 5 times or less in the past two years. The impact on district court is not going to be great. Another option is if we are going to utilize another outside source, we would have to look at if it going to be a fiscal cost? So, let's keep it the same as what we

currently have for providers on other appeals and then providers know the what the standard is as well.

Rep. Porter: This committee's opinion in the past has been wait for MMIS because you don't have an effective tracking and audit system in place. I'm more willing to doing this as MMIS will soon be online. My concern is the normal billing errors that would bring the hammer down. Being a provider of Medicaid services there are many times that we are in direct arguments with the department on whether or not it is a covered service. If we are constantly submitting claims that don't meet the words of medical necessity, then does that constitute abuse of the program?

Alm: This is going to be the last step in the process. We can work with the providers to educate them on how to reduce billing errors. This sanction is for providers who continually bill hoping they get paid and don't want to work with us and hopefully will wake up the provider on what they need to do.

Rep. Porter: That is how I would see it. My concern is, currently we have developed almost a relationship of working off the system of denials and not the other parts of the systems. It seems it leaves it up to individual judgment rather than a base set of criteria that a patient would have to meet to use a service. It seems there will be a huge learning curve based upon this implication. You always had the policy that you bill us and we will look at it and see if we can pay it.

Alm: We will be educating providers. We don't have that many that are abusing the system.

Rep. Porter: Last time we looked at these bills there were positive fiscal notes attached. Do you plan on having a fiscal note stating the positive and negative impacts?

Alm: We didn't feel because of the small number that there would be a cost to the department.

Rep. Porter: Our last discussion, two or four years ago we talked about the national cases and the component of being able to join in those cases and many were drug rebate issues and big dollars were laying out there. Does this move us into a position to do that again or does this have nothing to do with that?

Alm: This has nothing to do with it. This law does not create a Medicaid fraud unit.

Rep. Fehr: In the past couple of years there were only five cases and if this law was in place they would have gone forward to sanctions?

Alm: That is correct.

Rep. Fehr: Tell us what was significant of those cases and what was involved. Under the current system, how were those cases concluded or resolved?

Alm: A provider billed double time and one that inappropriately billed services by a person who was not authorized to bill services. One of the providers is no longer practicing medicine and one is still under review.

Rep. Fehr: The double billing was billing two times for the same session?

Alm: That's my understanding.

Rep. Fehr: What about the author person? Explain that.

Alm: It was an employee that was billing at a higher code than they were supposed to.

Rep. Silbernagel: Can you explain MMIS?

Chairman Weisz: Medicaid Management Information System.

Rep. Silbernagel: Can you explain the scope and intent of it is?

Alm: It is a way to process claims. An automated billing system.

Vice-Chair Hofstad: I'm hung up on medical necessity. It is an ambiguous term. Help me understand that and how are you going to deal with that term.

Cindy Sheldon: Deputy Director for ND Medical Services. The sanctions we are talking about in here are not affiliated with medical necessity as coding and billing issues. We have medical experts in the division that review the documents. It is a hard term to define. I don't believe if ten of your claims come back and deemed not medically necessary, is that going to lead to a sanction? I don't believe that. The sanctions have been double billing and services that never transpired.

Rep. Porter: In regards to the fine, did you discuss the stair step approach rather than a flat $10,000 per act?

Alm: Yes we did and looked at other states' laws. The $10,000 is the max. We have no set minimum.

Rep. Porter: Each instance you have a checklist to go through for each civil penalty. At what point would this flip into the criminal side?

Alm: The provider would have to pay back any overpayment. We do have a list in administrative rules that we would do a checklist and do a determination of what the amount of the civil monetary sanction would be. If we wanted to refer it to the office of Inspector General on the federal side or a local state's attorney, we will make that referral as well.

Rep. Silbernagel: You mentioned other states have Medicaid fraud units. What differentiates what other states are doing from what ND is doing?

Alm: I can't answer that question. Cindy can.

Cindy Sheldon: Other states have a Medicaid Fraud Control Unit and it usually is housed outside of the Medicaid agency, but not an internal unit, like the Bismarck, ND Medicaid. We are one of the states that does not have one.

NO OPPOSITION

Chairman Weisz closed the hearing on SB 2114.

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SB 2114
March 25, 2013
Job #20431

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

Relating to sanctions against a provider who provides services under a provider agreement with medical assistance.

Minutes: *See Attachment #1*

Chairman Weisz: Let's look at 2114. That is the one for the fraud and penalties.

Rep. Porter: Explained the amendment. (See Attachment #1)

Chairman Weisz: On your first part, they could be liable for up to 25% of the fraudulent payment plus a fine of $5,000 if it is fraud or abuse.

Rep. Porter: I think it is either or.

Jonathan Alm: Attorney from the DHS. It is or. This 25% is if we have induced a payment. If we paid on a claim of $100,000, we paid $20,000 of that because the rest was an act of fraud. We could sanction them for 25% of the $20,000 we had paid them. If we received $100,000 claim, but did not pay anything then we could look at the $5,000 penalty for each act of fraud.

Rep. Silbernagel: You feel this will give you sufficient teeth to do what you were trying to set forward here?

Alm: Yes.

Rep. Porter: I move the amendment.

Rep. Silbernagel: Second.

Rep. Fehr: Given the experience that I had a number of years ago with the department, I'm going to ask that I be recused from any voting on this bill.

Chairman Weisz: You don't get recused in committee, only on the floor.

Rep. Mooney: Can you explain number 7 again Rep. Porter?

Rep. Porter: In the discussion we had during the committee hearing, there was language in the original bill that talked about medical necessity. That being one of the indicators that fraud and abuse could be used to go against a provider. The department's normal course of business, they want you to submit the claims when you provide the service. Then they may reject them based on medical necessity and that opens up the appeals process. Then you can go back to the department and appeal their decision and have a hearing with the department. This allows that practice to continue. This keeps the standard normal business practice they have right now in operation.

VOICE VOTE (on amendment): MOTION CARRIED

Rep. Silbernagel: I move a Do Pass as amended on SB 2114.

Rep. Looysen: Second

ROLL CALL VOTE: 11 y 2 n 0 absent

Bill Carrier: Rep. Silbernagel

VK
3/25/13

13.8112.01001
Title.02000

Adopted by the Human Services Committee

March 25, 2013

PROPOSED AMENDMENTS TO SENATE BILL NO. 2114

Page 1, line 3, after "assistance" insert "; and to provide a penalty"

Page 1, line 16, replace "ten thousand dollars for" with "twenty-five percent of the amount the department was induced to pay as a result of"

Page 1, line 18, after the underscored period insert "A provider, an affiliate of a provider, or any combination of provider and affiliates, is liable to the department for up to five thousand dollars on each act of fraud or abuse which did not induce the department to make an erroneous payment. This sanction is in addition to the applicable rules established by the department.

4."

Page 1, line 22, replace "4." with "5."

Page 2, line 3, replace "5." with "6."

Page 3, line 11, replace "6." with:

"7. Determinations of medical necessity may not lead to imposition of remedies, duties, prohibitions, and sanctions under this section.

8."

Page 3, line 14, replace "7." with "9."

Renumber accordingly

Date: 3-25-13
Roll Call Vote #: 1

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2114

House Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Porter Seconded By Rep. Silbernagel

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. MOONEY		
VICE-CHAIRMAN HOFSTAD			REP. MUSCHA		
REP. ANDERSON			REP. OVERSEN		
REP. DAMSCHEN					
REP. FEHR					
REP. KIEFERT					
REP. LANING					
REP. LOOYSEN					
REP. PORTER					
REP. SILBERNAGEL					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

See attachment #1 Voice Vote

Proposed amendment - replace 10,000. dollars

motion Carried

Date: 3-25-13
Roll Call Vote #: 2

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2114

House Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 13.8112.01001

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment
☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Silbernagel Seconded By Rep. Looysen

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ		✓	REP. MOONEY	✓	
VICE-CHAIRMAN HOFSTAD	✓		REP. MUSCHA	✓	
REP. ANDERSON	✓		REP. OVERSEN	✓	
REP. DAMSCHEN	✓				
REP. FEHR		✓			
REP. KIEFERT	✓				
REP. LANING	✓				
REP. LOOYSEN	✓				
REP. PORTER	✓				
REP. SILBERNAGEL	✓				

Total (Yes) 11 No 2

Absent 0

Floor Assignment Rep. Silbernagel

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2114: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (11 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). SB 2114 was placed on the Sixth order on the calendar.

Page 1, line 3, after "assistance" insert "; and to provide a penalty"

Page 1, line 16, replace "ten thousand dollars for" with "twenty-five percent of the amount the department was induced to pay as a result of"

Page 1, line 18, after the underscored period insert "A provider, an affiliate of a provider, or any combination of provider and affiliates, is liable to the department for up to five thousand dollars on each act of fraud or abuse which did not induce the department to make an erroneous payment. This sanction is in addition to the applicable rules established by the department.

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Page 3, line 11, replace "6." with:

"7. Determinations of medical necessity may not lead to imposition of remedies, duties, prohibitions, and sanctions under this section.

8."

Page 3, line 14, replace "7." with "9."

Renumber accordingly

2013 CONFERENCE COMMITTEE
SB 2114

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2114
4/10/13
21075

☒ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to sanctions against a provider who provides services under a provider agreement with medical assistance.

Minutes:

Sen. Anderson, Sen. Larsen, Sen. Axness are present.

Rep. Anderson, Rep. Silbernagel, Rep. Mooney are present.

Senator Anderson opens the conference committee for SB 2114

Senator Anderson asks about the amendments made to SB 2114

Representative Silbernagle discusses preventing fraud and abuse, and this was a good starting point.

Senator Anderson shares about fines and the board of pharmacy.

Senator Larsen motions Senate accede to House Amendments.

Senator Axness seconds

6 Yes
0 No
0 Absent

Motion passes.

Senate Carrier: Senator Anderson

House Carrier: Representative Anderson.

Date 4-10

Roll Call Vote # 1

2013 SENATE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 2114 as (re) engrossed

Senate Human Services Committee

Action Taken ☑ SENATE accede to House Amendments

☐ SENATE accede to House Amendments and further amend

☐ HOUSE recede from House amendments

☐ HOUSE recede from House amendments and amend as follows

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Sen Larsen Seconded by: Axness

Senators	2/10			Yes	No	Representatives	4/10			Yes	No
Sen. Anderson	✓			✓		Rep. Anderson	✓			✓	
Sen. Larsen	✓			✓		Rep. Silbernagel	✓			✓	
Sen. Axness	✓			✓		Rep. Mooney	✓			✓	
Total Senate Vote						Total Rep. Vote					

Vote Count Yes: 5 No: — Absent: _____

Senate Carrier Sen Anderson House Carrier Rep Anderson

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

REPORT OF CONFERENCE COMMITTEE

SB 2114: Your conference committee (Sens. Anderson, Larsen, Axness and Reps. Anderson, Silbernagel, Mooney) recommends that the **SENATE ACCEDE** to the House amendments as printed on SJ page 939 and place SB 2114 on the Seventh order.

SB 2114 was placed on the Seventh order of business on the calendar.

2013 TESTIMONY

SB 2114

Attachment #1

Testimony
Senate Bill Number 2114 - Department of Human Services
Senate Human Services Committee
Senator Judy Lee, Chairman
January 21, 2013

Chairman Lee, and members of the Senate Human Services Committee, I am Jon Alm with the Department of Human Services. I appear before you to support Senate Bill 2114, which was introduced on behalf of the Department of Human Services Department.

The State Auditor's office, in its October 2010 Performance Audit, recommended that North Dakota Medicaid ensure the implementation of Medicaid civil sanctions and other sanctions are imposed, as applicable, following investigations of providers which identify inappropriate billings, fraud, and/or abuse. Over the past two years, the Medicaid Program Integrity staff have enhanced the fraud and abuse policies and procedures, strengthened audit activities, updated North Dakota Administrative Code chapter 75-02-05 on Provider Integrity (chapter 75-02-05), developed a suspected fraud reporting mechanism for ease of reporting, and have been proactively engaging in the identification of suspected Medicaid fraud and abuse. In an effort to further enhance program integrity efforts, the Department is proposing to implement civil monetary sanctions to deter providers from engaging in fraud and abuse activities. I have attached a copy of chapter 75-02-05 to my testimony for your reference.

The language in this bill addressing the Department's ability to issue civil monetary sanctions begins on page 1, line 15, which says, [A] provider, an affiliate of a provider, or any combination of provider and affiliates, is liable to the department for up to $10,000 for each act of fraud or abuse.

This sanction is in addition to the applicable rules established by the department. An act is something done intentionally, voluntarily, or with a purpose. For example, each act may pertain to each false or abuse claim. The act or number of acts will be determined by the Department. The act must meet the definition of "fraud" or "abuse" set forth in chapter 75-02-05 before civil monetary sanctions may be considered. Page 1, line 18, requires a provider, an affiliate of a provider, or any combination of provider and affiliates, to reimburse the Department for investigation fees, costs, and expenses for any investigation and action brought in connection with a civil monetary sanction. Page 3, line 14, details that the State's share of all civil sanctions, investigative fees, costs, expenses, and interest received by the Department from issuing a civil monetary sanction must be deposited into the State's general fund.

The Department would use chapter 75-02-05 in carrying out the civil monetary sanctions provided in this bill. Chapter 75-02-05 outlines a provider's responsibilities to the Department, grounds for sanctions, how the Department investigates providers, and activities leading to and including sanctions. Providers' responsibilities include ensuring that services are medically necessary, retaining appropriate documentation, accepting payment as full, filing claims in a timely manner, and complying with all applicable Centers for Medicare and Medicaid Services (CMS) regulations. The Department may sanction a provider or a provider's affiliate for a number of reasons including when the provider or provider's affiliate presents a false or fraudulent claim or information, fails to disclose records, fails to comply with the terms of the provider agreement, defrauds any health care benefit program, and when a provider or provider's affiliate is suspended or excluded from other Medicaid programs or by Medicare. The Department is able to impose

sanctions, including requiring a provider to attend educational programs, implementing of a business integrity agreement, suspending Medicaid payments, imposing pre-payment or post-payment review of claims, recovering costs of the investigation, requiring a provider self-audit, making referrals to the appropriate state regulatory agency or licensing agency, suspending a provider from participation in the Medicaid program, and imposing prior authorization of all services and a peer review at the provider's expense.

As established by chapter 75-02-05, the Department will evaluate the severity of the fraud or abuse before imposing a civil monetary sanction. In evaluating the severity of the fraud or abuse, the Department may consider the seriousness of the offense, the extent of the violations, prior violations, prior imposition of sanctions against the provider, the provider's agreement to make restitution to the Department, or actions taken or recommended by peer groups or licensing boards, access to care for recipients, whether the provider self-disclosed the finding, and the provider's willingness to participate in a performance improvement plan.

Civil sanctions will be applied in cases where the provider has not improved practices after the Department has addressed repeated concerns with them and there has been no improvement or resolution in their practice, or if the provider has not complied with the remedies determined by the Department pursuant to the sanction. For example, if a Qualified Service Provider (QSP) supplies an incorrect date for payment for services in error, and it is not a systemic pattern; a civil sanction would not be imposed. However, a civil sanction may be applied if a medical provider had been sanctioned with a pre-payment review of claims due to erroneous billing practices and the same billing practices do

not improve over the course of 12 months. The civil sanction will be used with providers who have consistent, severe, and repetitive concerns; the Department will use civil sanctions as a last resort in restricting adverse provider practices.

If the Department issues a civil monetary sanction on a provider or affiliate, the provider's and affiliate's review and appeal rights are set forth on page 2, starting on line 3 through page 3, line 10. A provider or affiliate who is assessed a sanction may request a review of the sanction by filing a statement of dispute with the Department within 30 days of the date of the Department's written notice of the sanction. Page 2, line 7, states that a provider or an affiliate may not request a review if the sanction imposed is termination or suspension, including failure to meet standards of licensure, certification, or registration, or if the provider or affiliate has been sanctioned by the Medicare program or by another state's Medicaid program. After the Department receives a provider's or affiliate's request for review and documentation that supports the request for review, the Department will assign the request for review to someone other than an individual who was involved in imposing the sanction. A provider or affiliate, if timely, can also request an informal conference regarding a review. As stated on page 2, line 25, a provider or affiliate may appeal the final decision of the Department to the district court in the manner provided in section 28-32-46 which can be further reviewed by the North Dakota Supreme Court as provided in section 28-32-49. The Department's written notice of sanction to the provider or affiliate will include language informing the provider or affiliate of its right to review and appeal.

The Department recognizes the importance of ensuring providers are aware of updates to North Dakota Century Code, Administrative Rules, or policies. As a result, the Department will provide training on fraud and abuse efforts and program changes by sending the information to providers in a provider newsletter and publishing the information on the 'Provider Updates' section on the Department's website. Additionally, Department staff are available to answer questions providers may have about the process.

This concludes my testimony. I would be happy to answer any questions the committee may have. Thank you.

CHAPTER 75-02-05
PROVIDER INTEGRITY

75-02-05-01. Purpose. The purpose underlying administrative remedies and sanctions in the medical assistance (medicaid) program is to ensure the proper and efficient utilization of medicaid funds by those individuals providing medical and other health services and goods to recipients of medical assistance.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-05-02. Authority and objective. Under authority of North Dakota Century Code chapter 50-24.1, the department of human services is empowered to promulgate such rules and regulations necessary to qualify for federal funds under section 1901 specifically, and title XIX generally of the Social Security Act. These rules are subject to the medical assistance state plan and to applicable federal regulation and state law.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-06-05.1, 50-24.1-04
Law Implemented: NDCC 50-24.1-04

75-02-05-03. Definitions. In this chapter, unless the context or subject matter otherwise requires:

1. "Abuse" means practices that:

   a. Are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to medicaid;

   b. Elicit reimbursement for services that are not medically necessary;

   c. Are in violation of an agreement or certificate of coverage; or

   d. Fail to meet professionally recognized standards for health care.

2. "Administrative or fiscal agent" means an organization which processes and pays provider claims on behalf of the department.

3. "Affiliates" means persons having an overt or covert relationship each with the other such that any one of them directly or indirectly controls or has the power to control another.

4. "Business integrity agreement" means an agreement between the department and the provider that addresses the concerns of the department and recognizes essential elements of required compliance for the provider to preempt further sanction, exclusion from participation, or termination.

5. "Client share" means the amount of monthly net income remaining after all appropriate deductions, disregards, and medicaid income levels have been allowed. This is also referred to as recipient liability.

6. "Closed-end medicaid provider agreement" means an agreement that is for a specified period of time not to exceed twelve months.

7. "Credible allegation of fraud" means an allegation which has been verified by the department.

8. "Department" means the department of human services.

9. "Division" means the medical services division of the department.

10. "Exclusion from participation" means permanent removal from provider participation in the North Dakota medical assistance program.

11. "Fraud" means deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or another and includes an act that constitutes fraud under applicable federal or state law.

12. "Licensed practitioner" means an individual, other than a physician who is licensed pursuant to North Dakota Century Code chapter 43-17, or otherwise authorized by the state to provide health care services.

13. "Medicaid" means "medical assistance" and is a term precisely equivalent thereto.

14. "Offsetting of payments" means a reduction or other adjustment of the amounts paid to a provider on pending and future bills for purposes of offsetting overpayments previously made to the provider.

15. "Open-end medicaid provider agreement" means an agreement that has no specific termination date and continues in force as long as it is agreeable to both parties.

16. "Person" means any natural person, company, firm, association, corporation, or other legal entity.

17. "Provider" means any individual or entity furnishing medicaid services under a provider agreement with the division of medical services.

18. "Sanction" means an action taken by the division against a provider for noncompliance with a federal or state law, rule, or policy, or with the provisions of the North Dakota medicaid provider agreement.

19. "Suspension from participation" means temporary suspension of provider participation in the North Dakota medicaid program for a specified period of time.

20. "Suspension of payments" means the withholding of payments due a provider until the matter in dispute between the provider and the division is resolved.

21. "Termination" means determining a provider to be indefinitely ineligible to be a medicaid provider.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 431.107

75-02-05-04. Provider responsibility. To assure quality medical care and services, medicaid payments may be made only to providers meeting established standards. Providers who are certified for participation in medicare are eligible for participation, providing no sanction has been imposed as provided for in section 75-02-05-08. Comparable standards for providers who do not participate in medicare are established by state law and appropriate licensing and standard-setting authorities in the health and mental health fields.

1. Payment for covered services under medicaid is limited to those services that are medically necessary for the proper management, control, or treatment of an individual's medical problem and provided under the physician's or licensed practitioner's direction and supervision.

2. Each provider agrees to retain documentation to support medical services rendered for a minimum of seven years and, upon request, to make the documentation available to persons acting on behalf of the department and the United States department of health and human services. A provider shall provide the records at no charge.

3. A provider must accept, as payment in full, the amounts paid in accordance with the payment structure established by the department. A provider performing a procedure or service may not request or receive any payment, in addition to the amounts established by the

department, from the recipient, or anyone acting on the recipient's behalf, for the same procedure or service. In cases where a client share has been properly determined by a county social service board, the provider may hold the recipient responsible for the client share.

4. No medicaid payment will be made for claims received by the department later than twelve months following the date the service was provided.

5. The department will process claims six months past the medicare explanation of benefits date if the provider followed medicare's timely filing policy.

6. In all joint medicare/medicaid cases, a provider must accept assignment of medicare payment to receive payment from medicaid for amounts not covered by medicare.

7. When the recipient has other medical insurance, all benefits available due from that other insurance must be applied prior to the provider accepting payment by medicaid.

8. A provider may not offer or accept a fee, portion of a fee, charge, rebate, or kickback for a medicaid patient referral.

9. Claims for payment and documentation must be submitted as required by the department or its designee.

10. A provider shall comply with all accepted standards of professional conduct and practice in dealing with recipients and the department.

11. A provider may not bill a recipient for services that are allowable under medicaid, but not paid due to the provider's lack of adherence to medicaid requirements.

12. Each provider shall comply with all applicable centers for medicare and medicaid services regulations.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 431.107

75-02-05-05. Grounds for sanctioning providers. Sanctions may be imposed by the division against a provider who:

1. Presents or causes to be presented for payment any false or fraudulent claim for care or services.

2. Submits or causes to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

3. Submits or causes to be submitted false information for the purpose of meeting prior authorization requirements.

4. Submits a false or fraudulent application to obtain provider status.

5. Fails to disclose or make available to the department or its authorized agent records of services provided to medicaid recipients and records of payments received for those services.

6. Fails to provide and maintain services to medicaid recipients within accepted medical and industry standards.

7. Fails to comply with the terms of the medicaid provider agreement or provider certification which is printed on the medicaid claim form.

8. Overutilizes the medicaid program by inducing, furnishing, or otherwise causing a recipient to receive care and services that are not medically necessary.

9. Rebates or accepts a fee or portion of a fee or charge for a medicaid patient referral.

10. Is convicted of a criminal offense arising out of the practice of medicine.

11. Fails to comply and to maintain compliance with all regulations and statutes, both state and federal, which are applicable to the provider's profession, business, or enterprise.

12. Is excluded from medicare.

13. Is suspended, excluded from participation, terminated, or sanctioned by any other state's medicaid program.

14. Is suspended or involuntarily terminated from participation in any governmentally sponsored medical program.

15. Bills or collects from the recipient any amount in violation of section 75-02-05-04.

16. Fails to correct deficient provider operations within a reasonable time, not to exceed thirty days, after receiving written notice of these deficiencies from the division, another responsible state agency, or their designees.

17. Is formally reprimanded or censured by an association of the provider's peers for unethical practices.

18. Fails to change or modify delivery patterns and services within a reasonable period after receipt of a request so to do by a peer review committee whose jurisdiction includes the provider.

19. Is convicted of a criminal offense arising out of the making of false or fraudulent statements or of an omission of fact for the purpose of securing any governmental benefit to which the provider is not entitled, or out of conspiring, soliciting, or attempting such an action.

20. Refuses to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments. A refusal of repayment exists if no repayment or arrangement for repayment is made within thirty days of the date written notice of discrepancy was sent.

21. Is served with a search warrant by a member of any law enforcement agency for the purpose of obtaining evidence of a crime of fraud committed by that provider against the medical assistance program, or is charged with such a crime, provided that no provider may be terminated from participation in the medical assistance program on such grounds.

22. Refuses to attend a division educational program or fails to agree to implement a business integrity agreement, if required by the division.

23. Defrauds any health care benefit program.

History: Effective July 1, 1980; amended effective November 1, 1983; July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 12.1-11-02; 42 CFR 455.13, 42 CFR 455.16, 42 CFR 431.107

75-02-05-06. Reporting of violations and investigation.

1. Information from any source indicating that a provider has failed or is failing to fulfill the provider's responsibilities, as set forth in section 75-02-05-04; or that a provider has acted in a manner which forms a ground for sanction as set forth in section 75-02-05-05 must be transmitted to the division.

2. The division shall investigate the matter and, if the report is substantiated, shall take whatever action or impose whatever sanction is most appropriate. The taking of any action or the imposition of any sanction does not preclude subsequent or simultaneous civil or criminal court action.

3. a. The division may investigate suspected fraud or abuse. The division may conduct an investigation to determine whether:

(1) Fraud or abuse exists and can be substantiated;

(2) Sufficient evident exists to support the recovery of overpayments or the imposition of sanctions; or

(3) The matter should be referred for action by another agency, including a law enforcement agency, to determine whether sufficient evidence exists to pursue any other civil or criminal action permitted by law.

b. The division may undertake an investigation to:

(1) Examine a provider's medical, financial, or patient records;

(2) Interview a provider and a provider's associates, agents, or employees;

(3) Verify a provider's professional credentials and the credentials of the provider's associates, agents, and employees;

(4) Interview recipients;

(5) Examine equipment, prescriptions, supplies, or other items used in a recipient's treatment;

(6) Sample a random mix of paid claims, prior authorizations, and medical records;

(7) Determine whether services provided to a recipient were medically necessary;

(8) Examine insurance claims or records or records of any other source of payment, including recipient payments; or

(9) The division may refer the case to the appropriate authority for further investigation and prosecution.

4. The division may contract with specialists outside the department as part of the investigation.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 455.14; 42 CFR 455.15; 42 CFR 455.16

75-02-05-07. Activities leading to and including sanction.

1. a. When the division determines that a provider has been rendering care or services in a form or manner inconsistent with program requirements or rules, or has received payment for which the provider may not be properly entitled, the division shall notify the provider in writing of the discrepancy noted. The notice to the provider may set forth:

(1) The nature of the discrepancy or inconsistency.

(2) The dollar value, if any, of such discrepancy or inconsistency.

(3) The method of computing such dollar values.

(4) Further actions which the division may take.

(5) Any action which may be required of the provider.

b. When the division has notified the provider in writing of a discrepancy or inconsistency, it may withhold payments on pending and future claims awaiting a response from the provider.

2. If the department determines that a provider's claims were not submitted properly or that a provider has engaged in suspected fraud or abuse, the division may require the provider to participate in and complete an educational program.

a. If the division decides that a provider should participate in an educational program, the division shall provide written notice to the provider, by certified mail, setting forth the following:

(1) The reason the provider is being directed to attend the educational program;

(2) The educational program determined by the division; and

(3) That continued participation as a provider in medicaid is contingent upon completion of the educational program identified by the division.

b. An educational program may be presented by the department. The educational program may include:

(1) Instruction on the correct submission of claims;

(2) Instruction on the appropriate utilization of services;

(3) Instruction on the correct use of provider manuals;

(4) Instruction on the proper use of procedure codes;

(5) Education on statutes, rules, and regulations governing the medicaid program;

(6) Education on reimbursement rates and payment methodologies;

(7) Instructions on billing or submitting claims; and

(8) Other educational tools identified by the division.

3. If a provider who is required to participate in an educational program refuses to participate in that program, the department shall suspend the provider from participation in medicaid until the provider successfully completes the required program. The timeframe to successfully complete the educational program may be extended upon provider request and with department approval.

4. If the department determines that a provider's claims were not submitted properly or that a provider has engaged in suspected fraud or abuse, the division of medical services may require the provider to implement a business integrity agreement. If the department requires a provider to enter a business integrity agrement and the provider refuses, the department shall ensure the provider is suspended from participation in medicaid until the provider implements the required agreement.

5. The division shall suspend all medicaid payments to a provider after the division determines there is a credible allegation of fraud for which an investigation is pending under the medicaid program unless the provider has demonstrated good cause why the division should not suspend payments or should suspend payment only in part.

6. The director of the division, or the director's designee, shall determine the appropriate sanction for a provider under this chapter. The following may be considered in determining the sanction to be imposed:

a. Seriousness of the provider's offense.

b. Extent of the provider's violations.

c. Provider's history of prior violations.

d. Prior imposition of sanctions against the provider.

e. Prior provision of information and training to the provider.

f. Provider's agreement to make restitution to the department.

g. Actions taken or recommended by peer groups or licensing boards.

h. Access to care for recipients.

i. Provider's self-disclosure or self-audit discoveries.

j. Provider's willingness to enter a business integrity agreement.

7. When a provider has been excluded from the medicare program, the provider will also be terminated or excluded from participation.

8. If the division determines there is a credible allegation of fraud, the division may impose any one or a combination of the following temporary sanctions:

a. Prepayment review of claims;

b. Postpayment review of claims;

c. Recovery of costs associated with an investigation;

d. Requirement of a provider self-audit;

e. Notification and referral to the appropriate state regulatory agency or licensing agency;

f. Suspension from participation in the medicaid program and withholding of payments to a provider;

g. Prior authorization of all services; and

h. Peer review at the provider's expense.

9. After the completion of a further investigation, the division shall document its findings in writing and provide a copy of that documentation to the provider. Following a determination by the division that the provider has engaged in fraud or abuse; the division may terminate, exclude or impose sanctions with conditions, including the following:

a. Recovery of overpayments;

b. Recovery of excess payments;

c. Recovery of costs associated with an investigation;

d. Requirement of a provider self-audit;

e. Prepayment review of claims;

f. Postpayment review of claims;

g. Notification and referral to the appropriate state regulatory agency or licensing agency;

h. Prior authorization of all services;

i. Penalties as established by the department; and

j. Peer review at the provider's expense.

10. A sanction may be applied to all known affiliates of a provider, provided that each sanctioned affiliate knew or should have known of the violation.

11. A provider subject to termination or exclusion from participation may not submit claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association to the department or its fiscal agenct for any services or supplies provided under the medicaid program except for any services or supplies provided prior to the effective date of the termination or exclusion.

12. A clinic, group, corporation, or other organization which is a provider may not submit claims for payment to the department or its fiscal agent for any services or supplies provided by a person within the clinic, group, corporation, or organization who has been terminated or is under exclusion from participation in this state or any other state or who has been excluded from medicare except for those services or supplies provided prior to the effective date of the termination or exclusion.

13. When the division determines there is a need to sanction a provider, the director of the division, or the director's designee, shall notify the provider in writing of the sanction imposed. The notice must advise the provider of the right of appeal, when applicable.

14. After the division sanctions a provider, the director of the division may notify the applicable professional society, board of registration or licensure, and any appropriate federal, state, or county agency of the reasons for the sanctions and the sanctions imposed.

15. If the department sanctions a provider who also serves as a billing agent for other providers, the department may also impose sanctions against the other providers upon a finding that the actions performed as the billing agent fails to meet department standards.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1 04
Law Implemented: NDCC 50-24.1-04; 42 CFR 455.13, 42 CFR 455.14, 42 CFR 455.15, 42 CFR 455.16, 42 CFR 455.17, 42 CFR 455.23

75-02-05-08. Imposition and extent of sanction. Repealed effective July 1, 2012.

75-02-05-09. Appeal and reconsideration.

1. A provider may not appeal a temporary sanction until further investigation has been completed and the division has made a final decision.

2. After completion of further investigation, if there is an imposition of a subsequent sanction, the provider may appeal the decision to impose sanctions unless the sanction imposed is termination or suspension and the notice states that the basis for the sanction is:

   a. The provider's failure to meet standards of licensure, certification, or registration where those standards are imposed by state or federal law as a condition to participation in the medicaid program.

   b. Because the provider has been similarly sanctioned by the medicare program or by another state's medicaid program.

3. An appeal must be filed with the department within thirty days of the date the notice of sanction is mailed to the provider.

4. Appeals taken are governed by chapter 75-01-03, and providers will be treated as claimants under that chapter.

5. Without prejudice to any right of appeal, the provider, upon receipt of notice of decision may in writing, request reconsideration. The request for reconsideration must include a statement refuting the stated basis for the imposition of the sanction. The division shall, within ten days after receipt of a request for reconsideration, make written response to the request, stating that imposition of the sanction has been affirmed or reversed.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 23-01-03, 23-16-01, 23-17.1-01, 23-20.1-04, 23-27-01, 25-16-02, 26.1-18-02, 43-05-09, 43-06-08, 43-12.1-03, 43-13-15, 43-15-15, 43-17-34, 43-26-13, 43-28-10, 43-32-17, 43-33-02, 43-37-03, 50-11.1-03;NDAC 75-01-03; 42 USC 1396a(a)(39); 42 CFR 431.151; 42 CFR 455.13

75-02-05-10. Provider information sessions. Repealed effective July 1, 2012.

#1

Testimony
Senate Bill Number 2114 - Department of Human Services
House Human Services Committee
Representative Robin Weisz, Chairman
March 19, 2013

Chairman Weisz, and members of the House Human Services Committee, I am Jonathan Alm, an attorney with the Department of Human Services (Department). I appear before you to support Senate Bill 2114, which was introduced on behalf of the Department.

The State Auditor's office, in its October 2010 Performance Audit, recommended that North Dakota Medicaid "ensure the implementation of Medicaid civil sanctions and other sanctions are imposed, as applicable, following investigations of providers which identify inappropriate billings, fraud, and/or abuse." Over the past two years, the Medicaid Program Integrity Unit staff have enhanced the fraud and abuse policies and procedures, strengthened audit activities, updated North Dakota Administrative Code chapter 75-02-05 on Provider Integrity (chapter 75-02-05), developed a suspected fraud reporting mechanism for ease of reporting, and have been proactively engaging in the identification of suspected Medicaid fraud and abuse. To further enhance program integrity efforts, the Department is proposing the implementation of civil monetary sanctions to deter providers from engaging in fraud and abuse activities. I have attached a copy of chapter 75-02-05 to my testimony.

The language in this bill addressing the Department's ability to issue civil monetary sanctions begins on page 1, line 15, which says, "[A] provider, an affiliate of a provider, or any combination of provider and affiliates, is liable to the department for up to ten thousand dollars for each act of fraud or abuse. This sanction is in addition to the applicable rules

established by the department." An act is something done intentionally or voluntarily or with a purpose. Each act may pertain to each false or abuse claim. The act or number of acts will be determined by the Department. The act must meet the definition of "fraud" or "abuse" set forth in chapter 75-02-05 before civil monetary sanctions may be considered. Page 1, line 18, requires a provider, an affiliate of a provider, or any combination of provider and affiliates to reimburse the Department for investigation fees, costs, and expenses for any investigation and action brought in connection with a civil monetary sanction. Page 3, line 14, requires that the State's share of all civil sanctions, investigative fees, costs, expenses, and interest received by the Department as a result of issuing a civil monetary sanction be deposited into the State's general fund.

The Department would use chapter 75-02-05 to carry out the imposition of civil monetary sanctions provided in this bill. Chapter 75-02-05 outlines a provider's responsibilities to the Department, the grounds for sanctions, how the Department investigates providers, and activities leading to and including sanctions. Providers' responsibilities include ensuring that services are medically necessary, retaining appropriate documentation, accepting payment as full, filing claims in a timely manner, and complying with all applicable Centers for Medicare and Medicaid Services regulations. The Department may sanction a provider or a provider's affiliate for a number of reasons including when the provider or provider's affiliate presents a false or fraudulent claim or information, fails to disclose records, fails to comply with the terms of the provider agreement, defrauds any health care benefit program, and when a provider or provider's affiliate is suspended or excluded from other Medicaid programs or by Medicare. The Department is able to impose

sanctions including requiring a provider to attend educational programs, implementing a business integrity agreement, suspending Medicaid payments, imposing prepayment or post-payment review of claims, recovering costs of the investigation, requiring a provider self-audit, making referrals to the appropriate state regulatory agency or licensing agency, suspending a provider from participation in the Medicaid program, and imposing prior authorization of all services and a peer review at the provider's expense.

As established by chapter 75-02-05, the Department will evaluate the severity of the fraud or abuse before imposing a civil monetary sanction. In evaluating the severity of the fraud or abuse, the Department may consider the seriousness of the offense, the extent of the violations, prior violations, prior imposition of sanctions against the provider, the provider's agreement to make restitution to the Department, actions taken or recommended by peer groups or licensing boards, access to care for recipients, whether the provider self-disclosed the finding, and the provider's willingness to participate in a performance improvement plan.

An example of when civil monetary sanctions may be applied would be in a case where the provider has not improved practices after the Department has addressed repeated concerns with the provider and there has been no improvement or resolution in the practice or if the provider has not complied with the remedies imposed by the Department pursuant to a non-monetary sanction. For instance, if a Qualified Service Provider supplies an incorrect date for payment for services in error, and it is an occasional or one-time mistake; a civil monetary sanction would not be imposed. However, a civil monetary sanction may be imposed if a medical provider had been sanctioned under chapter 75-02-05 with a pre-

payment review of claims due to erroneous billing practices and the same billing practices do not improve over the course of 12 months. The civil monetary sanction will be used with providers who have consistent, severe, and repetitive concerns.

If the Department issues a civil monetary sanction on a provider or affiliate, the provider's and affiliate's review and appeal rights are set forth on page 2, starting on line 3 through page 3, line 10. A provider or affiliate who is assessed a sanction may request a review of the sanction by filing a statement of dispute with the Department within 30 days of the date of the Department's written notice of the sanction. Page 2, line 7, states that a provider or an affiliate may not request a review if the sanction imposed is termination or suspension if the provider or affiliate failed to meet standards of licensure, certification, or registration, or if the provider or affiliate has been sanctioned by the Medicare program or by another state's Medicaid program. After the Department receives a provider's or affiliate's request for review and documentation that supports the request for review, the Department will assign the request for review to someone other than an individual who was involved in imposing the sanction. A provider or affiliate, if timely, can also request an informal conference regarding a review. As stated on page 2, line 25, a provider or affiliate may appeal the final decision of the Department to the district court in the manner provided in section 28-32-46, which can be further reviewed by the North Dakota Supreme Court as provided in section 28-32-49. The Department's written notice of sanction to the provider or affiliate will include language informing the provider or affiliate of its right to review and appeal.

The Department recognizes the importance of ensuring providers are aware of updates to North Dakota Century Code, Administrative Rules, or policies. As a result, the Department intends to provide training on fraud and abuse deterrence efforts and on program changes by sending the information to providers in a provider newsletter and publishing the information on the 'Provider Updates' section on the Department's website. Additionally, Department staff are available to answer questions providers may have about the process.

This concludes my testimony. I would be happy to try to answer any questions the committee may have. Thank you.

CHAPTER 75-02-05
PROVIDER INTEGRITY

75-02-05-01. Purpose. The purpose underlying administrative remedies and sanctions in the medical assistance (medicaid) program is to ensure the proper and efficient utilization of medicaid funds by those individuals providing medical and other health services and goods to recipients of medical assistance.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-05-02. Authority and objective. Under authority of North Dakota Century Code chapter 50-24.1, the department of human services is empowered to promulgate such rules and regulations necessary to qualify for federal funds under section 1901 specifically, and title XIX generally of the Social Security Act. These rules are subject to the medical assistance state plan and to applicable federal regulation and state law.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-06-05.1, 50-24.1-04
Law Implemented: NDCC 50-24.1-04

75-02-05-03. Definitions. In this chapter, unless the context or subject matter otherwise requires:

1. "Abuse" means practices that:

   a. Are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to medicaid;

   b. Elicit reimbursement for services that are not medically necessary;

   c. Are in violation of an agreement or certificate of coverage; or

   d. Fail to meet professionally recognized standards for health care.

2. "Administrative or fiscal agent" means an organization which processes and pays provider claims on behalf of the department.

3. "Affiliates" means persons having an overt or covert relationship each with the other such that any one of them directly or indirectly controls or has the power to control another.

4. "Business integrity agreement" means an agreement between the department and the provider that addresses the concerns of the department and recognizes essential elements of required compliance for the provider to preempt further sanction, exclusion from participation, or termination.

5. "Client share" means the amount of monthly net income remaining after all appropriate deductions, disregards, and medicaid income levels have been allowed. This is also referred to as recipient liability.

6. "Closed-end medicaid provider agreement" means an agreement that is for a specified period of time not to exceed twelve months.

7. "Credible allegation of fraud" means an allegation which has been verified by the department.

8. "Department" means the department of human services.

9. "Division" means the medical services division of the department.

10. "Exclusion from participation" means permanent removal from provider participation in the North Dakota medical assistance program.

11. "Fraud" means deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or another and includes an act that constitutes fraud under applicable federal or state law.

12. "Licensed practitioner" means an individual, other than a physician who is licensed pursuant to North Dakota Century Code chapter 43-17, or otherwise authorized by the state to provide health care services.

13. "Medicaid" means "medical assistance" and is a term precisely equivalent thereto.

14. "Offsetting of payments" means a reduction or other adjustment of the amounts paid to a provider on pending and future bills for purposes of offsetting overpayments previously made to the provider.

15. "Open-end medicaid provider agreement" means an agreement that has no specific termination date and continues in force as long as it is agreeable to both parties.

16. "Person" means any natural person, company, firm, association, corporation, or other legal entity.

17. "Provider" means any individual or entity furnishing medicaid services under a provider agreement with the division of medical services.

18. "Sanction" means an action taken by the division against a provider for noncompliance with a federal or state law, rule, or policy, or with the provisions of the North Dakota medicaid provider agreement.

19. "Suspension from participation" means temporary suspension of provider participation in the North Dakota medicaid program for a specified period of time.

20. "Suspension of payments" means the withholding of payments due a provider until the matter in dispute between the provider and the division is resolved.

21. "Termination" means determining a provider to be indefinitely ineligible to be a medicaid provider.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 431.107

75-02-05-04. Provider responsibility. To assure quality medical care and services, medicaid payments may be made only to providers meeting established standards. Providers who are certified for participation in medicare are eligible for participation, providing no sanction has been imposed as provided for in section 75-02-05-08. Comparable standards for providers who do not participate in medicare are established by state law and appropriate licensing and standard-setting authorities in the health and mental health fields.

1. Payment for covered services under medicaid is limited to those services that are medically necessary for the proper management, control, or treatment of an individual's medical problem and provided under the physician's or licensed practitioner's direction and supervision.

2. Each provider agrees to retain documentation to support medical services rendered for a minimum of seven years and, upon request, to make the documentation available to persons acting on behalf of the department and the United States department of health and human services. A provider shall provide the records at no charge.

3. A provider must accept, as payment in full, the amounts paid in accordance with the payment structure established by the department. A provider performing a procedure or service may not request or receive any payment, in addition to the amounts established by the

department, from the recipient, or anyone acting on the recipient's behalf, for the same procedure or service. In cases where a client share has been properly determined by a county social service board, the provider may hold the recipient responsible for the client share.

4. No medicaid payment will be made for claims received by the department later than twelve months following the date the service was provided.

5. The department will process claims six months past the medicare explanation of benefits date if the provider followed medicare's timely filing policy.

6. In all joint medicare/medicaid cases, a provider must accept assignment of medicare payment to receive payment from medicaid for amounts not covered by medicare.

7. When the recipient has other medical insurance, all benefits available due from that other insurance must be applied prior to the provider accepting payment by medicaid.

8. A provider may not offer or accept a fee, portion of a fee, charge, rebate, or kickback for a medicaid patient referral.

9. Claims for payment and documentation must be submitted as required by the department or its designee.

10. A provider shall comply with all accepted standards of professional conduct and practice in dealing with recipients and the department.

11. A provider may not bill a recipient for services that are allowable under medicaid, but not paid due to the provider's lack of adherence to medicaid requirements.

12. Each provider shall comply with all applicable centers for medicare and medicaid services regulations.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 431.107

75-02-05-05. Grounds for sanctioning providers. Sanctions may be imposed by the division against a provider who:

1. Presents or causes to be presented for payment any false or fraudulent claim for care or services.

2. Submits or causes to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

3. Submits or causes to be submitted false information for the purpose of meeting prior authorization requirements.

4. Submits a false or fraudulent application to obtain provider status.

5. Fails to disclose or make available to the department or its authorized agent records of services provided to medicaid recipients and records of payments received for those services.

6. Fails to provide and maintain services to medicaid recipients within accepted medical and industry standards.

7. Fails to comply with the terms of the medicaid provider agreement or provider certification which is printed on the medicaid claim form.

8. Overutilizes the medicaid program by inducing, furnishing, or otherwise causing a recipient to receive care and services that are not medically necessary.

9. Rebates or accepts a fee or portion of a fee or charge for a medicaid patient referral.

10. Is convicted of a criminal offense arising out of the practice of medicine.

11. Fails to comply and to maintain compliance with all regulations and statutes, both state and federal, which are applicable to the provider's profession, business, or enterprise.

12. Is excluded from medicare.

13. Is suspended, excluded from participation, terminated, or sanctioned by any other state's medicaid program.

14. Is suspended or involuntarily terminated from participation in any governmentally sponsored medical program.

15. Bills or collects from the recipient any amount in violation of section 75-02-05-04.

16. Fails to correct deficient provider operations within a reasonable time, not to exceed thirty days, after receiving written notice of these deficiencies from the division, another responsible state agency, or their designees.

17. Is formally reprimanded or censured by an association of the provider's peers for unethical practices.

18. Fails to change or modify delivery patterns and services within a reasonable period after receipt of a request so to do by a peer review committee whose jurisdiction includes the provider.

19. Is convicted of a criminal offense arising out of the making of false or fraudulent statements or of an omission of fact for the purpose of securing any governmental benefit to which the provider is not entitled, or out of conspiring, soliciting, or attempting such an action.

20. Refuses to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments. A refusal of repayment exists if no repayment or arrangement for repayment is made within thirty days of the date written notice of discrepancy was sent.

21. Is served with a search warrant by a member of any law enforcement agency for the purpose of obtaining evidence of a crime of fraud committed by that provider against the medical assistance program, or is charged with such a crime, provided that no provider may be terminated from participation in the medical assistance program on such grounds.

22. Refuses to attend a division educational program or fails to agree to implement a business integrity agreement, if required by the division.

23. Defrauds any health care benefit program.

History: Effective July 1, 1980; amended effective November 1, 1983; July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 12.1-11-02; 42 CFR 455.13, 42 CFR 455.16, 42 CFR 431.107

75-02-05-06. Reporting of violations and investigation.

1. Information from any source indicating that a provider has failed or is failing to fulfill the provider's responsibilities, as set forth in section 75-02-05-04; or that a provider has acted in a manner which forms a ground for sanction as set forth in section 75-02-05-05 must be transmitted to the division.

2. The division shall investigate the matter and, if the report is substantiated, shall take whatever action or impose whatever sanction is most appropriate. The taking of any action or the imposition of any sanction does not preclude subsequent or simultaneous civil or criminal court action.

3. a. The division may investigate suspected fraud or abuse. The division may conduct an investigation to determine whether:

(1) Fraud or abuse exists and can be substantiated;

(2) Sufficient evident exists to support the recovery of overpayments or the imposition of sanctions; or

(3) The matter should be referred for action by another agency, including a law enforcement agency, to determine whether sufficient evidence exists to pursue any other civil or criminal action permitted by law.

b. The division may undertake an investigation to:

(1) Examine a provider's medical, financial, or patient records;

(2) Interview a provider and a provider's associates, agents, or employees;

(3) Verify a provider's professional credentials and the credentials of the provider's associates, agents, and employees;

(4) Interview recipients;

(5) Examine equipment, prescriptions, supplies, or other items used in a recipient's treatment;

(6) Sample a random mix of paid claims, prior authorizations, and medical records;

(7) Determine whether services provided to a recipient were medically necessary;

(8) Examine insurance claims or records or records of any other source of payment, including recipient payments; or

(9) The division may refer the case to the appropriate authority for further investigation and prosecution.

4. The division may contract with specialists outside the department as part of the investigation.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 455.14; 42 CFR 455.15; 42 CFR 455.16

75-02-05-07. Activities leading to and including sanction.

1. a. When the division determines that a provider has been rendering care or services in a form or manner inconsistent with program requirements or rules, or has received payment for which the provider may not be properly entitled, the division shall notify the provider in writing of the discrepancy noted. The notice to the provider may set forth:

(1) The nature of the discrepancy or inconsistency.

(2) The dollar value, if any, of such discrepancy or inconsistency.

(3) The method of computing such dollar values.

(4) Further actions which the division may take.

(5) Any action which may be required of the provider.

b. When the division has notified the provider in writing of a discrepancy or inconsistency, it may withhold payments on pending and future claims awaiting a response from the provider.

2. If the department determines that a provider's claims were not submitted properly or that a provider has engaged in suspected fraud or abuse, the division may require the provider to participate in and complete an educational program.

a. If the division decides that a provider should participate in an educational program, the division shall provide written notice to the provider, by certified mail, setting forth the following:

(1) The reason the provider is being directed to attend the educational program;

(2) The educational program determined by the division; and

(3) That continued participation as a provider in medicaid is contingent upon completion of the educational program identified by the division.

b. An educational program may be presented by the department. The educational program may include:

(1) Instruction on the correct submission of claims;

(2) Instruction on the appropriate utilization of services;

(3) Instruction on the correct use of provider manuals;

(4) Instruction on the proper use of procedure codes;

(5) Education on statutes, rules, and regulations governing the medicaid program;

(6) Education on reimbursement rates and payment methodologies;

(7) Instructions on billing or submitting claims; and

(8) Other educational tools identified by the division.

3. If a provider who is required to participate in an educational program refuses to participate in that program, the department shall suspend the provider from participation in medicaid until the provider successfully completes the required program. The timeframe to successfully complete the educational program may be extended upon provider request and with department approval.

4. If the department determines that a provider's claims were not submitted properly or that a provider has engaged in suspected fraud or abuse, the division of medical services may require the provider to implement a business integrity agreement. If the department requires a provider to enter a business integrity agrement and the provider refuses, the department shall ensure the provider is suspended from participation in medicaid until the provider implements the required agreement.

5. The division shall suspend all medicaid payments to a provider after the division determines there is a credible allegation of fraud for which an investigation is pending under the medicaid program unless the provider has demonstrated good cause why the division should not suspend payments or should suspend payment only in part.

6. The director of the division, or the director's designee, shall determine the appropriate sanction for a provider under this chapter. The following may be considered in determining the sanction to be imposed:

a. Seriousness of the provider's offense.

b. Extent of the provider's violations.

c. Provider's history of prior violations.

d. Prior imposition of sanctions against the provider.

e. Prior provision of information and training to the provider.

f. Provider's agreement to make restitution to the department.

g. Actions taken or recommended by peer groups or licensing boards.

h. Access to care for recipients.

i. Provider's self-disclosure or self-audit discoveries.

j. Provider's willingness to enter a business integrity agreement.

7. When a provider has been excluded from the medicare program, the provider will also be terminated or excluded from participation.

8. If the division determines there is a credible allegation of fraud, the division may impose any one or a combination of the following temporary sanctions:

a. Prepayment review of claims;

b. Postpayment review of claims;

c. Recovery of costs associated with an investigation;

d. Requirement of a provider self-audit;

e. Notification and referral to the appropriate state regulatory agency or licensing agency;

f. Suspension from participation in the medicaid program and withholding of payments to a provider;

g. Prior authorization of all services; and

h. Peer review at the provider's expense.

9. After the completion of a further investigation, the division shall document its findings in writing and provide a copy of that documentation to the provider. Following a determination by the division that the provider has engaged in fraud or abuse; the division may terminate, exclude or impose sanctions with conditions, including the following:

a. Recovery of overpayments;

b. Recovery of excess payments;

c. Recovery of costs associated with an investigation;

d. Requirement of a provider self-audit;

e. Prepayment review of claims;

f. Postpayment review of claims;

g. Notification and referral to the appropriate state regulatory agency or licensing agency;

h. Prior authorization of all services;

i. Penalties as established by the department; and

j. Peer review at the provider's expense.

10. A sanction may be applied to all known affiliates of a provider, provided that each sanctioned affiliate knew or should have known of the violation.

11. A provider subject to termination or exclusion from participation may not submit claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association to the department or its fiscal agenct for any services or supplies provided under the medicaid program except for any services or supplies provided prior to the effective date of the termination or exclusion.

12. A clinic, group, corporation, or other organization which is a provider may not submit claims for payment to the department or its fiscal agent for any services or supplies provided by a person within the clinic, group, corporation, or organization who has been terminated or is under exclusion from participation in this state or any other state or who has been excluded from medicare except for those services or supplies provided prior to the effective date of the termination or exclusion.

13. When the division determines there is a need to sanction a provider, the director of the division, or the director's designee, shall notify the provider in writing of the sanction imposed. The notice must advise the provider of the right of appeal, when applicable.

14. After the division sanctions a provider, the director of the division may notify the applicable professional society, board of registration or licensure, and any appropriate federal, state, or county agency of the reasons for the sanctions and the sanctions imposed.

15. If the department sanctions a provider who also serves as a billing agent for other providers, the department may also impose sanctions against the other providers upon a finding that the actions performed as the billing agent fails to meet department standards.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1 04
Law Implemented: NDCC 50-24.1-04; 42 CFR 455.13, 42 CFR 455.14, 42 CFR 455.15, 42 CFR 455.16, 42 CFR 455.17, 42 CFR 455.23

75-02-05-08. Imposition and extent of sanction. Repealed effective July 1, 2012.

75-02-05-09. Appeal and reconsideration.

1. A provider may not appeal a temporary sanction until further investigation has been completed and the division has made a final decision.

2. After completion of further investigation, if there is an imposition of a subsequent sanction, the provider may appeal the decision to impose sanctions unless the sanction imposed is termination or suspension and the notice states that the basis for the sanction is:

   a. The provider's failure to meet standards of licensure, certification, or registration where those standards are imposed by state or federal law as a condition to participation in the medicaid program.

   b. Because the provider has been similarly sanctioned by the medicare program or by another state's medicaid program.

3. An appeal must be filed with the department within thirty days of the date the notice of sanction is mailed to the provider.

4. Appeals taken are governed by chapter 75-01-03, and providers will be treated as claimants under that chapter.

5. Without prejudice to any right of appeal, the provider, upon receipt of notice of decision may in writing, request reconsideration. The request for reconsideration must include a statement refuting the stated basis for the imposition of the sanction. The division shall, within ten days after receipt of a request for reconsideration, make written response to the request, stating that imposition of the sanction has been affirmed or reversed.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 23-01-03, 23-16-01, 23-17.1-01, 23-20.1-04, 23-27-01, 25-16-02, 26.1-18-02, 43-05-09, 43-06-08, 43-12.1-03, 43-13-15, 43-15-15, 43-17-34, 43-26-13, 43-28-10, 43-32-17, 43-33-02, 43-37-03, 50-11.1-03;NDAC 75-01-03; 42 USC 1396a(a)(39); 42 CFR 431.151; 42 CFR 455.13

75-02-05-10. Provider information sessions. Repealed effective July 1, 2012.

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PROPOSED AMENDMENTS TO SENATE BILL NO. 2114

Page 1, line 16, replace "ten thousand dollars for" with "twenty-five percent of the amount the department was induced to pay as a result of"

Page 1, line 18, after "3." insert:

"A provider, an affiliate of a provider, or any combination of provider and affiliates, is liable to the department for up to five thousand dollars on each act of fraud or abuse which did not induce the department to make an erroneous payment. This sanction is in addition to the applicable rules established by the department.

4."

Page 1, line 22, replace "4." with "5."

Page 2, line 3, replace "5." with "6."

Page 3, line 11, replace "6." with:

"7. Determinations of medical necessity may not lead to imposition of remedies, duties, prohibitions, and sanctions under this section.

8."

Page 3, line 14, replace "7." with "9."

Renumber accordingly