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Texas Dentists for Medicaid Reform

Frequently Asked Questions about Medicaid Due Process Rights

TDMR has put together this publication to give dental and other Medicaid providers some common language understanding of the provisions of Senate Bill 1803 now in force to protect their due process rights. We have tried to use the text of the bill that is on the Secretary of State's website as much as possible but format it so it is more understandable. That being said is not intended as legal advice or a definitive version of the bill and its contents and meaning. It is meant to act as an informal guide. Consult a lawyer should you need legal advice.

1. What is Medicaid "abuse?"

"Abuse" means: a practice by a provider that is inconsistent with sound fiscal, business, or medical practices and that results in an unnecessary cost to the Medicaid program; or the reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for health care; or a practice by a recipient that results in an unnecessary cost to the Medicaid program.

2. What does "fraud," "allegations of fraud" and "credible allegation of fraud" mean?

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person, including any act that constitutes fraud under applicable federal or state law.

"Allegation of fraud" means an allegation of Medicaid fraud received by the commission from any source that has not been verified by the state, including an allegation based on:
(A) a fraud hot line complaint;
(B) claims data mining;
(C) data analysis processes; or
(D) a pattern identified through provider audits, civil false claims cases, or law enforcement investigations.

"Credible allegation of fraud" means an allegation of fraud that has been verified by the state. An allegation is considered to be credible when the commission has:
(A) verified that the allegation has indicia of reliability; and
(B) reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

3. What is the definition of a “payment hold?”

''Payment hold'' means the temporary denial of reimbursement under the Medicaid program for items or services furnished by a specified provider.

4. What does HHSC do when it receives a complaint about a Medicaid provider?

If the commission receives a complaint or allegation of Medicaid fraud or abuse from any source, the office must conduct a preliminary investigation to determine whether there is a sufficient basis to warrant a full investigation.

A preliminary investigation must begin not later than the 30th day after the date the commission receives a complaint or allegation or has reason to believe that fraud or abuse has occurred. A preliminary investigation shall be completed not later than the 90th day after it began.

If the findings of a preliminary investigation give the office reason to believe that an incident of fraud or abuse involving possible criminal conduct has occurred In the Medicaid program, the office must take the following action, as appropriate, not later than the 30th day after the completion of the preliminary investigation.

(A) if a provider is suspected of fraud or abuse involving criminal conduct, the office must refer the case to the state's Medicaid fraud control unit, provided that the criminal referral does not preclude the office from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions; or

(B) if there is reason to believe that a recipient has defrauded the Medicaid program, the office may conduct a full investigation of the suspected fraud.

Whenever the office learns or has reason to suspect that a provider's records are being withheld, concealed, destroyed, fabricated, or in any way falsified, the office shall immediately refer the case to the state's Medicaid fraud control unit. However, such criminal referral does not preclude the office from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions.

5. What does OIG do and when do they place a payment hold?

The commission shall maintain a record of all allegations of fraud or abuse against a provider containing the date each allegation was received or identified and the source of the allegation, if available. The record is confidential.

If the commission receives an allegation of fraud or abuse against a provider from any source, the commission's office of inspector general shall conduct a preliminary investigation of the allegation to determine whether there is a sufficient basis to warrant a full investigation. A preliminary investigation must begin not later than the 30th day after the date the commission receives or identifies an allegation of fraud or abuse.

In conducting a preliminary investigation, the office must review the allegations of fraud or abuse and all facts and evidence relating to the allegation and must prepare a preliminary investigation report before the allegation of fraud or abuse may proceed to a full investigation. The preliminary investigation report must document the allegation, the evidence reviewed, if available, the procedures used to conduct the preliminary investigation, the findings of the preliminary investigation, and the office's determination of whether a full investigation is warranted.

If the state's Medicaid fraud control unit or any other law enforcement agency accepts a fraud referral from the office for investigation, a payment hold based on a credible allegation of fraud may be continued until:

(1) that investigation and any associated enforcement proceedings are complete; or

(2) the state's Medicaid fraud control unit, another law enforcement agency, or other prosecuting authorities determine that there is insufficient evidence of fraud by the provider.

If the state's Medicaid fraud control unit or any other law enforcement agency declines to accept a fraud referral from the office for investigation, a payment hold based on a credible allegation of fraud must be discontinued unless the commission has alternative federal or state authority under which it may impose a payment hold or the office makes a fraud referral to another law enforcement agency.

On a quarterly basis, the office must request a certification from the state's Medicaid fraud control unit and other law enforcement agencies as to whether each matter accepted by the unit or agency on the basis of a credible allegation of fraud referral continues to be under investigation and that the continuation of the payment hold is warranted.

6. When does a Medicaid provider get notification of a payment hold?

In addition to other instances authorized under state or federal law, the office shall impose without prior notice a payment hold on claims for reimbursement submitted by a provider to compel production of records, when requested by the state's Medicaid fraud control unit, or on the determination that a credible allegation of fraud exists, the office must notify the provider of the payment hold within:

(i) Five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold such notice.

(ii) Thirty days if requested by law enforcement in writing to delay sending such notice, which request for delay may be renewed in writing up to twice and in no event may exceed 90 days.

INFORMATION TO BE INCLUDED IN NOTICE OF PAYMENT HOLD

In addition, the notice of payment hold provided under this subdivision must also include:

(A) the specific basis for the hold, including identification of the claims supporting the allegation at that point in the investigation and a representative sample of any documents that form the basis for the hold; and

(B) a description of administrative and judicial due process remedies, including the provider's right to seek informal resolution, a formal administrative appeal hearing, or both.

7. What actions does a Medicaid provider have to take to dispute the payment hold and what is the process?

There are two options for a provider – straight to a SOAH hearing or using an informal resolution process first. But a provider must make sure they request a SOAH hearing within the time limits set even if they wish to attempt informal resolution otherwise that option is lost should informal resolution fail. Appeal of the SOAH decision can be made to the Travis County courts for judicial review.

a. TIME REQUIREMENTS FOR REQUEST FOR SOAH PAYMENT HOLD HEARING BY PROVIDER

On timely written request by a provider subject to a payment hold, other than a hold requested by the state's Medicaid fraud control unit, the office shall file a request with the State Office of Administrative Hearings for an expedited administrative hearing regarding the hold.

The provider must request an expedited administrative hearing under this subdivision not later than the 30th day after the date the provider receives notice from the office.

COSTS FOR A SOAH HEARING ON PAYMENT HOLD

Unless otherwise determined by the administrative law judge for good cause at an expedited administrative hearing, the state and the provider shall each be responsible for:

(A) one-half of the costs charged by the State Office of Administrative Hearings;

(B) one-half of the costs for transcribing the hearing;

(C) the party's own costs related to the hearing, including the costs associated with preparation for the hearing, discovery, depositions, and subpoenas, service of process and witness expenses, travel expenses, and investigation expenses; and

(D) all other costs associated with the hearing that are incurred by the party, including attorney's fees.

ADVANCING SECURITY FOR SOAH HEARING COSTS

The executive commissioner and the State Office of Administrative Hearings shall jointly adopt rules that require a provider, before an expedited administrative hearing, to advance security for the costs for which the provider is responsible under that subdivision.

b. INFORMAL RESOLUTION OF PAYMENT HOLD

The executive commissioner shall adopt rules that allow a provider subject to a payment hold, other than a hold requested by the state's Medicaid fraud control unit, to seek an informal resolution of the issues identified by the office in the notice.

TIME REQUIREMENTS FOR REQUEST FOR INFORMAL MEETING ON PAYMENT HOLD BY PROVIDER

A provider must request an initial informal resolution meeting not later than the deadline prescribed for requesting an expedited administrative hearing.

SCHEDULING BY OIG OF INFORMAL MEETING

On receipt of a timely request, the office shall schedule an initial informal resolution meeting not later than the 60th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office, if requested by the provider.

The office shall give notice to the provider of the time and place of the initial informal resolution meeting not later than the 30th day before the date the meeting is to be held.

SECOND INFORMAL MEETING
A provider may request a second informal resolution meeting not later than the 20th day after the date of the initial informal resolution meeting.

On receipt of a timely request, the office shall schedule a second informal resolution meeting not later than the 45th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office, if requested by the provider.

The office shall give notice to the provider of the time and place of the second informal resolution meeting not later than the 20th day before the date the meeting is to be held.

A provider must have an opportunity to provide additional information before the second informal resolution meeting for consideration by the office.

RECORDING OF INFORMAL RESOLUTION MEETINGS.
The commission shall, at no expense to the provider who requested the meeting, provide for an informal resolution meeting to be recorded. The recording of an informal resolution meeting shall be made available to the provider who requested the meeting.

INFORMAL RESOLUTION VS. SOAH HEARING
A provider's decision to seek an informal resolution does not extend the time by which the provider must request an expedited administrative hearing.

However, a hearing initiated shall be stayed until the informal resolution process is completed.

OIG CAN MAKE UP FURTHER RULES TO MAKE PAYMENT HOLDS
The office shall, in consultation with the state's Medicaid fraud control unit, establish guidelines under which payment holds or program exclusions:

(A) may permissively be imposed on a provider; or
(B) shall automatically be imposed on a provider.

CASE REVIEW SUPERVISED BY NEW MEDICAL AND DENTAL DIRECTORS
The office shall employ a medical director who is a licensed physician who preferably has significant knowledge of the Medicaid program. The medical director shall ensure that any investigative findings based on medical necessity or the quality of medical care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

The office shall employ a dental director who is a licensed dentist who preferably has significant knowledge of the Medicaid program. The dental director shall ensure that any investigative findings based on the necessity of dental services or the quality of dental care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

The dental director is now Linda Altenhoff.

PREPAYMENT REVIEWS AND PAYMENT HOLDS
Subject to the Government Code, and notwithstanding any other law, the department may impose a payment hold on future claims submitted by a provider.

8. Can a Medicaid provider appeal a SOAH decision on a payment hold?

Following an expedited administrative hearing under Subdivision (3), a provider subject to a payment hold, other than a hold requested by the state's Medicaid fraud control unit, may appeal a final administrative order by filing a petition for judicial review in a district court in Travis County.

9. What happens if a Medicaid provider receives a notice of overpayment recoupment?

A provider can appeal a notice of recoupment to either SOAH, again with an option of an informal process, or to HHSC appeals. Again, it appears if the provider takes the informal process, they must request a SOAH/HHSC appeals hearing within the initial time limit if they wish to go to SOAH/HHSC appeals if the process fails. Final appeal is to a judicial review by Travis County courts.

NOTICE OF PROPOSED RECOUPMENT OF OVERPAYMENT OR DEBT
The commission or the commission's office of inspector general shall provide a provider with written notice of any proposed recoupment of an overpayment or debt and any damages or penalties relating to a proposed recoupment of an overpayment or debt arising out of a fraud or abuse investigation.

The notice must include:

(1) the specific basis for the overpayment or debt;
(2) a description of facts and supporting evidence;
(3) a representative sample of any documents that form the basis for the overpayment or debt;
(4) the extrapolation methodology;
(5) the calculation of the overpayment or debt amount;
(6) the amount of damages and penalties, if applicable; and
(7) a description of administrative and judicial due process remedies, including the provider's right to seek informal resolution, a formal administrative appeal hearing, or both.

TIME LIMIT FOR PROVIDER TO REQUEST APPEAL WITH SOAH OR HHSC APPEALS DIVISION
A provider must request an appeal under this section not later than the 15th day after the date the provider is notified that the commission or the commission's office of inspector general will seek to recover an overpayment or debt from the provider.

INFORMAL RESOLUTION
A provider must request an initial informal resolution meeting under this section not later than the 30th day after the date the provider receives notice.

On receipt of a timely request, the office shall schedule an initial informal resolution meeting not later than the 60th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office if requested by the provider.
The office shall give notice to the provider of the time and place of the initial informal resolution meeting not later than the 30th day before the date the meeting is to be held.

A provider may request a second informal resolution meeting not later than the 20th day after the date of the initial informal resolution meeting. On receipt of a timely request, the office shall schedule a second informal resolution meeting not later than the 45th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office if requested by the provider.

The office shall give notice to the provider of the time and place of the second informal resolution meeting not later than the 20th day before the date the meeting is to be held. A provider must have an opportunity to provide additional information before the second informal resolution meeting for consideration by the office.

RECORDING OF INFORMAL RESOLUTION MEETINGS.
The commission shall, at no expense to the provider who requested the meeting, provide for an informal resolution meeting to be recorded. The recording of an informal resolution meeting shall be made available to the provider who requested the meeting.

TIME LIMIT FOR OIG TO SEND HEARING REQUEST TO SOAH OR HHSC
On receipt of a timely written request by a provider who is the subject of a recoupment of overpayment or recoupment of debt arising out of a fraud or abuse investigation, the office of inspector general shall file a docketing request with the State Office of Administrative Hearings or the Health and Human Services Commission appeals division, as requested by the provider, for an administrative hearing regarding the proposed recoupment amount and any associated damages or penalties.

The office shall file the docketing request under this section not later than the 60th day after the date of the provider's request for an administrative hearing or not later than the 60th day after the completion of the informal resolution process, if applicable.

COSTS ASSOCIATED WITH APPEAL
Unless otherwise determined by the administrative law judge for good cause, at any administrative hearing under this section before the State Office of Administrative Hearings, the state and the provider shall each be responsible for:

(1) one-half of the costs charged by the State Office of Administrative Hearings;

(2) one-half of the costs for transcribing the hearing;

(3) the party's own costs related to the hearing, including the costs associated with preparation for the hearing, discovery, deposit ions, and subpoenas, service of process and witness expenses, travel expenses, and investigation expenses; and

(4) all other costs associated with the hearing that are incurred by the party, including attorney's fees.

PROVIDER TO ADVANCE SECURITY FOR COSTS

The executive commissioner and the State Office of Administrative Hearings shall jointly adopt rules that require a provider, before an administrative hearing under this section before the State Office of Administrative Hearings, to advance security for the costs for which the provider is responsible.

10. Can a Medicaid provider appeal a SOAH or HHSC appeals division decision on an overpayment recoupment?

Following an administrative hearing, a provider who is the subject of a recoupment of overpayment or recoupment of debt arising out of a fraud or abuse investigation may appeal a final administrative order by filing a petition for judicial review in a district court in Travis County.

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