

- 1 (A) a fraud hotline complaint;
- 2 (B) claims data mining;
- 3 (C) data analysis processes; or
- 4 (D) a pattern identified through provider
- 5 audits, civil false claims cases, or law enforcement
- 6 investigations.

7 (3) "Credible allegation of fraud" means an allegation
8 of fraud that has been verified by the state. An allegation is
9 considered to be credible when the commission has:

10 (A) verified that the allegation has indicia of
11 reliability; and

12 (B) reviewed all allegations, facts, and
13 evidence carefully and acts judiciously on a case-by-case basis.

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

19 (5) [~~(2)~~] "Furnished" refers to items or services
20 provided directly by, or under the direct supervision of, or
21 ordered by a practitioner or other individual (either as an
22 employee or in the individual's own capacity), a provider, or other
23 supplier of services, excluding services ordered by one party but
24 billed for and provided by or under the supervision of another.

25 (6) "Payment hold" [~~(3)~~ "~~Hold on payment~~"] means the
26 temporary denial of reimbursement under the Medicaid program for
27 items or services furnished by a specified provider.

1 (7) "Physician" includes an individual licensed to
2 practice medicine in this state, a professional association
3 composed solely of physicians, a partnership composed solely of
4 physicians, a single legal entity authorized to practice medicine
5 owned by two or more physicians, and a nonprofit health corporation
6 certified by the Texas Medical Board under Chapter 162, Occupations
7 Code.

8 (8) [~~4~~] "Practitioner" means a physician or other
9 individual licensed under state law to practice the individual's
10 profession.

11 (9) [~~5~~] "Program exclusion" means the suspension of
12 a provider from being authorized under the Medicaid program to
13 request reimbursement of items or services furnished by that
14 specific provider.

15 (10) [~~6~~] "Provider" means a person, firm,
16 partnership, corporation, agency, association, institution, or
17 other entity that was or is approved by the commission to:

18 (A) provide medical assistance under contract or
19 provider agreement with the commission; or

20 (B) provide third-party billing vendor services
21 under a contract or provider agreement with the commission.

22 SECTION 2. Section 531.102, Government Code, is amended by
23 amending Subsections (f) and (g) and adding Subsections (l), (m),
24 and (n) to read as follows:

25 (f)(1) If the commission receives a complaint or allegation
26 of Medicaid fraud or abuse from any source, the office must conduct
27 a preliminary investigation as provided by Section 531.118(c) [~~an~~

1 ~~integrity review~~] to determine whether there is a sufficient basis
2 to warrant a full investigation. A preliminary investigation [~~An~~
3 ~~integrity review~~] must begin not later than the 30th day after the
4 date the commission receives a complaint or allegation or has
5 reason to believe that fraud or abuse has occurred. A preliminary
6 investigation [~~An integrity review~~] shall be completed not later
7 than the 90th day after it began.

8 (2) If the findings of a preliminary investigation [~~an~~
9 ~~integrity review~~] give the office reason to believe that an
10 incident of fraud or abuse involving possible criminal conduct has
11 occurred in the Medicaid program, the office must take the
12 following action, as appropriate, not later than the 30th day after
13 the completion of the preliminary investigation [~~integrity~~
14 ~~review~~]:

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

21 (B) if there is reason to believe that a
22 recipient has defrauded the Medicaid program, the office may
23 conduct a full investigation of the suspected fraud, subject to
24 Section 531.118(c).

25 (g)(1) Whenever the office learns or has reason to suspect
26 that a provider's records are being withheld, concealed, destroyed,
27 fabricated, or in any way falsified, the office shall immediately

1 refer the case to the state's Medicaid fraud control unit. However,
2 such criminal referral does not preclude the office from continuing
3 its investigation of the provider, which investigation may lead to
4 the imposition of appropriate administrative or civil sanctions.

5 (2) In addition to other instances authorized under
6 state or federal law, the office shall impose without prior notice a
7 payment hold on [payment of] claims for reimbursement submitted by
8 a provider to compel production of records, when requested by the
9 state's Medicaid fraud control unit, or on the determination that a
10 credible allegation of fraud exists, subject to Subsections (l) and
11 (m), as applicable [~~on receipt of reliable evidence that the~~
12 ~~circumstances giving rise to the hold on payment involve fraud or~~
13 ~~wilful misrepresentation under the state Medicaid program in~~
14 ~~accordance with 42 C.F.R. Section 455.23, as applicable]~~. The
15 office must notify the provider of the payment hold [~~on payment~~] in
16 accordance with 42 C.F.R. Section 455.23(b). In addition to the
17 requirements of 42 C.F.R. Section 455.23(b), the notice of payment
18 hold provided under this subdivision must also include:

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

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

27 (3) On timely written request by a provider subject to

1 a payment hold [~~on payment~~] under Subdivision (2), other than a hold
2 requested by the state's Medicaid fraud control unit, the office
3 shall file a request with the State Office of Administrative
4 Hearings for an expedited administrative hearing regarding the
5 hold. The provider must request an expedited administrative
6 hearing under this subdivision not later than the 30th [~~10th~~] day
7 after the date the provider receives notice from the office under
8 Subdivision (2). Unless otherwise determined by the administrative
9 law judge for good cause at an expedited administrative hearing,
10 the state and the provider shall each be responsible for:

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

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

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

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

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

26 (5) Following an expedited administrative hearing
27 under Subdivision (3), a provider subject to a payment hold, other

1 than a hold requested by the state's Medicaid fraud control unit,
2 may appeal a final administrative order by filing a petition for
3 judicial review in a district court in Travis County.

4 (6) The executive commissioner [~~commission~~] shall
5 adopt rules that allow a provider subject to a [~~hold on~~] payment
6 hold under Subdivision (2), other than a hold requested by the
7 state's Medicaid fraud control unit, to seek an informal resolution
8 of the issues identified by the office in the notice provided under
9 that subdivision. A provider must request [~~seek~~] an initial
10 informal resolution meeting under this subdivision not later than
11 the deadline prescribed by Subdivision (3) for requesting an
12 expedited administrative hearing. On receipt of a timely request,
13 the office shall schedule an initial informal resolution meeting
14 not later than the 60th day after the date the office receives the
15 request, but the office shall schedule the meeting on a later date,
16 as determined by the office, if requested by the provider. The
17 office shall give notice to the provider of the time and place of
18 the initial informal resolution meeting not later than the 30th day
19 before the date the meeting is to be held. A provider may request a
20 second informal resolution meeting not later than the 20th day
21 after the date of the initial informal resolution meeting. On
22 receipt of a timely request, the office shall schedule a second
23 informal resolution meeting not later than the 45th day after the
24 date the office receives the request, but the office shall schedule
25 the meeting on a later date, as determined by the office, if
26 requested by the provider. The office shall give notice to the
27 provider of the time and place of the second informal resolution

1 meeting not later than the 20th day before the date the meeting is
2 to be held. A provider must have an opportunity to provide
3 additional information before the second informal resolution
4 meeting for consideration by the office. A provider's decision to
5 seek an informal resolution under this subdivision does not extend
6 the time by which the provider must request an expedited
7 administrative hearing under Subdivision (3). However, a hearing
8 initiated under Subdivision (3) shall be stayed [~~at the office's~~
9 ~~request~~] until the informal resolution process is completed.

10 (7) [(5)] The office shall, in consultation with the
11 state's Medicaid fraud control unit, establish guidelines under
12 which payment holds [~~on payment~~] or program exclusions:

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

15 (1) The office shall employ a medical director who is a
16 licensed physician under Subtitle B, Title 3, Occupations Code, and
17 the rules adopted under that subtitle by the Texas Medical Board,
18 and who preferably has significant knowledge of the Medicaid
19 program. The medical director shall ensure that any investigative
20 findings based on medical necessity or the quality of medical care
21 have been reviewed by a qualified expert as described by the Texas
22 Rules of Evidence before the office imposes a payment hold or seeks
23 recoupment of an overpayment, damages, or penalties.

24 (m) The office shall employ a dental director who is a
25 licensed dentist under Subtitle D, Title 3, Occupations Code, and
26 the rules adopted under that subtitle by the State Board of Dental
27 Examiners, and who preferably has significant knowledge of the

1 Medicaid program. The dental director shall ensure that any
2 investigative findings based on the necessity of dental services or
3 the quality of dental care have been reviewed by a qualified expert
4 as described by the Texas Rules of Evidence before the office
5 imposes a payment hold or seeks recoupment of an overpayment,
6 damages, or penalties.

7 (n) To the extent permitted under federal law, the office,
8 acting through the commission, shall adopt rules establishing the
9 criteria for initiating a full-scale fraud or abuse investigation,
10 conducting the investigation, collecting evidence, accepting and
11 approving a provider's request to post a surety bond to secure
12 potential recoupments in lieu of a payment hold or other asset or
13 payment guarantee, and establishing minimum training requirements
14 for Medicaid provider fraud or abuse investigators.

15 SECTION 3. Subchapter C, Chapter 531, Government Code, is
16 amended by adding Sections 531.118, 531.119, 531.120, 531.1201, and
17 531.1202 to read as follows:

18 Sec. 531.118. PRELIMINARY INVESTIGATIONS OF ALLEGATIONS OF
19 FRAUD OR ABUSE AND FRAUD REFERRALS. (a) The commission shall
20 maintain a record of all allegations of fraud or abuse against a
21 provider containing the date each allegation was received or
22 identified and the source of the allegation, if available. The
23 record is confidential under Section 531.1021(g) and is subject to
24 Section 531.1021(h).

25 (b) If the commission receives an allegation of fraud or
26 abuse against a provider from any source, the commission's office
27 of inspector general shall conduct a preliminary investigation of

1 the allegation to determine whether there is a sufficient basis to
2 warrant a full investigation. A preliminary investigation must
3 begin not later than the 30th day after the date the commission
4 receives or identifies an allegation of fraud or abuse.

5 (c) In conducting a preliminary investigation, the office
6 must review the allegations of fraud or abuse and all facts and
7 evidence relating to the allegation and must prepare a preliminary
8 investigation report before the allegation of fraud or abuse may
9 proceed to a full investigation. The preliminary investigation
10 report must document the allegation, the evidence reviewed, if
11 available, the procedures used to conduct the preliminary
12 investigation, the findings of the preliminary investigation, and
13 the office's determination of whether a full investigation is
14 warranted.

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

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

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

24 (e) If the state's Medicaid fraud control unit or any other
25 law enforcement agency declines to accept a fraud referral from the
26 office for investigation, a payment hold based on a credible
27 allegation of fraud must be discontinued unless the commission has

1 alternative federal or state authority under which it may impose a
2 payment hold or the office makes a fraud referral to another law
3 enforcement agency.

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

10 Sec. 531.119. WEBSITE POSTING. The commission's office of
11 inspector general shall post on its publicly available website a
12 description in plain English of, and a video explaining, the
13 processes and procedures the office uses to determine whether to
14 impose a payment hold on a provider under this subchapter.

15 Sec. 531.120. NOTICE AND INFORMAL RESOLUTION OF PROPOSED
16 RECOUPMENT OF OVERPAYMENT OR DEBT. (a) The commission or the
17 commission's office of inspector general shall provide a provider
18 with written notice of any proposed recoupment of an overpayment or
19 debt and any damages or penalties relating to a proposed recoupment
20 of an overpayment or debt arising out of a fraud or abuse
21 investigation. The notice must include:

- 22 (1) the specific basis for the overpayment or debt;
23 (2) a description of facts and supporting evidence;
24 (3) a representative sample of any documents that form
25 the basis for the overpayment or debt;
26 (4) the extrapolation methodology;
27 (5) the calculation of the overpayment or debt amount;

1 (6) the amount of damages and penalties, if
2 applicable; and

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

6 (b) A provider must request an initial informal resolution
7 meeting under this section not later than the 30th day after the
8 date the provider receives notice under Subsection (a). On receipt
9 of a timely request, the office shall schedule an initial informal
10 resolution meeting not later than the 60th day after the date the
11 office receives the request, but the office shall schedule the
12 meeting on a later date, as determined by the office if requested by
13 the provider. The office shall give notice to the provider of the
14 time and place of the initial informal resolution meeting not later
15 than the 30th day before the date the meeting is to be held. A
16 provider may request a second informal resolution meeting not later
17 than the 20th day after the date of the initial informal resolution
18 meeting. On receipt of a timely request, the office shall schedule
19 a second informal resolution meeting not later than the 45th day
20 after the date the office receives the request, but the office shall
21 schedule the meeting on a later date, as determined by the office if
22 requested by the provider. The office shall give notice to the
23 provider of the time and place of the second informal resolution
24 meeting not later than the 20th day before the date the meeting is
25 to be held. A provider must have an opportunity to provide
26 additional information before the second informal resolution
27 meeting for consideration by the office.

Sec. 531.1201. APPEAL OF DETERMINATION TO RECOUP

OVERPAYMENT OR DEBT. (a) 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. 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.

(b) 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,

1 discovery, depositions, and subpoenas, service of process and
2 witness expenses, travel expenses, and investigation expenses; and

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

5 (c) The executive commissioner and the State Office of
6 Administrative Hearings shall jointly adopt rules that require a
7 provider, before an administrative hearing under this section
8 before the State Office of Administrative Hearings, to advance
9 security for the costs for which the provider is responsible under
10 Subsection (b).

11 (d) Following an administrative hearing under Subsection
12 (a), a provider who is the subject of a recoupment of overpayment or
13 recoupment of debt arising out of a fraud or abuse investigation may
14 appeal a final administrative order by filing a petition for
15 judicial review in a district court in Travis County.

16 Sec. 531.1202. RECORD OF INFORMAL RESOLUTION MEETINGS. The
17 commission shall, at no expense to the provider who requested the
18 meeting, provide for an informal resolution meeting held under
19 Section 531.102(g)(6) or 531.120(b) to be recorded. The recording
20 of an informal resolution meeting shall be made available to the
21 provider who requested the meeting.

22 SECTION 4. The heading to Section 32.0291, Human Resources
23 Code, is amended to read as follows:

24 Sec. 32.0291. PREPAYMENT REVIEWS AND PAYMENT [~~POSTPAYMENT~~]
25 HOLDS.

26 SECTION 5. Subsections (b) and (c), Section 32.0291, Human
27 Resources Code, are amended to read as follows:

LFF
10/2
20

1 (b) Subject to Section 531.102, Government Code, and
2 notwithstanding [~~Notwithstanding~~] any other law, the department
3 may impose a payment [~~postpayment~~] hold on [~~payment of~~] future
4 claims submitted by a provider [~~if the department has reliable~~
5 ~~evidence that the provider has committed fraud or wilful~~
6 ~~misrepresentation regarding a claim for reimbursement under the~~
7 ~~medical assistance program. The department must notify the~~
8 ~~provider of the postpayment hold not later than the fifth working~~
9 ~~day after the date the hold is imposed].~~

10 (c) A payment hold authorized by this section is governed by
11 the requirements and procedures specified for a payment hold under
12 Section 531.102, Government Code, including the notice
13 requirements under Subsection (g) of that section. [~~On timely~~
14 ~~written request by a provider subject to a postpayment hold under~~
15 ~~Subsection (b), the department shall file a request with the State~~
16 ~~Office of Administrative Hearings for an expedited administrative~~
17 ~~hearing regarding the hold. The provider must request an expedited~~
18 ~~hearing under this subsection not later than the 10th day after the~~
19 ~~date the provider receives notice from the department under~~
20 ~~Subsection (b). The department shall discontinue the hold unless~~
21 ~~the department makes a prima facie showing at the hearing that the~~
22 ~~evidence relied on by the department in imposing the hold is~~
23 ~~relevant, credible, and material to the issue of fraud or wilful~~
24 ~~misrepresentation.]~~

25 SECTION 6. Subsection (d), Section 32.0291, Human Resources
26 Code, is repealed.

27 SECTION 7. The House Committee on Public Health, the House

65
16
dec

S.B. No. 1803

1 Committee on Human Services, and the Senate Committee on Health and
2 Human Services shall periodically request and review information
3 from the Health and Human Services Commission and the commission's
4 office of inspector general to monitor the enforcement of and the
5 protections provided by the changes in law made by this Act and to
6 recommend additional changes in law to further the purposes of this
7 Act. In performing the duties required under this section, the
8 House Committee on Public Health and the House Committee on Human
9 Services shall perform the duties jointly and the Senate Committee
10 on Health and Human Services shall perform the duties
11 independently.

12 SECTION 8. If before implementing any provision of this Act
13 a state agency determines that a waiver or authorization from a
14 federal agency is necessary for the implementation of that
15 provision, the agency affected by the provision shall request the
16 waiver or authorization and may delay implementing that provision
17 until the waiver or authorization is granted.

18 SECTION 9. This Act takes effect September 1, 2013.

S.B. No. 1803

David Newhurst

President of the Senate

Joe Straus

Speaker of the House

I hereby certify that S.B. No. 1803 passed the Senate on April 9, 2013, by the following vote: Yeas 31, Nays 0; and that the Senate concurred in House amendments on May 21, 2013, by the following vote: Yeas 31, Nays 0.

Dacey Spaw

Secretary of the Senate

I hereby certify that S.B. No. 1803 passed the House, with amendments, on May 17, 2013, by the following vote: Yeas 119, Nays 20, three present not voting.

Robert Haney

Chief Clerk of the House

Approved:

14 JUNE '13

Date

Rick Perry

Governor

FILED IN THE OFFICE OF THE
SECRETARY OF STATE
10PM O'CLOCK

JUN 14 2013

[Signature]
Secretary of State