Virginia Regulatory Town Hall

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Fast Track Proposed Regulation
Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30-95 (NEW CHAPTER)
Regulation title	Standards Established and Methods Used for Fee-for-Service Reimbursement
Action title	Timely Claims Filing
Date this document prepared	October 17, 2013

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 14 (2010) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

Please provide a brief summary (no more than 2 short paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes.

This action incorporates the federally mandated 12-month time period (from the date of service) for providers to submit their original claims for services rendered. In addition, this action creates an additional 13-month deadline in which Medicaid providers may resubmit previously denied claims for reconsideration by DMAS. There is currently no set deadline in DMAS regulations for such reconsiderations, which has the effect of both DMAS and providers attempting to deal with open accounts for sometimes years at a time. This action brings closure to providers and DMAS by establishing a generous 13-month resubmission policy. This action also allows DMAS to establish clear, predictable deadlines which are objectively verifiable.

Statement of final agency action

Please provide a statement of the final action taken by the agency including (1) the date the action was taken, (2) the name of the agency taking the action, and (3) the title of the regulation.

I hereby approve the foregoing Agency Background document with the attached amended regulations, Requirements for Provider Reimbursement: Timely Claims Filing (12 VAC 30-95-10) and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the *Code of Virginia* § 2.2-4012.1, of the Administrative Process Act.

___11/23/13____ _/s/ Cynthia Jones_____

Date Cynthia B. Jones, Director

Dept. of Medical Assistance Services

Legal basis

Please identify the state and/or federal legal authority to promulgate this proposed regulation, including (1) the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., agency, board, or person. Your citation should include a specific provision authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency/board/person's overall regulatory authority.

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, §§ 32.1-324 and 325, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

The *Social Security Act* § 1902(a)(37) (the *Act*) and Title 42 of the *Code of Federal Regulations* § 447.45 set out federal requirements, applicable to all Medicaid programs, for the timely payment of providers' claims. All Medicaid programs must require providers to submit their claims for payment within 12 months of the date when the service was rendered as well as process clean claims for payment within certain time standards.

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Detail the specific reasons the regulation is essential to protect the health,

safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.

The purpose of this action is to establish in regulations a set deadline for the resubmission of originally denied claims for reimbursement. This action also creates a new Chapter in the DMAS section of the Virginia Administrative Code (VAC) entitled "Standards Established and Methods Used for Fee-for-Service Reimbursement" in which DMAS intends to place new regulations addressing often frequently contested provider reimbursement issues, such as the use of electronic signatures and electronic medical records.

'This action has no affect on the health, safety, or welfare of either Medicaid individuals or citizens of the Commonwealth. This action is strictly administrative in nature and will enable DMAS and enrolled providers to maintain their accounts as current.

Rationale for using fast track process

Please explain the rationale for using the fast track process in promulgating this regulation. Why do you expect this rulemaking to be noncontroversial?

Please note: If an objection to the use of the fast-track process is received within the 30-day public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, the agency shall (i) file notice of the objections with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

DMAS believes that the Fast-Track option is the most efficient rule-making process for creating a final regulation with public input. DMAS does not anticipate any negative response to this action as it is expected to create greater stability and predictability for providers in managing their reimbursement funding and accounts with DMAS. In addition, a new VAC chapter for reimbursement issues creates a forum for DMAS to promulgate regulations that provide additional information to providers regarding topics like requirements for electronic signatures and medical records, which are areas in which DMAS' providers have requested additional guidance for emerging technologies.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. (Provide more detail about these changes in the "Detail of changes" section.) Please be sure to define any acronyms.

This action creates a new chapter in the Virginia Administrative Code, Chapter 95 regarding Standards Established and Methods Used for Fee-for-Service Reimbursement.

Currently, DMAS administers its federally required claims processing system consistent with §1902(a)(37) of the *Act* and 42 CFR § 447.45. This action does not propose to change any of these ongoing policies and procedures as the federal requirements do not permit it. This action proposes to set standards for the filing of providers' claims which have already been initially denied.

In SFY 2011, DMAS' monthly average number of all claim types (paper, electronic, point-of-sale, and encounters) was 4.8 million claims; in SFY 2012, this average was 4.8 million and; in SFY 2013, this average was 5.5 million.

The current claims processing system, upon being presented with a claim, verifies: (i) the current eligibility of the Medicaid individual and the service provider; (ii) the provider's eligibility to perform the service (a podiatrist is not allowed perform brain surgery, for example); (iii) the service does not exceed the agency's service limits and the service is logical for the individual's characteristics (a claim for a man's delivery of a baby, for example, would not be paid); (iv) the claim is not a duplicate nor conflicts with one currently being processed for payment and; (v) the prior authorization documentation of the service if the agency requires it. Fee-for-service providers are allowed up to 12 months from the date that a service is rendered in which to submit their original claims for payment to DMAS. Claims that pass these initial checks are deemed to be "clean".

DMAS receives providers' claims in various forms and pays the following amounts, to its claims processing fiscal agent, to process them: paper claims (48 ¢); electronic claims (20 ¢); point-of-sale claims (21 ¢) and; encounters (18 ¢). Most providers use electronic claims filing ((FY 2011 93.8%; FY 2012 95.1%; FY 2013 97.7%) of submitted claims are electronic). Point-of-sale claims are submitted by pharmacies. Encounter claims are submitted by managed care organizations, Logisticare (transportation claims), and DentaQuest (dental claims). As of FY 2013, a claims processing report showed the following average days to process the claims and average days to writing the providers' checks:

Type of Provider	Average Days to Process	Average Days to Write Check
Inpatient Hospital	8	17
Outpatient Hospital	11	21
Nursing Home	4	12
Practitioner	3	12
Transportation	1	10

Claims failing the standard 'clean claim' checks are denied. Such denial notices are returned to the billing providers in their weekly remittance vouchers which set out the reason for the denial. At this time, providers are expected to review their remittances and seek to make timely corrections of the errors (technical corrections of invalid identification numbers or invalid procedure code numbers, for example, or supplying background documentation, such as prior authorization documentation) in their claims. Such corrected claims are then re-submitted to DMAS for processing.

All providers do not do this, however. In the recent past, DMAS has experienced an increasing number of previously denied claim resubmissions, some as old as 5 years, from a variety of provider types. The following lists the types of provider that have been re-submitting very old claims for reconsideration and the amounts that DMAS has paid in SFY 2013:

Inpatient Hospitals	$15,924,817.
Outpatient Hospitals	$1,669,613.
Personal Care	$34,309.
Practitioner	$1,574,625.
Independent Laboratories	$94,347.
Cross Over Claims (XVIII)	$309,009.
Skilled Nursing Facility	$3,922.
Transportation	$5,042.

Practitioner (almost 50%) and Cross Over (Title XVIII) (33%) represent the two largest percentages of re-submitted previously-denied claims. Inpatient/outpatient hospitals' resubmissions result in the largest expenditures, ($15.9 M and $1.6 M, respectively) because these two services represent the highest cost services.

Currently, DMAS has no regulatory time limits for providers to resubmit previously-denied claims. Some providers have re-submitted claims for dates of services as old as 5 years after the original claim. Also, some providers have re-submitted (multiple times) claims which have already been denied. DMAS has observed an increase in this activity over the last several years. DMAS is proposing to allow providers up to an additional 13 months, from the initial denial date of the original claim, to re-submit claims that have been corrected or supply additional documentation for DMAS' re-consideration. By establishing a 13-month deadline for the re-submission of previously denied claims, DMAS is maximizing flexibility for providers while implementing a process to set reasonable limits on open provider accounts. Revised (previously denied) claims which are resubmitted later than the suggested time frame will be denied.

DMAS is providing for two exceptions, as set out in 12 VAC 30-95-10 E, to this new limitation: (i) if a provider's claim was retracted by a third party payor, DMAS will consider the date of the retraction notice by the third party payor as the beginning date of the initial 12-month timely filing period, and; (ii) in situations of retroactive eligibility, DMAS will consider the date of the notification of delayed eligibility from the local department of social services as the beginning date of the initial 12-month timely filing period. Both of these situations are outside of the fee-for-service providers' abilities to control so that to refuse payment of such claims would be inappropriate.

Issues

Please identify the issues associated with the proposed regulatory action, including:
1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;

2) the primary advantages and disadvantages to the agency or the Commonwealth; and
3) other pertinent matters of interest to the regulated community, government officials, and the public.
If there are no disadvantages to the public or the Commonwealth, please indicate.

The primary advantage of this action is that it creates a predictable deadline for both DMAS and Medicaid fee-for-service providers in which both entities can finally and fully close out open accounts. This enhances the ability of providers and DMAS to efficiently administer their funds and accounts.

Fee-for-service providers, who are in the habit of delaying their remittance reconciliations for years on end, are not expected to agree with this recommended policy. Providers who have the practice of repeatedly re-submitting previously denied claims, in the hopes if finally being paid, are also not expected to agree with this recommended policy. Pharmacies and managed care organizations will not be affected by this action because they use, respectively, point of sale claim submission and encounter claims. All fee-for-service providers will be affected by this proposal.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

The requirements in this regulation are not more restrictive than federal requirements.

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

There are no localities particularly affected by this regulation since the Medicaid program operates statewide.

Regulatory flexibility analysis

Please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5)

the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

DMAS is moving forward with the least restrictive means that ensure appropriate documentation of claims for billed Medicaid services. By creating a 13-month deadline for claims resubmission, DMAS is maximizing flexibility for providers while implementing a process to put reasonable limits on open provider accounts.

Economic impact

Please identify the anticipated economic impact of the proposed new regulations or amendments to the existing regulation. When describing a particular economic impact, please specify which new requirement or change in requirement creates the anticipated economic impact.

Projected cost to the state to implement and enforce the proposed regulation, including (a) fund source / fund detail, and (b) a delineation of one-time versus on-going expenditures	N/A
Projected cost of the *new regulations or changes to existing regulations* on localities.	N/A
Description of the individuals, businesses or other entities likely to be affected by the *new regulations or changes to existing regulations*.	All Medicaid Providers enrolled with DMAS
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	118,437 enrolled fee-for-service providers.
All projected costs of the *new regulations or changes to existing regulations* for affected individuals, businesses, or other entities. Please be specific and include all costs. Be sure to include the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses. Specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the proposed regulatory changes or new regulations.	N/A
Beneficial impact the regulation is designed to produce.	Bring clarification to reimbursement regulations and enable both DMAS and providers to close out lin-

	gering accounts.

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in §2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

DMAS could have opted for a shorter time frame for the resubmission of denied claims, such as is found in the private sector. Some health insurance entities allow only a single 12-month period for providers to submit their claims with re-submissions not permitted. Other such entities only allow 180 days for providers to submit their claims. However, because this issue is one of long standing with many Medicaid providers, DMAS determined that the best approach would be to create a generous deadline that would give providers a reasonable deadline in which to finalize any outstanding accounts with the Agency.

Family impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; or encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment.

Detail of changes

Please list all changes that are being proposed and the consequences of the proposed changes. If the proposed regulation is a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory action.

Section number	Proposed requirements	Other regulations and law that apply	Intent and likely impact of proposed requirements
12 VAC 30-95-10	13-month deadline for resubmission of denied reimbursement claims	N/A	Bring finality to the denied claims adjudication process. Impact will be to bring closure and predictability to

			open provider accounts for both DMAS and its Medicaid fee-for-service providers.