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**OFFICE OF THE LIEUTENANT GOVERNOR
ALASKA**

M E M O R A N D U M

TO: Triptaa Surve
Department of Health and Social Services

FROM: April Simpson, Office of the Lieutenant Governor 
465.4081

DATE: January 7, 2020

RE: Filed Permanent Regulations: Department of Health and Social Services

Department of Health and Social Services Regulation re: Medicaid, Provider & Recipient Participation; Duty of Provider (7 AAC 105, 160)

Attorney General File:	2019200651
Regulation Filed:	1/7/2020
Effective Date:	2/6/2020
Print:	233, April 2020

cc with enclosures: Harry Hale, Department of Law
Judy Herndon, LexisNexis

ORDER ADOPTING CHANGES TO REGULATIONS
OF THE DEPARTMENT OF HEALTH & SOCIAL SERVICES

The attached 7 pages of regulations, dealing with the 72 Hour Rule & Provider Self-Audits, specifically, Medicaid, Provider & Recipient Participation; Duty of Provider to Identify & Repay Self-Identified Overpayments (7 AAC 105, 160), are adopted and certified to be a correct copy of the regulation changes that the Department of Health and Social Services adopts under the authority of AS 47.05.010, AS 47.05.200, AS 47.05.235, AS 47.07.030, AS 47.07.040, AS 47.07.074, and after compliance with the Administrative Procedure Act (AS 44.62), specifically including notice under AS 44.62.190 and 44.62.200 and opportunity for public comment under AS 44.62.210.

This action is not expected to require an increased appropriation.

In considering public comments, the Department of Health and Social Services paid special attention to the cost to private persons of the regulatory action being taken.

The regulation changes adopted under this order take effect on the 30th day after they have been filed by the lieutenant governor, as provided in AS 44.62.180.

Date: 12/16/19


Adam Crum, Commissioner
Department of Health & Social Services

April Simpson for

FILING CERTIFICATION

I, Kevin Meyer, Lieutenant Governor for the State of Alaska, certify that¹ on January 7, 2020, at 2:47 p.m., I filed the attached regulations according to the provisions of AS 44.62.040 - 44.62.120.

April Simpson
for Lieutenant Governor *Kevin Meyer*

Effective: February 6, 2020.

Register: 233, April 2020.

FOR DELEGATION OF THE LIEUTENANT GOVERNOR'S AUTHORITY

I, KEVIN MEYER, LIEUTENANT GOVERNOR OF THE STATE OF ALASKA, designate the following state employees to perform the Administrative Procedures Act filing functions of the Office of the Lieutenant Governor:

**Josh Applebee, Chief of Staff
Kady Levale, Notary Administrator
April Simpson, Regulations and Initiatives Specialist**

IN TESTIMONY WHEREOF, I have signed and affixed the Seal of the State of Alaska, in Juneau, on December 11th, 2018.



Kevin Meyer

**KEVIN MEYER
LIEUTENANT GOVERNOR**

The introductory language of 7 AAC 105.230(d) is amended to read:

(d) A provider shall maintain a clinical or therapeutic record [, INCLUDING A RECORD OF THERAPEUTIC SERVICES,] in accordance with professional standards applicable to the provider, for each recipient. The clinical record must include

...

7 AAC 105.230(d)(5) is amended to read:

(5) start [STOP] and stop [START] times for time-based billing codes;

(A) a provider may only bill for a unit of service if the actual direct service time spent is in excess of 50 percent of the time value of the procedure code billed;

(B) direct service time associated with a particular procedure code shall be calculated in the aggregate [ACCUMULATED] by the direct service provider for each date of service when determining the appropriate number of units that may be billed;

(C) a provider may not use pre-populated clinical notes or time-sheets to document actual start [STOP] and stop [START] times;

(D) a provider may not bill for services without proper start and stop times [TIME-IN AND TIME-OUT] documentation;

(E) the use of documentation that does not specify both start and stop times [TIME IN AND TIME OUT] will result in an overpayment;

(F) the following table shall be used when billing for time-based billing codes under this section and identifies the appropriate number of units to bill using a 15-minute time-based code:

Units	Number of Minutes of Direct Service Time
1	≥ 8 minutes through 22 minutes
2	≥ 23 minutes through 37 minutes
3	≥ 38 minutes through 52 minutes
4	≥ 53 [52] minutes through 67 minutes
5	≥ 68 minutes through 82 minutes
6	≥ 83 minutes through 97 minutes
7	≥ 98 minutes through 112 minutes
8	≥ 113 minutes through 127 minutes
The pattern remains the same for direct service times in excess of 2 hours.	

7 AAC 105.230(d)(6) is amended to read:

(6) annotated case notes identifying each service or supply delivered;

(A) the case notes must be dated and either signed or initialed by the individual who provided each service;

(B) for electronic records, an electronic signature that complies with the requirements of AS 09.80 (Uniform Electronic Transactions Act) satisfies the signature requirement under this section [; THE INDIVIDUAL WHOSE NAME IS ON THE ELECTRONIC SIGNATURE AND THE PROVIDER BEAR THE RESPONSIBILITY FOR THE AUTHENTICITY OF THE INFORMATION BEING ATTESTED TO]; and

7 AAC 105.230(d)(7) is repealed and readopted to read:

(7) except for facilities identified in 7 AAC 12.990(26), all records maintained contemporaneously with the service provided; for purposes of this section, contemporaneous record keeping means documentation is done not later than 14 days after the service ends; a provider may not bill for services for which records were not kept contemporaneously as required under this section.

7 AAC 105.230(h) is amended to read:

(h) A provider may not submit a claim to the department for a service if a provider does not maintain records in compliance with this chapter, **including records that must be maintained contemporaneously under this section.**

7 AAC 105.230 is amended by adding new subsections to read:

(i) Documentation of start and stop times as set out in this section is not required for evaluation and management codes, but documentation must be maintained in accordance with professional guidance as adopted by reference in 7 AAC 160.900(a).

(j) Any claim submitted for reimbursement for which the provider fails to maintain documentation required by this section is considered an overpayment and subject to recoupment under 7 AAC 105.260. (Eff. 2/1/2010, Register 193; am 6/7/2018, Register 226; am

2/6/2020 Register 233)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 160.115(d) is amended to read:

(d) If a provider identifies overpayments through the biennial review or audit, [DURING THE NORMAL COURSE OF BUSINESS, OR BOTH,] the provider shall report each overpayment to the department not later than 10 business days after identification of that overpayment. **Overpayment reports shall be submitted to the Department of Health and Social Services, Office of the Commissioner, Medicaid Program Integrity.** In this subsection, "business day" means a day other than Saturday, Sunday, or a legal holiday under AS 44.12.010.

7 AAC 160.115(e) is amended to read:

(e) A provider who was reimbursed

(1) \$30,000 or greater for services during the year shall submit a report to the department detailing the claims audited or reviewed together with the results of that review or audit; [. A PROVIDER WHO WAS REIMBURSED]

(2) \$10,000 or greater but less than \$30,000 is not required to submit the report to the department but must have the report available for review by the department; [. A PROVIDER WHO WAS REIMBURSED]

(3) less than \$10,000 is not required to produce a report but shall have an [A] attestation form on file and available for review by the department [. THE REPORT SHALL BE MADE IN WRITING, INCLUDE AN ATTESTATION ON A FORM PRESCRIBED BY THE DEPARTMENT, AND BE SUBMITTED, IF REQUIRED, TO THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES, OFFICE OF THE COMMISSIONER, MEDICAID PROGRAM INTEGRITY. THE REIMBURSEMENT VALUES REFERENCED ARE BASED UPON THE REIMBURSEMENT VALUES REPORTED IN EACH UNITED STATES INTERNAL REVENUE SERVICE FORM 1099 THAT THE DEPARTMENT ISSUES TO THE PROVIDER BY CALENDAR YEAR].

7 AAC 160.115(f) is repealed and readopted to read:

(f) The reimbursement values referenced in (e) of this section are based upon the reimbursement values reported in each United States Internal Revenue Service form 1099 that the department issues to the provider by calendar year.

7 AAC 160.115(g) is repealed and readopted to read:

(g) The report or attestation required under this section must be made in writing on a form approved by the department and submitted, if required, to the Department of Health and Social Services, Office of the Commissioner, Medicaid Program Integrity. The report must include

- (1) the method used to sample the claims;
- (2) the sampled claims Medicaid assigned transaction control number (TCN);
- (3) the outcome of the individual claim audit;
- (4) the identified amount of overpayment back to the department; and
- (5) if appropriate, a corrective action plan.

7 AAC 160.115(h) is repealed and readopted to read:

(h) A provider shall retain all audit documents, reports, and attestations created as a result of the review for at least seven calendar years following completion.

7 AAC 160.115(i) is repealed and readopted to read:

(i) Not later than 60 days after identification of the overpayment, the provider shall repay the department unless the provider has a repayment agreement with the department. The department may, in the repayment agreement, authorize repayment through one of the following means:

- (1) a lump sum payable not later than two months after the date of the discovery of the overpayment;
- (2) a payment plan not to exceed two years in length; the department may extend the payment plan beyond two years based on the following factors:

(A) the provider's history of compliance with the Medicaid program generally, including prior payment agreements;

(B) the amount of the overpayment;

(C) the amount of revenue the provider is receiving from Medicaid;

(D) any other factors that would impact repayment, such as type of services being provided;

(3) by offsetting future billings by the provider; if a provider chooses to offset future billings, the amount offset must be repaid not later than two years from the date of the agreement.

7 AAC 160.115 is amended by adding new subsections to read:

(j) If a provider defaults on a repayment under (i) of this section, the department may require immediate payment of the total amount due. If a provider defaults on paying the total amount, the provider is subject to sanctions under 7 AAC 105.400 - 7 AAC 105.490. Sanctions may include termination from the Medicaid program in accordance with 7 AAC 105.410.

(k) Under this section, an overpayment is identified when the provider has, through the exercise of reasonable diligence, determined that the provider has received an overpayment and quantified the amount of the overpayment.

(l) The department may review the results of a provider-conducted self-review for accuracy. If the provider does not provide an opportunity for department review under this subsection or obstructs the review, or if the department determines that the provider's self-review is inaccurate, the department may impose sanctions under 7 AAC 105.400 - 7 AAC 105.490.

(m) For purposes of this section,

(1) "default" means any default that results in written notice from the department;

(2) “immediate repayment” means a payment this is made not later than 30 days after written notice is provided under (m)(1) of this section. (Eff. 6/7/2018, Register 226; am 2 / 6 / 2020, Register 233)

Authority: AS 47.05.010 AS 47.05.235 AS 47.07.040
AS 47.05.200 AS 47.07.030 AS 47.07.074

The editor’s note in 7 AAC 160.115 is changed to read:

Editor’s note: For information regarding the conduct of a self-audit, please refer to the CMS self-audit toolkit, Conducting a Self-Audit: A Guide for Physicians and Other Health Care Professionals, February 2016. The toolkit may be obtained at the following website:

<https://www.cms.gov/Medicare-Medicaid-Coordination-Fraud-Prevention/Medicaid-Integrity-Education/audit-toolkit.html>. The address of the Department of Health and Social Services,

Office of the Commissioner, Medicaid Program Integrity is 3601 C Street, Anchorage, Alaska 99503.