By Senator Saunders

25-813A-99

A bill to be entitled

An act relating to Medicaid physician fraud; creating s. 409.9131, F.S.; providing legislative findings and intent; providing definitions; providing for review of certain physician records; requiring notice before such review is conducted; requiring notice of due process rights in certain circumstances; specifying procedures for determination of overpayment; providing guidelines for sanctions in cases of overbilling and acceptance of overpayment; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 409.9131, Florida Statutes, is created to read:

409.9131 Special provisions relating to integrity of the Medicaid program.--

(1) LEGISLATIVE FINDINGS AND INTENT.--It is the intent of the Legislature that physicians be subject to Medicaid fraud and abuse investigations in accordance with the provisions set forth in this section as a supplement to the provisions contained in s. 409.913. If a conflict exists between the provisions of this section and s. 409.913, it is the intent of the Legislature that the provisions of this section control.

(2) DEFINITIONS.--For the purposes of this section, the term:

(a) "Active practice" means that a physician must have regularly provided medical care and treatment to patients within the past 3 years.

(b) "Medical necessity" or "medically necessary" means that the provision of goods or services is necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, to the maximum extent possible, the agency must use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty and who is licensed under the same chapter as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided.

(c) "Peer" means a physician licensed in this state who is, whenever possible, of the same specialty or subspecialty and who is licensed under the same chapter as the physician under review and in active practice.

(d) "Peer review" means an evaluation of the professional practices of a Medicaid physician provider by a peer or peers in order to assess the medical necessity, appropriateness, and quality of care provided, as such care is compared to that customarily furnished by the physician's peers and to recognized health care standards.

(e) "Physician" means a person licensed to practice medicine under chapter 458 or a person licensed to practice osteopathic medicine under chapter 459.

(f) "Professional services" means procedures provided to a Medicaid recipient, either directly by or under the supervision of a physician who is a registered provider for the Medicaid program.

(3) ONSITE RECORDS REVIEW; APPOINTMENT REQUIRED.--As specified in s. 409.913(8), the agency may investigate, review or analyze a physician's medical records of Medicaid patients. The physician must make such records available to the agency during normal business hours. The agency must provide notice to the physician at least 24 hours before such visit, and the physician may schedule an appointment for the agency's visit within the 24-hour period, if necessary to avoid disruption of patient care.

(4) NOTICE OF DUE PROCESS RIGHTS REQUIRED.--Whenever the agency seeks an administrative remedy against a physician pursuant to this section or s. 409.913, the physician must be advised of his or her rights to due process under chapter 120.

(5) DETERMINATIONS OF OVERPAYMENT; EDUCATIONAL AUDIT REQUIRED.--In making a determination of overpayment to a physician, the agency must:

(a) Use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods or combinations thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, and other generally accepted statistical methods. To the maximum extent possible, such statistical methods for physician services must compare physicians of the same

specialty or subspecialty, if applicable; must take into consideration the physician's case mix; and must have a 95 percent or greater confidence level. Appropriate analytical methods may include, but are not limited to, reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to Medicaid recipients during the review period and the quantities of the same products paid for by the Medicaid program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same period. In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such statistical methods as evidence of overpayment.

(b) Refer all physician service claims for peer review when an investigation of overpayment is being conducted by the agency, except as required by s. 409.913(4).

Unless the agency has substantial evidence of willful fraud, the first audit of any physician pursuant to this subsection must be for the purposes of educating the physician regarding Medicaid billing and documentation and collecting any overpayments in the sample medical records.

(6) ADMINISTRATIVE SANCTIONS.--In determining the appropriate administrative sanctions to be applied to a physician, or the duration of any suspension or termination, the agency shall consider the factors specified in s. 409.913(16). Based upon these factors, the agency may limit administrative sanctions to the amount of the sample overpayment.

Section 2. This act shall take effect October 1, 1999.

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SENATE SUMMARY

Provides legislative intent with respect to, and guidelines for conducting, investigations of Medicaid fraud and abuse. Prescribes minimum standards for peer review. Requires certain procedures to be used in determining whether overpayment has occurred. Provides procedural safeguards for physicians under investigation. Provides standards for determining sanctions for overbilling and collecting overpayments.