

# PROPOSED RULES

Proposed rules include new rules, amendments to existing rules, and repeals of existing rules. A state agency shall give at least 30 days' notice of its intention to adopt a rule before it adopts the rule. A state agency shall give all interested persons a reasonable opportunity to submit data, views, or arguments, orally or in writing (Government Code, Chapter 2001).

**Symbols in proposed rule text.** Proposed new language is indicated by underlined text. ~~[Square brackets and strikethrough]~~ indicate existing rule text that is proposed for deletion. “(No change)” indicates that existing rule text at this level will not be amended.

## TITLE 1. ADMINISTRATION

### PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

#### CHAPTER 371. MEDICAID AND OTHER HEALTH AND HUMAN SERVICES FRAUD AND ABUSE PROGRAM INTEGRITY

The Texas Health and Human Services Commission (HHSC) proposes amendments to Chapter 371 to implement recent legislation and to update and correct existing rules.

HHSC proposes to amend §§371.11, 371.17, 371.23, 371.25, 371.27, 371.29, and 371.31, concerning Office of Inspector General; §§371.200, 371.201, 371.203, 371.204, 371.206, 371.208, 371.210, 371.212, 371.214, and 371.216, concerning Utilization Review; §§371.1001, 371.1005, 371.1007, 371.1009, 371.1011, 371.1013, and 371.1015, concerning Provider Disclosure and Screening; §§371.1301, 371.1305, 371.1307, and 371.1309, concerning Investigations; §§371.1601, 371.1603, 371.1609, 371.1611, 371.1613, 371.1615, 371.1617, 371.1619, 371.1651, 371.1653, 371.1655, 371.1657, 371.1659, 371.1663, 371.1665, 371.1667, 371.1669, 371.1701, 371.1703, 371.1705, 371.1707, 371.1709, 371.1711, 371.1715, 371.1717, and 371.1719, concerning Administrative Actions and Sanctions; to repeal Subchapter A, concerning Introduction, and §371.1, concerning Purpose and Scope; §371.13, concerning Statutory Authority; §371.19, concerning Investigations; §371.1002, concerning Minimum Collection Goal; §371.1003, concerning Definitions; §371.1303, concerning Definitions; §371.1607, concerning Definitions; and §371.1713, concerning Restricted Reimbursement; and proposes new §371.1, concerning Definitions; §371.3, concerning Purpose and Authority; and §371.1311, concerning Role of the OIG and Special Investigative Units.

#### BACKGROUND AND JUSTIFICATION

The existing rules in Chapter 371 include various provisions to ensure the integrity of Medicaid and other HHS programs by discovering, preventing, and correcting fraud, waste, or abuse.

The rules in Chapter 371 are new, amended, or repealed to implement various provisions of Senate Bill 207 (S.B. 207), 84th Legislature, Regular Session, 2015; and to clarify, update, or eliminate obsolete provisions.

S.B. 207 amended various provisions in Texas Government Code Chapter 531 related to the Office of Inspector General's (OIG's) authority and duties. Among other things, the bill amended timelines in the OIG's investigation of fraud, waste, and abuse; clarified the use of payment holds; required the adoption of rules for opening and prioritizing cases; and re-

quired criminal history record information checks on health care professionals who wish to enroll as Medicaid providers.

The proposed amendments consequently revise the current process for investigations and provider background checks as mandated by S.B. 207. The amendments also include components and clarifications related to management practices and processes of the OIG, provider disclosure and screening, administrative actions and sanctions, and grounds for enforcement by the OIG.

The new rules as proposed consolidate all definitions into a single rule; move and revise the rule regarding the purpose of the chapter; and address the role of the OIG related to managed care organizations' Special Investigation Units.

In addition, portions of proposed new §371.1 and proposed amended §371.1009 are intended to alleviate an administrative burden currently experienced by providers. Providers enrolled in Texas Medicaid and Medicare historically have been able to submit new location information to the Texas Medicaid and Healthcare Partnership (the Texas Medicaid claims administrator) using Provider Information Change (PIC) forms alone. Business addresses submitted using a PIC form are currently not in compliance with Texas Medicaid rules, which require a completed application for each practice location. Proposed language in §371.1 and §371.1009 clarifies the requirements for a provider that wishes to add a location to its practice that will serve Texas Medicaid recipients.

HHSC intends that any obligations or requirements that accrued under Chapter 371 before the effective date of these rules will be governed by the prior rules in Chapter 371, and that those rules continue in effect for this purpose. HHSC does not intend for the amendments to the rules in Chapter 371 to affect the prior operation of the rules; any prior actions taken under the rules; any validation, cure, right, privilege, obligation, or liability previously acquired, accrued, accorded, or incurred under the rules; any violation of the rules or any penalty, forfeiture, or punishment incurred under the rules before their amendment; or any investigation, proceeding, or remedy concerning any privilege, obligation, liability, penalty, forfeiture, or punishment. HHSC additionally intends that any investigation, proceeding, or remedy may be instituted, continued, or enforced, and the penalty, forfeiture, or punishment imposed, as if the rules had not been amended.

HHSC intends that should any sentence, paragraph, subdivision, clause, phrase, or section of the amended or new rules in Chapter 371 be determined, adjudged, or held to be unconstitutional, illegal, or invalid, the same shall not affect the validity of the subchapter as a whole, or any part or provision hereof other than the part so declared to be unconstitutional, illegal, or invalid, and shall not affect the validity of the subchapter as a whole.

#### SECTION-BY-SECTION SUMMARY

Subchapter A is proposed for repeal because its only section, current §371.1, is repealed.

Proposed §371.1, which will be placed in Subchapter B, consolidates all definitions currently found in the chapter, adds definitions for multiple acronyms used throughout the chapter, and amends the definitions of "complete application" and "enrollment application" regarding the addition of a practice location.

Proposed §371.3 and §371.11 address the purpose and scope of the rules for this chapter.

Proposed §371.3 describes the responsibility and authority of the OIG.

Proposed §371.11 describes the OIG's duties. To clarify the rule's subject matter, the rule's heading is amended by deleting the words "Purpose and." Section 371.11 also is amended to delete unnecessary language.

Proposed §371.13 is being repealed because the content is included in §371.3.

Proposed §371.19 is being repealed because the language is obsolete or redundant.

Proposed §371.23 updates cross references to other rules.

Proposed §371.27 updates a cross reference to another rule.

Proposed §371.203 adds the requirement of provider training and education of the Diagnosis Related Group (DRG) validation criteria and the requirement that federal coding guidelines be used in the DRG assignment, consistent with Texas Government Code §531.1023 and §531.1024.

Proposed §371.1002 is being repealed to remove information that is no longer relevant.

Proposed §371.1003 is being repealed because all definitions are now consolidated in proposed new §371.1.

Proposed §371.1009 updates language referenced in Texas Government Code §531.1032, and provides that the OIG may rely on validated screenings performed by other entities, as provided in 42 C.F.R. §455.410.

Proposed §371.1011 updates language to be consistent with Texas Government Code §531.1032, which requires the Executive Commissioner to adopt guidelines for evaluating criminal history record information.

Proposed §371.1015 removes the recommendation to abate an enrollment because HHSC no longer abates enrollment decisions. An applicant is either enrolled or denied.

Proposed §371.1301 removes unnecessary language not in alignment with the subchapter's subject matter.

Proposed §371.1303 is being repealed because all definitions are now consolidated in proposed new §371.1.

Proposed §371.1305 implements Texas Government Code §531.102(p), which requires the Executive Commissioner, in consultation with the OIG, to adopt rules establishing criteria for prioritizing cases and delineating relevant factors for the preliminary investigative process.

Proposed §371.1307 updates time frames for the completion of investigatory processes to be consistent with Texas Government Code §531.102(f-1).

Proposed §371.1311 outlines the role of the OIG and managed care organization's special investigative units for coordination of

investigations of fraud, waste, or abuse in accordance with Texas Government Code §531.113(e).

Proposed §371.1607 is being repealed because all definitions are now consolidated in proposed new §371.1.

Proposed §371.1617 addresses the procedural effect of failing to timely request an appeal of an imposition of a sanction, consistent with Texas Government Code §531.1201. The section also eliminates the term "contested case" because it is redundant.

Proposed §371.1663 adds new paragraphs (22) - (24) to be consistent with Texas Government Code §§531.1131, 531.1132, and 531.117. Section 371.1663 is further amended to eliminate redundant language.

Proposed §371.1703 reflects that the OIG can cancel a provider contract under certain circumstances.

Proposed §371.1705 addresses the provider exclusion process and clarifies that a provider who has been excluded from the federal system will be excluded in Texas as required by federal law. The state action will be a reciprocal action, and another hearing on this type of exclusion will not be had once the appellate process has been concluded on the federal level. This does not affect the due process rights granted when the state OIG initiates the exclusion process. Section 371.1705 updates the description of the information that will be in a notice and updates a regulatory reference. Erroneous references to Title VIII of the Social Security Act are also amended to reference Title XVIII.

Proposed §371.1707 addresses the contents of a final notice of exclusion and the effective date that exclusion begins. Erroneous references to Title VIII of the Social Security Act are also amended to reference Title XVIII.

Proposed §371.1713 is being repealed because it contains a process the OIG does not use.

Proposed §371.1715 deletes unnecessary language and outlines factors considered when damages or penalties are imposed, as reflected in Texas Government Code §531.102(q).

Proposed §371.1717 adds clarifying language that more accurately reflects the reinstatement process after a provider has been excluded.

In addition to the revisions specifically described, the proposed rules make several general changes. Throughout the rules, the term "waste" is inserted with references to fraud and abuse to more accurately reflect the OIG's mission. Terms throughout the rules are changed to be consistent with the definitional section. In addition, the term "OIG" is generally substituted for the term "Inspector General" to more accurately reflect the division of authority. Finally, nonsubstantive language changes are proposed throughout the chapter for language consistency, capitalization corrections, and punctuation corrections.

#### Fiscal Note

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that for each year of the first five years the proposed rules are in effect, there will be no impact to costs and revenues to state or local government.

#### Small Business and Micro-business Impact Analysis

HHSC has determined that there will be no adverse economic effect on small businesses or micro businesses to comply with the proposed rules, as they will not be required to alter their business practices as a result of the proposed rules.

## Public Benefit

Charles Smith, Chief Deputy Executive Commissioner, has determined that for each year of the first five years the proposed rules are in effect, the expected public benefit is that the rules will ensure the integrity of Medicaid and other HHS programs by discovering, preventing, and correcting fraud, waste, and abuse.

Ms. Rymal has also determined that there are no probable economic costs to persons who are required to comply with the proposed rules. The proposal will not affect a local economy.

## Regulatory Analysis

HHSC has determined that this proposal is not a "major environmental rule" as defined by §2001.0225 of the Texas Government Code. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

## Takings Impact Assessment

HHSC has determined that this proposal does not restrict or limit an owner's right to his or her private real property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under §2007.043 of the Texas Government Code.

## Public Comment

Written comments on the proposal may be submitted to Lisa Barragan, Texas Health and Human Services Commission-OIG, Broadmoor 902 (MC 1350), 11501 Burnet Road, Austin, Texas 78758; by fax to (512) 833-6484; or by e-mail to Lisa.Barragan@hhsc.state.tx.us within 30 days of publication in the *Texas Register*.

## SUBCHAPTER A. INTRODUCTION

### 1 TAC §371.1

#### Legal Authority

The repeal is proposed under Texas Government Code §531.102(a-2), which requires the Executive Commissioner to work in consultation with the Office of Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program.

The repeal implements Texas Government Code Chapter 531, as amended by S.B. 207. No other statutes, articles, or codes are affected by the proposal.

#### §371.1. *Purpose and Scope.*

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 15, 2016.

TRD-201600177

Karen Ray

Chief Counsel

Texas Health and Human Services Commission

Earliest possible date of adoption: February 28, 2016

For further information, please call: (512) 424-6900



## SUBCHAPTER B. OFFICE OF INSPECTOR GENERAL

### 1 TAC §§371.1, 371.3, 371.11, 371.17, 371.23, 371.25, 371.27, 371.29, 371.31

#### Legal Authority

The amendments and new rules are proposed under Texas Government Code §531.102(a-2), which requires the Executive Commissioner to work in consultation with the Office of Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program.

The amendments and new rules implement Texas Government Code Chapter 531, as amended by S.B. 207. No other statutes, articles, or codes are affected by the proposal.

#### §371.1. *Definitions.*

The following words and terms, when used in this chapter, have the following meanings unless the context clearly indicates otherwise:

(1) Abuse--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; the reimbursement for 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) Address of record--

(A) an HHS provider's current mailing or physical address, including a working fax number, as provided to the appropriate HHS program's claims administrator or as required by contract, statute, or regulation; or

(B) a non-HHS provider's last known address as reflected by the records of the United States Postal Service or the Texas Secretary of State's records for business organizations, if applicable.

#### (3) Affiliate; affiliate relationship--A person who:

(A) has a direct or indirect ownership interest (or any combination thereof) of five percent or more in the person;

(B) is the owner of a whole or part interest in any mortgage, deed of trust, note or other obligation secured (in whole or in part) by the entity whose interest is equal to or exceeds five percent of the value of the property or assets of the person;

(C) is an officer or director of the person, if the person is a corporation;

(D) is a partner of the person, if the person is organized as a partnership;

(E) is an agent or consultant of the person;

(F) is a consultant of the person and can control or be controlled by the person or a third party can control both the person and the consultant;

(G) is a managing employee of the person, that is, a person (including a general manager, business manager, administrator or director) who exercises operational or managerial control over a person or part thereof, or directly or indirectly conducts the day-to-day operations of the person or part thereof;

(H) has financial, managerial, or administrative influence over the operational decisions of a person;

(I) shares any identifying information with another person, including tax identification numbers, social security numbers, bank accounts, telephone numbers, business addresses, national provider numbers, Texas provider numbers, and corporate or franchise names; or

(J) has a former relationship with another person as described in subparagraphs (A) - (I) of this definition, but is no longer described, because of a transfer of ownership or control interest to an immediate family member or a member of the person's household of this section within the previous five years if the transfer occurred after the affiliate received notice of an audit, review, investigation, or potential adverse action, sanction, board order, or other civil, criminal, or administrative liability.

(4) Agent--Any person, company, firm, corporation, employee, independent contractor, or other entity or association legally acting for or in the place of another person or entity.

(5) Allegation of fraud--Allegation of Medicaid fraud received by HHSC from any source that has not been verified by the state, including an allegation based on:

(A) a fraud hotline 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.

(6) Applicant--An individual or an entity that has filed an enrollment application to become a provider, re-enroll as a provider, or enroll a new practice location in a Medicaid program or the Children's Health Insurance Program as described in definition (23) of this section.

(7) At the time of the request--Immediately upon request and without delay.

(8) Audit--A financial audit, attestation engagement, performance audit, compliance audit, economy and efficiency audit, effectiveness audit, special audit, agreed-upon procedure, nonaudit service, or review conducted by or on behalf of the state or federal government. An audit may or may not include site visits to the provider's place of business.

(9) Auditor--The qualified person, persons, or entity performing the audit on behalf of the state or federal government.

(10) Business day--A day that is not a Saturday, Sunday, or state legal holiday. In computing a period of business days, the first day

is excluded and the last day is included. If the last day of any period is a Saturday, Sunday, or state legal holiday, the period is extended to include the next day that is not a Saturday, Sunday, or state legal holiday.

(11) C.F.R.--The Code of Federal Regulations.

(12) CHIP--The Texas Children's Health Insurance Program or its successor, established under Title XXI of the federal Social Security Act (42 U.S.C. §§1397aa et seq.) and Chapter 62 of the Texas Health and Safety Code.

(13) Claim--

(A) A written or electronic application, request, or demand for payment by the Medicaid or other HHS program for health care services or items; or

(B) A submitted request, demand, or representation that states the income earned or expense incurred by a provider in providing a product or a service and that is used to determine a rate of payment under the Medicaid or other HHS program.

(14) Claims administrator--The entity an operating agency has designated to process and pay Medicaid or HHS program provider claims.

(15) Closed-end contract--A contract or provider agreement for a specific period of time. It may include any specific requirements or provisions deemed necessary by the OIG to ensure the protection of the program. It must be renewed for the provider to continue to participate in the Medicaid or other HHS program.

(16) CMS--The Centers for Medicare & Medicaid Services or its successor. CMS is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid and CHIP.

(17) Complete Application--A provider enrollment application that contains all the required information, including:

(A) all questions answered completely, including correct dates of birth, social security numbers, license numbers, and all requirements per provider type defined in the Texas Medicaid Provider Procedures Manual;

(B) IRS Form W-9, if required;

(C) signed and certified provider agreements;

(D) Provider Information Form (PIF-1);

(E) Principal Information Forms (PIF-2) on all persons required to be disclosed, if required;

(F) full disclosure of all criminal history, including copies of complete dispositions on all criminal history;

(G) full disclosure of all board or licensing orders, including documentation of compliance with current board orders;

(H) full disclosure of all corporate compliance agreements, settlement agreements, state or federal debt, and sanctions;

(I) documentation of an active license that is not subject to expiration within 30 days of submission of the enrollment application, if required;

(J) completion of a pre-enrollment site visit by HHSC, if required, and all required current documentation (e.g., liability insurance);

(K) documentation of fingerprints of a provider or any person with a five percent or more direct or indirect ownership in the provider, if required; and

(L) any additional documentation related to the addition of a practice location, if required or requested by HHSC.

(18) Conviction or convicted--Means that:

(A) a judgment of conviction has been entered against an individual or entity by a federal, state, or local court, regardless of whether:

(i) there is a post-trial motion or an appeal pending;  
or

(ii) the judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;

(B) a federal, state, or local court has made a finding of guilt against an individual or entity;

(C) a federal, state, or local court has accepted a plea of guilty or nolo contendere by an individual or entity; or

(D) an individual or entity has entered into participation in a first offender, deferred adjudication, pre-trial diversion, or other program or arrangement where judgment of conviction has been withheld.

(19) Credible allegation of fraud--An allegation of fraud that has been verified by the state. An allegation is considered to be credible when HHSC has carefully reviewed all allegations, facts, and evidence and has verified that the allegation has indicia of reliability. HHSC acts judiciously on a case-by-case basis.

(20) DADS--The Texas Department of Aging and Disability Services, or its successor or designee; the state agency responsible for administering long-term services and support for people who are aging and people with intellectual and physical disabilities.

(21) Day--A calendar day.

(22) Delivery of a health care item or service--Providing any item or service to an individual to meet his or her physical, mental or emotional needs or well-being, whether or not reimbursed under Medicare, Medicaid, or any federal health care program.

(23) Enrollment application--Documentation required by HHSC that an applicant submits to HHSC to enroll or re-enroll as a provider or to add a practice location. An enrollment application includes any supplemental forms used to add practice locations for Medicare-enrolled or limited-risk providers, as determined by HHSC.

(24) Exclusion--The suspension of a provider or any person from being authorized under the Medicaid program to request reimbursement of items or services furnished by that specific provider.

(25) Executive Commissioner--The HHSC Executive Commissioner.

(26) False statement or misrepresentation--Any statement or representation that is inaccurate, incomplete, or untrue.

(27) Federal health care program--Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States government (other than the federal employee health insurance program under Chapter 89 of Title 5, U.S.C.).

(28) Fraud--Any 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. The term does not include unintentional technical, clerical, or administrative errors.

(29) Full investigation--Review and development of evidence to support an allegation or complaint to resolution through dismissal, settlement, or formal hearing.

(30) Furnished--Items or services provided or supplied, directly or indirectly, by any person. This includes items and services manufactured, distributed, or otherwise provided by persons that do not directly submit claims to Medicare, Medicaid, or any federal health care program, but that supply items or services to providers, practitioners, or suppliers who submit claims to these programs for such items or services. This term does not include persons that submit claims directly to these programs for items and services ordered or prescribed by another person.

(A) Directly--The provision of items and services by individuals or entities (including items and services provided by them, but manufactured, ordered, or prescribed by another individual or entity) who submit claims to Medicare, Medicaid, or any federal health care program.

(B) Indirectly--The provision of items and services manufactured, distributed, or otherwise supplied by individuals or entities who do not directly submit claims to Medicare, Medicaid, or other federal health care programs, but that provide items and services to providers, practitioners, or suppliers who submit claims to these programs for such items and services.

(31) Health information--Any information, whether oral or recorded in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse, and that relates to:

(A) the past, present, or future physical or mental health or condition of an individual;

(B) the provision of health care to an individual; or

(C) the past, present, or future payment for the provision of health care to an individual.

(32) HHS--Health and human services. Means:

(A) a health and human services agency under the umbrella of HHSC, including HHSC;

(B) a program or service provided under the authority of HHSC, including Medicaid and CHIP; or

(C) a health and human services agency, including those agencies delineated in Texas Government Code §531.001.

(33) HHSC--The Texas Health and Human Services Commission or its successor or designee.

(34) HIPAA--Collectively, the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§1320d et seq., and regulations adopted under that act, as modified by the Health Information Technology for Economic and Clinical Health Act (HITECH) (P.L. 111-105), and regulations adopted under that act at 45 C.F.R. Parts 160 and 164.

(35) Immediate family member--An individual's spouse (husband or wife); natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-, mother-, daughter-, son-, brother-, or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

(36) Indirect ownership interest--Any ownership interest in an entity that has an ownership interest in another entity. The term includes an ownership interest in any entity that has an indirect ownership interest in the entity at issue.

(37) Inducement--An attempt to entice or lure an action on the part of another in exchange for, without limitation, cash in any amount, entertainment, any item of value, a promise, specific performance, or other consideration.

(38) Inspector General--The individual appointed to be the director of the OIG by the Texas Governor in accordance with Texas Government Code §531.102(a-1).

(39) "Item" or "service" means--

(A) Any item, device, medical supply or service provided to a patient:

(i) that is listed in an itemized claim for program payment or a request for payment; or

(ii) for which payment is included in other federal or state health care reimbursement methods, such as a prospective payment system; and

(B) In the case of a claim based on costs, any entry or omission in a cost report, books of account, or other documents supporting the claim.

(40) Jurisdiction--An issue or matter that the OIG has authority to investigate and act upon.

(41) Knew or should have known--A person, with respect to information, knew or should have known when the person had or should have had actual knowledge of information, acted in deliberate ignorance of the truth or falsity of the information, or acted in reckless disregard of the truth or falsity of the information. Proof of a person's specific intent to commit a program violation is not required in an administrative proceeding to show that a person acted knowingly.

(42) Managed care plan--A plan under which a person undertakes to provide, arrange for, pay for, or reimburse, in whole or in part, the cost of any health care service. A part of the plan must consist of arranging for or providing health care services as distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term does not include an insurance plan that indemnifies an individual for the cost of health care services.

(43) Managing employee--An individual, regardless of the person's title, including a general manager, business manager, administrator, officer, or director, who exercises operational or managerial control over the employing entity, or who directly or indirectly conducts the day-to-day operations of the entity.

(44) MCO--Managed care organization. Has the meaning described in §353.2 of this title (relating to Definitions) and for purposes of this chapter includes an MCO's special investigative unit under Texas Government Code §531.113(a)(1), and any entity with which the MCO contracts for investigative services under Texas Government Code §531.113(a)(2).

(45) MCO provider--An association, group, or individual health care provider furnishing services to MCO members under contract with an MCO.

(46) Medicaid or Medicaid program--The Texas medical assistance program established under Texas Human Resources Code Chapter 32 and regulated in part under Title 42 C.F.R. Part 400 or its successor.

(47) Medicaid-related funds--Any funds that:

(A) a provider obtains or has access to by virtue of participation in Medicaid; or

(B) a person obtains through embezzlement, misuse, misapplication, improper withholding, conversion, or misappropriation of funds that had been obtained by virtue of participation in Medicaid.

(48) Medical assistance--Includes all of the health care and related services and benefits authorized or provided under state or federal law for eligible individuals of this state.

(49) Member of household--An individual who is sharing a common abode as part of a single-family unit, including domestic employees, partners, and others who live together as a family unit.

(50) OAG--Office of the Attorney General of Texas or its successor.

(51) OIG--HHSC Office of the Inspector General, or its successor or designee.

(52) OIG's method of finance--The sources and amounts authorized for financing certain expenditures or appropriations made in the General Appropriations Act.

(53) Operating agency--A state agency that operates any part of the Medicaid or other HHS program.

(54) Overpayment--The amount paid by Medicaid or other HHS program or the amount collected or received by a person by virtue of the provider's participation in Medicaid or other HHS program that exceeds the amount to which the provider or person is entitled under §1902 of the Social Security Act or other state or federal statutes for a service or item furnished within the Medicaid or other HHS programs. This includes:

(A) any funds collected or received in excess of the amount to which the provider is entitled, whether obtained through error, misunderstanding, abuse, misapplication, misuse, embezzlement, improper retention, or fraud;

(B) recipient trust funds and funds collected by a person from recipients if collection was not allowed by Medicaid or other HHS program policy; or

(C) questioned costs identified in a final audit report that found that claims or cost reports submitted in error resulted in money paid in excess of what the provider is entitled to under an HHS program, contract, or grant.

(55) Ownership interest--A direct or indirect ownership interest (or any combination thereof) of five percent or more in the equity in the capital, stock, profits, or other assets of a person or any mortgage, deed, trust, note, or other obligation secured in whole or in part by the person's property or assets.

(56) Payment hold (suspension of payments)--An administrative sanction that withholds all or any portion of payments due a provider until the matter in dispute, including all investigation and legal proceedings, between the provider and HHSC or an operating agency are resolved. This is a temporary denial of reimbursement under Medicaid for items or services furnished by a specified provider.

(57) Person--Any legally cognizable entity, including an individual, firm, association, partnership, limited partnership, corporation, agency, institution, MCO, Special Investigative Unit, CHIP participant, trust, non-profit organization, special-purpose corporation, limited liability company, professional entity, professional association,

professional corporation, accountable care organization, or other organization or legal entity.

(58) Person with a disability--An individual with a mental, physical, or developmental disability that substantially impairs the individual's ability to provide adequately for the person's care or his or her own protection, and:

(A) who is 18 years of age or older; or

(B) who is under 18 years of age and who has had the disabilities of minority removed.

(59) Physician--An individual licensed to practice medicine in this state, a professional association composed solely of physicians, a partnership composed solely of physicians, a single legal entity authorized to practice medicine owned by two or more physicians, or a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Texas Occupations Code.

(60) Practitioner--An individual licensed or certified under state law to practice the individual's profession.

(61) Preliminary investigation--A review by the OIG undertaken to verify the merits of a complaint/allegation of fraud, waste, or abuse from any source. The preliminary investigation determines whether there is sufficient basis to warrant a full investigation.

(62) Prima facie--Sufficient to establish a fact or raise a presumption unless disproved.

(63) Probationary contract--A contract or provider agreement for any period of time that must be renewed by the OIG for the provider to continue to participate in the program. It may include any special requirements or provisions deemed necessary by the OIG to ensure the protection of the program. It may also be referred to as a provisional contract, depending upon the terminology used by the provider's agency and program area.

(64) Professionally recognized standards of health care--Statewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is an issue, recognize as applying to those peers practicing or providing care within the state of Texas.

(65) Program violation--A failure to comply with a Medicaid or other HHS provider contract or agreement, the Texas Medicaid Provider Procedures Manual or other official program publications, or any state or federal statute, rule, or regulation applicable to the Medicaid or other HHS program, including any action that constitutes grounds for enforcement as delineated in this chapter.

(66) Provider--Any person, including an MCO and its subcontractors, that:

(A) is furnishing Medicaid or other HHS services under a provider agreement or contract with a Medicaid or other HHS operating agency;

(B) has a provider or contract number issued by HHSC or by any HHS agency or program or its designee to provide medical assistance, Medicaid, or any other HHS service in any HHS program, including CHIP, under contract or provider agreement with HHSC or an HHS agency; or

(C) provides third-party billing services under a contract or provider agreement with HHSC.

(67) Provider agreement--A contract, including any and all amendments and updates, with Medicaid or other HHS program to subcontract services, or with an MCO to provide services.

(68) Provider screening process--The process in which a person participates to become eligible to participate and enroll as a provider in Medicaid or other HHS program. This process includes enrollment under this chapter or Chapter 352 of this title (relating to Medicaid and Children's Health Insurance Program Provider Enrollment), 42 C.F.R. Part 1001, or other processes delineated by statute, rule, or regulation.

(69) Provisional contract--A contract or provider agreement for any period of time that must be renewed by the OIG for the provider to continue to participate in the program. It may include any special requirements or provisions deemed necessary by the OIG to ensure the protection of the program. It may also be referred to as a probationary contract, depending upon the terminology used by the provider's agency and program area.

(70) Reasonable request--Request for access, records, documentation, or other items deemed necessary or appropriate by the OIG or a requesting agency to perform an official function, and made by a properly identified agent of the OIG or a requesting agency during hours that a person, business, or premises is open for business.

(71) Recipient--A person eligible for and covered by the Medicaid or any other HHS program.

(72) Records and documentation--Records and documents in any form, including electronic form, which include:

(A) medical records, charting, other records pertaining to a patient, radiographs, laboratory and test results, molds, models, photographs, hospital and surgical records, prescriptions, patient or client assessment forms, and other documents related to diagnosis, treatment, or service of patients;

(B) billing and claims records, supporting documentation such as Title XIX forms, delivery receipts, and any other records of services provided to recipients and payments made for those services;

(C) cost reports and documentation supporting cost reports;

(D) managed care encounter data and financial data necessary to demonstrate solvency of risk-bearing providers;

(E) ownership disclosure statements, articles of incorporation, bylaws, corporate minutes, and other documentation demonstrating ownership of corporate entities;

(F) business and accounting records and support documentation;

(G) statistical documentation, computer records, and data;

(H) clinical practice records, including patient sign-in sheets, employee sign-in sheets, office calendars, daily or other periodic logs, employment records, and payroll documentation related to items or services rendered under an HHS program; and

(I) records affidavits, business records affidavits, evidence receipts, and schedules.

(73) Recoupment of overpayment--A sanction imposed to recover funds paid to a provider or person to which the provider or person was not entitled.

(74) Requesting agency--The OIG; the OAG's Medicaid Fraud Control Unit or Civil Medicaid Fraud Division; any other state or federal agency authorized to conduct compliance, regulatory, or program integrity functions on a provider, a person, or the services rendered by the provider or person.

(75) Risk analysis--The process of defining and analyzing the dangers to individuals, businesses, and governmental entities posed by potential natural and human-caused adverse events. A risk analysis can be either quantitative, which involves numerical probabilities, or qualitative, which involves observations that are not numerical in nature.

(76) Sanction--Any administrative enforcement measure imposed by the OIG pursuant to this chapter other than administrative actions defined in §371.1701 of this chapter (relating to Administrative Actions).

(77) Sanctioned entity--An entity that has been convicted of any offense described in 42 C.F.R. §§1001.101 - 1001.401 or has been terminated or excluded from participation in Medicare, Medicaid in Texas, or any other state or federal health care program.

(78) Services--The types of medical assistance specified in §1905(a) of the Social Security Act (42 U.S.C. §1396d(a)) and other HHS program services authorized under federal and state statutes that are administered by HHSC and other HHS agencies.

(79) SIU--A Special Investigative Unit of an MCO as defined under Texas Government Code §531.113(a)(1).

(80) Social Security Act--Legislation passed by Congress in 1965 that established the Medicaid program under Title XIX of the Act and created the Medicare program under Title XVIII of the Act.

(81) Solicitation--Offering to pay or agreeing to accept, directly or indirectly, overtly or covertly, any remuneration in cash or in kind to or from another for securing a patient or patronage for or from a person licensed, certified, or registered or enrolled as a provider or otherwise by a state health care regulatory or HHS agency.

(82) State health care program--A State plan approved under Title XIX, any program receiving funds under Title V or from an allotment to a State under such Title, any program receiving funds under Subtitle I of Title XX or from an allotment to a State under Subtitle I of Title XX, or any State child health plan approved under Title XXI.

(83) Substantial contractual relationship--A relationship in which a person has direct or indirect business transactions with an entity that, in any fiscal year, amounts to more than \$25,000 or five percent of the entity's total operating expenses, whichever is less.

(84) Suspension of payments (payment hold)--An administrative sanction that withholds all or any portion of payments due a provider until the matter in dispute, including all investigation and legal proceedings, between the provider and HHSC or an operating agency or its agent(s) are resolved. This is a temporary denial of reimbursement under the Medicaid or other HHS program for items or services furnished by a specified provider.

(85) System recoupment--Any action to recover funds paid to a provider or other person to which they were not entitled, by means other than the imposition of a sanction under this chapter. It may include any routine payment correction by an agency or an agency's fiscal agent to correct an overpayment that resulted without any alleged wrongdoing.

(86) TEFRA--The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, a federal law that allows states to make medical assistance available to certain children with disabilities without counting their parent's income.

(87) Terminated--Means:

(A) with respect to a Medicaid or CHIP provider, the revocation of the billing provider's Medicaid or CHIP billing privileges

after the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and

(B) with respect to a Medicare provider, supplier, or eligible professional, the revocation of the provider's, supplier's, or eligible professional's Medicare billing privileges after the provider, supplier, or eligible professional has exhausted all applicable appeal rights or the timeline for appeal has expired.

(88) Terminated for cause--Termination based on allegations related to fraud, program violations, integrity, or improper quality of care.

(89) Title V--Title V (Maternal and Child Health Services Block Grant) of the Social Security Act, codified at 42 U.S.C. §§701 et seq.

(90) Title XVIII--Title XVIII (Medicare) of the Social Security Act, codified at 42 U.S.C. §§1395 et seq.

(91) Title XIX--Title XIX (Medicaid) of the Social Security Act, codified at 42 U.S.C. §§1396-1 et seq.

(92) Title XX--Title XX (Social Services Block Grant) of the Social Security Act, codified at 42 U.S.C. §§1397 et seq.

(93) Title XXI--Title XXI (State Children's Health Insurance Program (CHIP)) of the Social Security Act, codified at 42 U.S.C. §§1397aa et seq.

(94) TMRP--The Texas Medical Review Program, which is the inpatient hospital utilization review process HHSC uses for hospitals reimbursed under HHSC's prospective payment system.

(95) U.S.C.--United States Code.

(96) Vendor hold--Any legally authorized hold or lien by any state or federal governmental unit against future payments to a person. Vendor holds may include tax liens, state or federal program holds, liens established by the OAG Collections Division, and State Comptroller voucher holds.

(97) Waste--Practices that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items, or services.

§371.3. Purpose and Authority.

(a) The OIG is responsible for preventing, detecting, auditing, inspecting, reviewing, and investigating fraud, waste, and abuse in Medicaid and other HHS programs. In addition, the OIG is responsible for enforcing state law relating to the provision of HHS in Medicaid and other HHS programs.

(b) The statutory authority for this chapter is provided by Texas Human Resources Code Chapters 32 and 36; Texas Government Code Chapter 531, and federal law (Social Security Act) and regulations (42 C.F.R.).

§371.11. [Purpose and] Scope.

(a) The OIG is responsible for preventing, detecting, auditing, inspecting, reviewing, and investigating fraud, waste, and abuse in the provision of HHS in Medicaid and other HHS programs. [The Office of Inspector General (the Inspector General) is a division within the Health and Human Services Commission (the Commission). The Inspector General is responsible for the investigation of fraud and abuse in the provision of health and human services (HHS) in Medicaid and other HHS programs.] As part of its authority, the OIG [Inspector General] may impose sanctions upon a finding by the OIG [Inspector General] of fraud, waste, or [and] abuse in Medicaid. The OIG [Inspector General] is also responsible for enforcing [the enforcement of] state

law relating to the provision of HHS [health and human services] in Medicaid and other HHS programs. As a result, the OIG [Inspector General] may also investigate a suspected regulatory violation in a non-Medicaid, HHS program and, upon a finding of a violation, may recommend [direct] the HHS program [to] take appropriate enforcement action to the extent of the HHS program's regulatory authority. The OIG [Inspector General] administers program integrity and enforces program violations to the extent of applicable law governing Medicaid and the provision of other HHS [health and human services]. This includes pursuing Medicaid and other HHS [health and human services] fraud, abuse, overpayment, or [and] waste. To accomplish the objectives of this chapter, the OIG [Inspector General] implements review processes to distinguish payment discrepancies that can be corrected through routine payment adjustments from those suspected to result from program violations requiring investigation and possible administrative enforcement or judicial action.

(b) The Inspector General establishes objectives and priorities for the OIG [office] that emphasize:

(1) coordinating investigative efforts to aggressively recover funds;

(2) allocating resources to cases that have the strongest supportive evidence and the greatest potential for recovery of money; and

(3) maximizing opportunities for referral of cases to the OAG [Office of the Attorney General].

(c) In addition to performing functions and duties otherwise provided by law, the OIG [Inspector General] may:

(1) assess administrative penalties otherwise authorized by law on behalf of HHSC [the Commission];

(2) request that the OAG [Attorney General] obtain an injunction to prevent a person from disposing of an asset identified by the OIG [Inspector General] as potentially subject to recovery by the OIG [Inspector General] due to the person's fraud, waste, or abuse;

(3) provide for coordination between the OIG and SIUs [Inspector General and special investigative units formed by managed care organizations] or entities with which managed care organizations contract to identify and investigate fraudulent claims and other types of program abuse by recipients and providers, and approve the plan of the SIUs [special investigative units] to prevent and reduce fraud, waste, or [and] abuse;

(4) audit the use and effectiveness of state or federal funds, including contract and grant funds, administered by a person or state agency receiving the funds from an HHS [a health and human services] agency;

(5) conduct investigations relating to the funds described in paragraph (4) of this subsection; and

(6) recommend policies promoting economical and efficient administration of the funds described in paragraph (4) of this subsection and the prevention and detection of fraud, waste, or [and] abuse in the administration of those funds.

(d) The OIG [Inspector General] may require employees of HHS [health and human services] agencies to provide assistance to the OIG [Inspector General] in connection with its duties relating to the review, inspection, investigation, or [and] audit of fraud, waste, abuse, or [and] overpayment in the provision of HHS [health and human services].

(e) The OIG [Inspector General] is entitled to access to any information maintained by an HHS [a health and human services] agency,

including internal records, relevant to the functions of the OIG [office]. This chapter sets forth the types of activities performed by the OIG [Inspector General] to ensure program integrity.

(f) HHSC [The Commission] may obtain any information or technology necessary to enable the OIG [Inspector General] to meet its responsibilities as mandated by state statute or other law.

#### §371.17. *Detection.*

The OIG [Inspector General] utilizes automation as well as other techniques to detect and identify program violations and possible fraud, waste, abuse, and overpayments. These automated detection systems are mandated by state and federal statutes. One automated system is additionally required to utilize neural network and learning technologies. These systems detect patterns of inappropriate billing from which an overpayment is identified immediately without the need for additional investigation. They also detect anomalous billing and service patterns, which then require investigation for evidence of program violations.

#### §371.23. *Surety Bond.*

(a) The OIG [Inspector General] may require each provider of medical assistance in the Medicaid program, in a provider type that has demonstrated significant potential for fraud, waste, or abuse, to file with the OIG [Inspector General] a surety bond in a reasonable amount. The amount of the surety bond may [shall] not exceed the maximum amount allowed by state or federal law, plus the maximum amount of penalties allowed by state and federal law.

(b) The OIG requires [Inspector General will require] a provider of medical assistance or person to file, with the OIG [Inspector General], a surety bond in a reasonable amount if the OIG [Inspector General] identifies acts or behavior that [which] indicate suspected fraud, waste, or abuse involving criminal conduct relating to the provider's services under the program that indicates the need for protection against potential future acts of fraud, waste, or abuse. The amount of the surety bond shall not exceed the maximum amount allowed by state or federal law, plus the maximum amount of penalties allowed by state and federal law.

(c) The surety bond required of a provider or person, by the OIG [Inspector General], under subsections (a) and (b) of this section must be payable to HHSC [the Commission] to compensate HHSC [the Commission] for damages resulting from, or penalties or fines imposed in connection with, an act of fraud, waste, or abuse committed by the provider or person under the program.

(d) The OIG [Inspector General] may require a provider of medical assistance or person to file[-] with the OIG [Inspector General], a surety bond in an amount and manner specified by the OIG [Inspector General]. A surety bond may be required if the OIG [Inspector General] identifies acts or behavior that [which] indicate suspected fraud, waste, or abuse that involves criminal conduct that relates to the provider's services under the program and that indicate [indicates] the need for protection against potential loss of recoupment of overpayments, penalties, damages, or other debts assessed against the provider by the OIG [Inspector General], due to potential default of the provider or failure of the provider to reimburse the OIG [Inspector General] assessed amounts. Among other reasons, a surety bond may be imposed in connection with a settlement agreement, a provisional, probationary, or closed end contract, or as a condition of reinstatement.

(e) Subject to subsection [subsections] (f) or (g) of this section, the OIG [Inspector General] may require each provider of medical assistance that establishes a resident's trust fund account to post a surety bond to secure the account. The bond must be payable to HHSC [the Commission] to compensate residents of the bonded provider for trust funds that are lost, stolen, or otherwise unaccounted for if the provider

does not repay any deficiency in a resident's trust fund account to the person legally entitled to receive the funds.

(f) For that portion of a case involving a resident's trust fund accounts, the OIG does [Inspector General will] not require the amount of a surety bond posted for a single facility provider under subsection (e) of this section to exceed the average of the total average monthly balance of all of the provider's resident trust fund accounts for the 12-month period preceding the bond issuance or renewal date. This limitation does not apply to any ~~other~~ type of violations other than resident trust fund accounts.

(g) If an employee of a provider of medical assistance is responsible for the loss of funds in a resident's trust fund account, the resident, the resident's family, and the resident's legal representative are not obligated to make any payments to the provider that would have been made out of the trust fund had the loss not occurred.

(h) Failure by a provider or person to post a surety bond timely and as required by the OIG [Inspector General] may result in imposition of any of the administrative actions or sanctions~~], as specified in §371.1631 and §371.1643,~~ and/or imposition of damages and penalties, as specified in ~~[§371.1721 et seq. of]~~ Subchapter G of this chapter (relating to Administrative Actions and Sanctions).

(i) Surety bonds required by the OIG [Inspector General] are considered administrative actions. Administrative actions are further described in §371.1701 of this chapter (relating to Administrative Actions) ~~[Subchapter G, §371.1629 and §371.1631 of this title].~~

*§371.25. Injunction to Prevent Disposing of Assets and Application to Debts.*

Based on the results of investigative findings and evidence that potential fraud, waste, or abuse exists and a potential overpayment, penalty, or damage has been identified, a method that may be used by the OIG [Inspector General], as a fiduciary for the state, is injunctive relief. The purpose of the injunctive relief is to ensure assets remain to reimburse the state monies owed such as recoupment of overpayments and assessed damages and penalties. The OIG [Inspector General] may request that the Attorney General obtain an injunction to prevent a provider or person from disposing of an asset identified by the OIG [Inspector General] as potentially subject to recovery by the OIG [Inspector General] due to the provider's or person's fraud, waste, or abuse. Upon final resolution of the case, any funds derived from the forfeited asset(s), after offsetting any expenses attributable to the sale of those assets, are applied to the unpaid debt by the OIG [will be applied, by the Inspector General, to the unpaid debt].

*§371.27. Prohibition against Solicitation of Medicaid or CHIP Recipients.*

(a) A provider or person who furnishes services, under the Medicaid program or Child Health Insurance Plan program, must comply with Chapter 102, Texas Occupations Code.

(b) A provider or person is prohibited from offering to pay or agreeing to accept, directly or indirectly, overtly or covertly, any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered or enrolled as a provider or otherwise by a state health care regulatory or HHS [health and human service] agency.

(c) A provider or person is prohibited from engaging in any of the actions or conduct described in the provisions relating to bribe, kickback, rebate, or inducement specified in §371.1669 of this chapter (relating to Self-Dealing) [Subchapter G, §371.1721].

(d) Providers or persons in violation of the prohibition against solicitation may be excluded from participation in the Medicaid and CHIP programs and may have their contract to participate cancelled.

*§371.29. Random Prepayment Review.*

The OIG [Inspector General] may perform a random prepayment review of claims submitted by Medicaid providers for reimbursement to determine whether the claim involves fraud, waste, or abuse. Suspect claims identified through this process may result in:

- (1) imposition of a recoupment of overpayments and/or other pertinent administrative sanctions or actions;
- (2) initiation of a full [full-scale] fraud, waste, or [and] abuse investigation;
- (3) referral for criminal or civil investigation and prosecution;
- (4) withholding payment of these claims for not more than five ~~[(5)]~~ working days without notice to the provider for which claims were submitted.

*§371.31. Federal Felony Match.*

The OIG has [Inspector General will implement] a system to cross-reference data collected for the programs identified in §531.008(c) of the Texas Government Code with the list of fugitive felons maintained by the federal government. The purpose of the data match is to identify fugitive felons who may be enrolled as recipients in programs that are referenced in §531.008(c) of the Texas Government Code.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 29, 2016.

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Karen Ray

Chief Counsel

Texas Health and Human Services Commission

Earliest possible date of adoption: February 28, 2016

For further information, please call: (512) 424-6900



**1 TAC §371.13, §371.19**

**Legal Authority**

The repeals are proposed under Texas Government Code §531.102(a-2), which requires the Executive Commissioner to work in consultation with the Office of Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program.

The repeals implement Texas Government Code Chapter 531, as amended by S.B. 207. No other statutes, articles, or codes are affected by the proposal.

*§371.13. Statutory Authority.*

*§371.19. Investigation.*

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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Karen Ray

Chief Counsel

Texas Health and Human Services Commission

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## SUBCHAPTER C. UTILIZATION REVIEW

### 1 TAC §§371.200, 371.201, 371.203, 371.204, 371.206, 371.208, 371.210, 371.212, 371.214, 371.216

#### Legal Authority

The amendments are proposed under Texas Government Code §531.102(a-2), which requires the Executive Commissioner to work in consultation with the Office of Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program.

The amendments implement Texas Government Code Chapter 531, as amended by S.B. 207. No other statutes, articles, or codes are affected by the proposal.

#### §371.200. *Inpatient Hospital Utilization Review Program.*

(a) HHSC [The Texas Medical Review Program (TMRP)] is the inpatient hospital utilization review process used by the Texas Health and Human Services Commission (Commission) for hospitals reimbursed under the Commission's prospective payment system. The Commission conducts the TMRP in accordance with:

(1) applicable federal regulations at 42 C.F.R. [Code of Federal Regulations] Part 456, Subparts A, B, and C, which require HHSC [the Commission] to operate a utilization review program that controls the utilization of inpatient hospital services and assesses the appropriateness and quality of those services; and

(2) an approved waiver under the Social Security Act, §1903(i)(4), as it relates to the use of Title XVIII utilization review procedures for Title XIX patients in acute care general hospitals other than hospitals reimbursed under TEFRA [the Tax Equity and Fiscal Responsibility Act (TEFRA)] reimbursement principles.

(b) The TEFRA review process relates directly to hospitals reimbursed under the TEFRA reimbursement principles and facility-specific [facility specific] per diem methodology.

#### §371.201. *Case Selection Process.*

(a) HHSC selects TMRP [The Texas Health and Human Services Commission (Commission) selects Texas Medical Review Program (TMRP)] cases for review by a statistically valid random sampling methodology and/or focused case selection. Cases [will] consist of paid inpatient claims for diagnosis-related [diagnostic related] groups (DRGs), which may include:

- (1) readmissions [Readmissions] up to 30 days;

- (2) ambulatory [Ambulatory] surgical procedures billed on inpatient claims;

- (3) questionable [Questionable] admissions or claims coding identified by other entities;

- (4) admissions [Admissions] identified through HHSC's [the Commission's] quality review program as potential quality of care concerns;

- (5) DRG payments made to freestanding rehabilitation facilities;

- (6) day [Day] or cost outlier payments; or

- (7) any [Any] other DRG or claims submission errors.

(b) HHSC [The Commission] selects TEFRA [Tax Equity and Fiscal Responsibility Act] and facility-specific [facility specific] per diem methodology cases for review by a statistically valid random sampling methodology and/or focused case selection. Cases [will] consist of paid inpatient claims for admissions to children's hospitals and freestanding psychiatric facilities.

#### §371.203. *TMRP [Texas Medical Review Program (TMRP)] Review Process.*

(a) The TMRP review process includes[, but is not limited to]:

- (1) Admission review to evaluate the medical necessity of the admission. For purposes of the TMRP reviews, medical necessity means the patient has a condition requiring treatment that can be safely provided only in the inpatient setting.

- (2) Diagnosis-related [Diagnosis related] group (DRG) validation to confirm documentation in the medical record of the critical elements necessary to assign a DRG. The hospital staff is responsible and held accountable for the accuracy of the required critical elements. Those elements are age, sex, discharge status, admission date, discharge date, principal diagnosis, principal and secondary procedures, any complications or comorbidities (secondary diagnoses), and Present on Admission (POA) indicators.

(A) POA review validates [will validate] the POA indicator assigned to the principal and secondary diagnoses codes reported on claim forms. If it is determined that the principal and/or secondary diagnoses were not present at the time the order for inpatient admission occurs, HHSC revises [the Commission will revise] the POA indicator for the diagnosis code. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered POA.

(B) DRG validation confirms that the principal and secondary diagnoses and procedures are sequenced correctly. The principal diagnosis is the diagnosis (condition) established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care. The secondary diagnoses are conditions that affect the patient care in terms of requiring: clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and/or monitoring, or in the case of a newborn, conditions the physician deems to have clinically significant implications for future health care needs. If the principal diagnosis, secondary diagnoses, or procedures are not substantiated in the medical record, are not sequenced correctly, or have been omitted, codes may be deleted, changed, or added.

(C) When the correct diagnosis and procedure coding and sequencing have been determined, the information is [will be] entered into the applicable version of the Grouper software for a DRG assignment. CMS-approved [The Centers for Medicare and Medicaid Services (CMS) approved] DRG Grouper software considers the re-

quired critical elements and determines the final DRG assignment. If the DRG validation process results in deletions, changes, or additions to the critical elements and these changes cause the DRG to be re-assigned, HHSC directs [the Texas Health and Human Services Commission (Commission) will direct] the claims administrator to adjust the payment to the hospital accordingly.

(3) Quality of care review to assess whether the care provided meets generally accepted standards of medical and hospital care practices or puts the patient at risk of unnecessary injury, disease, or death. Quality of care review includes the use of discharge screens and generic quality screens. If quality of care issues are identified, physician consultants under contract with HHSC [the Commission,] and of the specialty related to the care provided[; will] determine possible clinical recommendations or corrective actions.

(4) Readmission review to evaluate each admission on its individual merits and determine if the second or subsequent admissions resulted from a premature discharge or were required to provide services that should have been provided in a previous admission.

(5) Day outlier review, which includes DRG validation, verifies the medical necessity of each day of the admission.

(6) Cost outlier review to verify that services billed were medically necessary, ordered by a physician or non-physician provider, rendered and billed appropriately, and substantiated in the medical record.

(b) HHSC reviews [The Commission will review] the complete medical record for the requested admission(s) to make decisions on all aspects of this review process. The complete medical record may include: emergency room records, medical/surgical history and physical examination, discharge summary, physicians' progress notes, physicians' orders, lab reports, diagnostic and imaging reports, operative reports, pathology reports, nurses' notes, medication sheets, vital signs sheets, therapy notes, specialty consultation reports, and special diagnostic and treatment records. If the complete medical record is not available during the review, HHSC issues [the Commission will issue] a preliminary technical denial and notifies [notify] the facility.

(c) A physician consultant under contract with HHSC makes [the Commission will make] all decisions concerning medical necessity, cause of readmission, and appropriateness of setting for the service provided. In the event the physician consultant determines the services were not medically necessary, should have been provided in a previous admission, or were not provided in the appropriate setting, the claim is [will be] denied, and HHSC notifies [the Commission will notify] the hospital in writing. If a hospital claim is denied for lack of medical necessity or for being provided in an inappropriate setting, HHSC considers [the Commission will consider] for denial physician and/or non-physician Medicaid provider claims associated with the hospital admission or service when such claims can be identified and are deemed to be the result of inappropriate admission orders. Physicians and/or non-physician providers are [will be] notified in writing if the claim for professional services is denied. The written notification explains [will explain] the process for appealing the denial.

(d) The OIG conducts training for providers, in a manner and format determined by the OIG, on at least an annual basis to communicate with and educate providers about the DRG validation criteria used by the OIG in conducting hospital utilization reviews and audits as outlined in this section.

*§371.204. Hospital Screening Criteria for TMRP [Texas Medical Review Program (TMRP)], TEFRA [Tax Equity and Fiscal Responsibility Act (TEFRA)], and Facility-Specific Per Diem Methodology Reviews.*

(a) HHSC [The Texas Health and Human Services Commission (Commission)] uses recognized evidence-based guidelines for inpatient hospital screening criteria. Non-physician reviewers use the guidelines as criteria for the initial approval or for the referral of inpatient reviews for medical necessity decisions. If the criteria are not met[;] or if the non-physician reviewer has any questions concerning the appropriateness of coding or quality of care, the non-physician reviewer refers [will refer] the medical record to a physician consultant under contract with HHSC [the Commission] for a decision. Even if the criteria are met, the physician consultant may determine that an inpatient admission was not medically necessary, and HHSC issues [and the Commission will issue] an admission denial. If a hospital claim is denied for lack of medical necessity or for being provided in an inappropriate setting, HHSC considers [the Commission will consider] for denial physician and/or non-physician Medicaid provider claims associated with the hospital admission or service when such claims can be identified and are deemed to be the result of inappropriate admission orders. A physician consultant may determine that an inpatient admission was not medically necessary if a physician admitted a patient in observation status and the patient was discharged from the outpatient status within the Texas Medicaid Provider Procedures Manual, or any subsequent provider manuals, defined observation period.

(b) For the purposes of the TMRP, TEFRA, and facility-specific per diem methodology reviews, medical necessity means that the patient has a condition requiring treatment that can be safely provided only in the inpatient setting.

*§371.206. Denials and Recoupments for TMRP [Texas Medical Review Program (TMRP)], TEFRA [Tax Equity and Fiscal Responsibility Act (TEFRA)] Hospitals, and Facility-Specific Per Diem Methodology Reviews.*

(a) Reviews conducted under the TMRP, TEFRA, and facility-specific per diem methodology[;] may result in denials of claims. HHSC notifies [The Texas Health and Human Services Commission (Commission) will notify] the hospital in writing of the denial decision[;] and instructs [instruct] the claims administrator to recoup payment. If a hospital claim is denied for lack of medical necessity or for being provided in an inappropriate setting, HHSC considers [the Commission will consider] for denial physician and/or non-physician Medicaid provider claims associated with the hospital admission or service when such claims can be identified and are deemed to be the result of inappropriate admission orders. Physicians and/or non-physician providers are [will be] notified in writing if the claim for professional services is denied. The written notification of denial explains [will explain] the appeal process. Types of denials are:

(1) Admission and days of stay denials. A physician consultant under contract with HHSC [the Commission] makes all decisions regarding medical necessity, cause of readmission, and appropriateness of setting.

(2) Technical denials. HHSC issues [The Commission will issue] a technical denial when a hospital fails to make the complete medical record available for review within specified time frames. These services may not be rebilled on an outpatient basis.

(A) For on-site reviews, if the complete medical record is not made available during the on-site review, HHSC issues [the Commission will issue] a preliminary technical denial at that time. The hospital is allowed 60 calendar days from the date of the exit conference to provide the complete medical record to HHSC [the Commission]. If the complete medical record is not received by HHSC [the Commission] within this time frame, HHSC issues [the Commission will issue] a final technical denial. If HHSC [the Commission] requests a copy of the medical record in writing, and the copy is not received within the specified time frame, HHSC issues [the Commission will issue] a pre-

liminary technical denial by certified mail or fax machine. The hospital has 60 calendar days from the date of the notice to submit the complete medical record. If the complete medical record is not received by HHSC [the Commission] within this time frame, HHSC issues [the Commission will issue] a final technical denial.

(B) For mail-in reviews, HHSC requests [the Commission will request] copies of medical records in writing. If HHSC [the Commission] does not receive the complete medical record within the specified time frame, HHSC issues [the Commission will issue] a preliminary technical denial by certified mail or fax machine. The hospital has 60 calendar days from the date of the notice to submit the complete medical record. If HHSC [the Commission] does not receive the complete medical record within this specified time frame, HHSC issues [the Commission will issue] a final technical denial.

(3) Readmission denial. If it is determined that the services provided in the second or subsequent admissions were the direct result of a premature discharge or should have been provided in the first or previous admission, HHSC denies [the Commission will deny] the admission in question.

(4) Day outlier denial. If it is determined that any days qualifying as outlier days during the admission were not medically necessary, HHSC denies [the Commission will deny] those days.

(5) Cost outlier denial. If it is determined that services delivered were not medically necessary, not ordered by a physician and/or authorized non-physician, not rendered or billed appropriately, or not substantiated in the medical record, HHSC denies [the Commission will deny] those services.

(b) When an admission denial or day of stay denial is issued, HHSC directs [the Commission will direct] the claims administrator to recoup payment. If a hospital claim is denied for lack of medical necessity or for being provided in an inappropriate setting, HHSC considers [the Commission will consider] for denial physician and/or non-physician Medicaid provider claims associated with the hospital admission or service when such claims can be identified and are deemed to be the result of inappropriate admission orders. HHSC makes [The Commission will make] an exception in the case of TMRP hospitals if the patient was placed in observation[;] and HHSC [the Commission] notified the hospital that it may submit a revised outpatient claim solely for medically necessary outpatient services provided during the Texas Medicaid Provider Procedures Manual (TMPPM), or any subsequent provider manuals, defined observation period. A physician's order for observation must be present in the physician's orders to document that the patient was placed in outpatient observation. The hospital must submit the revised outpatient claim and a copy of HHSC's [the Commission's] notification letter to the claims administrator at the address indicated in the notification letter. The claims administrator must receive the outpatient claim and copy of the notification letter within 120 calendar days of the date of the notification letter. The claims administrator may consider payment for the medically necessary services provided during the TMPPM-defined observation period. The hospital may provide observation services in any part of the hospital where a patient can be assessed, monitored, and treated.

§371.208. *Appeals Related to [The] Utilization Review Department Review Decisions.*

If a hospital receives notification from HHSC [the Texas Health and Human Services Commission (HHSC)] Utilization Review Unit of an adverse decision regarding medical necessity of admission, days of stay, diagnosis related group (DRG) validation, or a final technical denial, the hospital may appeal to HHSC. The written notification of adverse decision sets [will set] out the responsible area and time frame within which HHSC must receive the appeal [must be received by

HHSC]. The Texas Medicaid Policy and Procedure Manual provides additional information on the appeal process.

§371.210. *Inpatient Utilization Review for Hospitals Reimbursed Under TMRP and TEFRA [the Tax Equity and Fiscal Responsibility Act (TEFRA)] Principles of Reimbursement[;] and Facility-Specific Per Diem Methodology Reviews.*

(a) The TEFRA and facility-specific per diem methodology reviews process includes the following:

(1) Admission review to evaluate the medical necessity of the admission. For purposes of the TMRP [Texas Medical Review Program (TMRP)], TEFRA, and facility-specific reviews, medical necessity means the patient has a condition requiring treatment that can be safely provided only in the inpatient setting.

(2) Continued stay review to verify the medical necessity of each day of stay.

(3) Quality of care review to assess whether the quality of care provided meets generally accepted standards of medical and hospital care practices or puts the patient at risk of unnecessary injury or death. Quality of care review includes the use of discharge screens and generic quality screens. If quality of care issues are identified, physician consultants under contract with HHSC [the Texas Health and Human Services Commission (Commission);] and of the specialty related to the care provided[; will] determine possible clinical recommendations or corrective actions.

(b) HHSC reviews [The Commission will review] the complete medical record for the requested admission(s) to make decisions on all aspects of this review process. The complete medical record may include: emergency room records, medical/surgical history and physical examination, discharge summary, physicians' progress notes, physicians' orders, lab reports, diagnostic and imaging reports, operative reports, pathology reports, nurses' notes, medication sheets, vital signs sheets, therapy notes, specialty consultation reports, and special diagnostic and treatment records. If the complete medical record is not available during the review, HHSC issues [the Commission will issue] a preliminary technical denial and notifies [notify] the facility.

(c) A physician consultant under contract with HHSC makes [the Commission will make] all decisions concerning medical necessity, cause of readmission, and appropriateness of setting for the service provided. In the event the physician consultant determines the services were not medically necessary, should have been provided in a previous admission, or were not provided in the appropriate setting, the claim is [will be] denied, and HHSC notifies [the Commission will notify] the hospital in writing. If a hospital claim is denied for lack of medical necessity or for being provided in an inappropriate setting, HHSC considers [the Commission will consider] for denial physician and/or non-physician Medicaid provider claims associated with the hospital admission or service when such claims can be identified and are deemed to be the result of inappropriate admission orders. Physicians and/or non-physician providers are [will be] notified in writing if the claim for professional services is denied. The written notification explains [will explain] the process for appealing the denial.

§371.212. *Minimum Data Set Assessments.*

(a) Under 40 TAC §19.801 (relating to Resident Assessment), a nursing facility must conduct initially and periodically thereafter a comprehensive, accurate, standardized, reproducible assessment of each nursing facility recipient's functional capacity that describes the recipient's ability to perform daily life functions and significant impairments in functional capacity. The nursing facility must conduct the assessment using a Minimum Data Set (MDS) Resident Assessment Instrument (RAI) based on the MDS RAI Resource Utilization Group

(RUG-III) 34-group case mix classification system selected by the state and established by CMS [the Centers for Medicare and Medicaid Services (CMS)].

(1) Requirements for completing the MDS are derived from the RAI, including the MDS, specified by the DADS [Department of Aging and Disability Services (DADS)]. The nursing facility must adhere to any updates released by CMS in addition to the state-specific [state specific] mandates. To the extent such CMS updates conflict with DADS-specific [DADS specific] mandates, the CMS updates [shall] control.

(2) Completion of the MDS does not remove the nursing facility's responsibility to document in a clinical record a detailed assessment of all relevant issues that affect the recipient. All clinical record documentation must chronicle, support, and be consistent with the findings of, rather than conflict with, each MDS assessment. Documentation in the clinical record must contain pertinent facts, findings, and observations about an individual's health history including past and present illnesses, treatments, and outcomes to support the care the recipients are receiving. Inconsistent and unsupported findings are not [will not be] validated and may result in an adjustment in the RUG-III classification.

(3) All coded items on MDS assessments submitted for Medicaid reimbursement must be supported by documentation in the recipient's clinical record. Sources of information (e.g., other health care professionals, family members) utilized for the MDS assessment must be identified and must be supported by the clinical record.

(4) Nursing facility resident records must be maintained in accordance with:

(A) 40 TAC §19.1910 (relating to Clinical Records);

(B) 40 TAC §19.1912 (relating to Additional Clinical Record Service Requirements);

(C) 40 TAC §19.1210 (relating to Certification and Recertification Requirements in Medicaid-Certified Facilities);

(D) 40 TAC §19.1924 (relating to Financial Records), including supporting documents and other records necessary to fully document the services and supplies provided and delivered to the resident, the medical necessity of those services and supplies, and records or documents necessary to determine whether payment for those items or services was due and was properly made;

(E) Section 354.1004 of this title (relating to Retention of Records), which requires a facility to maintain all records necessary to fully disclose the services provided and to retain these records for a period of five years from the date of the service, or until all audit questions are resolved, whichever is longer;

(F) HIPAA [the Health Insurance and Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 United States Code §§1320d-1320d-8];

(G) 45 C.F.R. [Code of Federal Regulations] Parts 160 and 164 (relating to Health Insurance Reform: Security Standards); and

(H) accepted professional health information management standards and practices.

(5) Documentation must have the recipient's name[;] and the signatures, dates of signatures, and titles of individuals providing care for the recipient. Documents, such as grids and flow sheets that include entries by multiple staff members at different times, must include complete dates with initials or signatures to clearly identify who provided the care. For purposes of this subchapter, a signature may be an original handwritten, electronic, photocopied [photocopier], or

facsimile-transmitted [facsimile transmitted] signature or an electronic signature submitted in compliance with HHSC policy unless the authenticity of the signature is in doubt.

(b) An admission comprehensive assessment must be completed by day 14 and include the Basic Assessment Tracking form and MDS Sections AA, AB-AD, A-R, Sections V and W. The annual assessment must be completed no later than the 366th day from the last comprehensive assessment and no later than 92 days from the previous assessment.

(1) The MDS Long-Term Care Medicaid Information Section and Section W must be completed on all MDS assessments submitted for Medicaid.

(2) An admission assessment or quarterly assessment establishes [will establish] RUG-III classification. Medical necessity is evaluated each time an MDS assessment is completed, until permanent medical necessity [(PMN)] is established by the Texas Medicaid claims administrator (MCA), as set out in 40 TAC §19.2403 (relating to Medical Necessity Determination).

(3) A significant-change assessment must be completed as soon as needed to provide appropriate care to the resident, but in no case later than 14 calendar days after the determination was made that a significant change occurred. The nursing facility must document the significant change in condition. The documentation must include a completed comprehensive MDS assessment with Resident Assessment Protocols [(RAPs)]. A significant change assessment resets the schedule for the next annual assessment.

(4) A quarterly assessment following an admission assessment, an annual assessment, or a significant change-in-status assessment must be completed within 92 days of the previous assessment.

(5) An MDS assessment is considered complete on the date the registered nurse (RN) assessment coordinator signs and dates the MDS assessment as complete. That date may not be prior to dates for all sections completed.

(6) The MDS assessment is considered timely if it is submitted in accordance with the federal MDS submission schedule and is received by the state MCA within 31 days after the completion date.

(7) Each MDS assessment submitted must indicate the reason for the assessment.

(8) Assessment time frames are based on the assessment reference date [(ARD)], which is the specific end-point for a common observation period (look back period) in the MDS assessment process.

(c) All MDS items shall be coded in accordance with 42 C.F.R. [Code of Federal Regulations] §483.20 (relating to Resident Assessment); the CMS [the Centers for Medicare and Medicaid Services] Long-Term Care Facility Resident Assessment Instrument User's Manual (RAI User's Manual); and state-specific [state specific] requirements. Coding for items described in this subsection must be based on observations over the look back period specified. If the observation did not occur during the look back period, it is not coded on the MDS.

(1) Cognitive Patterns. The look back period for items described in this paragraph is seven days.

(A) Comatose Code One is claimed only when the recipient's clinical record includes a documented neurological diagnosis of coma or persistent vegetative state. The clinical record must include physician documentation of a diagnosis of coma or persistent vegetative state.

(B) Short-Term Memory Code One is claimed when it is determined that the recipient lacks the functional capacity to recall

recent events. Documentation in the clinical record must support the resident's capacity to remember short-term events.

(C) For Cognitive Skills for Daily Decision Making, code the correct response between zero and three that supports the recipient's level of ability based on the clinical record. The recipient's clinical record must include documentation describing the recipient's actual performance in making everyday decisions about tasks or activities of daily living.

(2) Communication/Hearing Patterns. For Making Self Understood, code the correct response between zero and three that supports the recipient's level of ability to make himself or herself understood. The recipient's clinical record must support the recipient's level of ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these. The look back period is seven days.

(3) Mood and Behavior Patterns.

(A) For Indicators of Depression, Anxiety and Sad mood, code between zero and two based on documented interactions and observations of the recipient. The recipient's clinical record must support the frequency of the indicators of depression, anxiety, and/or sad mood. The look back period is 30 days.

(B) For Behavioral Symptoms, code between zero and three the frequency of behavioral symptoms manifested by the resident across all three shifts as it occurred during the look back period. The look back period is seven days. Record the frequency of behavioral symptoms manifested by the resident across all three shifts.

(4) Physical Functioning and Structural Problems. The look back period for items described in this paragraph is seven days.

(A) For Self Performance, code between zero and four or eight for self performance by the recipient in bed mobility, transfer, eating, and toilet use during the look back period. The clinical record must capture the total picture of the recipient's actual self care performance for each activity of daily living (ADL) over the seven day period, 24 hours a day.

(B) For ADL Support Provided, code from zero and three or eight to support assistance provided by staff in bed mobility, transfer, and toilet use. The clinical record must reflect the support provided by staff, for each ADL, over a 24-hour period, during the look back period.

(5) Continence Appliances and Programs. The look back period for items described in this paragraph is 14 days.

(A) For Scheduled Toileting Plan, check if recipient is on any scheduled toileting program. The documentation must include a plan for bowel and/or bladder elimination whereby staff members at scheduled times each day either take the recipient to the toilet, give the recipient a urinal, or remind the recipient to go to the toilet. This includes bowel habit training and/or prompted voiding, but does not include changing wet garments. A "program" refers to a specific approach that is organized, planned, documented, monitored and evaluated. The recipient's toileting schedule must be in a place where it is clearly communicated, available to and easily accessible to all staff. The care plan must indicate the recipient is on a routine toileting schedule.

(B) For Bladder Retraining Program, check if recipient is on any bladder retraining program that is a retraining program to teach the recipient to consciously delay urinating or to resist the urge to urinate. The care plan must include individualized goals and ap-

proaches that is organized, planned, documented, monitored, and evaluated.

(6) Disease Diagnosis. The disease conditions described in this paragraph require a physician-documented diagnosis in the clinical record. The look back period is seven days.

(A) For Diseases, code diabetes, aphasia, cerebral palsy, hemiplegia/hemiparesis, multiple sclerosis, and/or quadriplegia if there is a documented physician diagnosis in the clinical record. Include active diagnoses only; do not include conditions that have been resolved or have not affected the recipient's functioning, medical treatment, or care plan.

(B) For Infections, code pneumonia and/or septicemia, if the infection was present with a documented relationship to the recipient's current functioning, medical treatment, or care plan. A physician documented diagnosis in the clinical record is required to code this item.

(7) Health Conditions. The look back period for items described in this paragraph is seven days. As applicable, review the clinical records (including the current nursing care plan) and consult with facility staff members and resident's family if the resident is unable to respond.

(A) For Problem Conditions, code documented problems or symptoms that affect or could affect the recipient's health or functional status and to identify risk factors for illness, accident, and functional decline, as they occurred during the look back period.

(B) For Dehydrated; Output Exceeds Intake Code only if the recipient has at least two of the following indicators:

(i) Receives less than 1500ml fluids daily;

(ii) One or more clinical signs or symptoms of dehydration; or

(iii) Fluid loss exceeds daily intake.

(C) For Delusions, the recipient's clinical record must support that the recipient holds fixed, false beliefs not shared by others based on observation during the look back period.

(D) For Fever, include documentation that the recorded temperature of 2.4 degrees Fahrenheit or greater than the documented established baseline for that recipient was observed during the look back period.

(E) For Hallucinations, the recipient's clinical record must support the recipient's false sensory perceptions that occur in the absence of any real stimuli as observed and documented during the look back period.

(F) For Internal bleeding, the clinical record must support frank or occult bleeding in the clinical record based on observations during the look back period, excluding simple nosebleeds that are easily controlled.

(G) For Vomiting, the clinical record must support that regurgitation of stomach contents occurred during the look back period.

(8) Oral/Nutritional Status. For Weight Change, code zero or one for weight loss. Code one if there is documented evidence of weight loss of five percent [5%] as observed during a 30-day look back period, or ten percent [10%] or more as observed during a 180-day look back period. Do not round the actual weight. If a recipient cannot be weighed, the facility must use the standard no-information code.

(9) Nutritional Approaches. The look back period for items described in this paragraph is seven days.

(A) For Parenteral/Intravenous, check if there is documentation that the recipient received parenteral and/or intravenous fluids administered for nutrition or hydration during the look back period. This item can [only] be coded only if there is supporting documentation that reflects an identified need for additional fluid intake for nutrition and/or hydration.

(B) For Feeding Tube, check if there is documentation that supports the presence of any type of tube that can deliver food, nutritional substances, fluids, and/or medications directly into the gastrointestinal system.

(C) Parenteral or Enteral Intake. The look back period for items described in this paragraph is seven days.

(i) For Total Calories, code between zero and four for the documented proportion of total calories actually received by the recipient via parenteral or tube feeding as observed during the look back period.

(ii) Average Fluid Intake: Code between zero and five for the average documented fluid intake by intravenous or tube feeding received by the recipient each day as observed in the look back period. The actual amount of fluid the recipient received each day by this mode must be recorded.

(10) Skin Condition. The look back period for items described in this paragraph is seven days.

(A) For Ulcers, code between zero and nine, corresponding to the number of skin ulcers at each stage, due to circulatory problems or pressure, as observed during the look back period. A description of the wound must be documented in the clinical record during the look back period.

(B) For Type of Ulcer, code between zero and four to indicate the highest staged pressure ulcer present as observed during the look back period. The staging of the pressure ulcer(s) must be coded as assessed, described and documented during the look back period.

(11) Other Skin Problems or Lesions present. The look back period for items described in this paragraph is seven days.

(A) For Burns (Second or Third Degree), check for the presence of burns, from any cause (e.g., heat, chemicals) and document in the clinical record. This category does not include first-degree burns.

(B) For Open Lesions/Sores, check if documentation supports the presence of open skin lesion(s) that are not coded elsewhere. Do not code skin tears or cuts. A description of the lesions/sores must be documented in the clinical record during the look back period.

(C) For Surgical Wounds, check if documentation supports the presence of healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites, on any part of the body. This category does not include healed surgical sites, stomas, or lacerations that required suturing or butterfly closure. Peripherally inserted central venous catheters [(PICC)] sites, central line sites, and peripheral intravenous sites are not coded as surgical wounds. A description of the wound must be documented in the clinical record during the look back period.

(12) Skin Treatments. Check all of the following provided and documented as observed during a look back period of seven days.

(A) Pressure relieving device(s) for chair, to include pressure relieving, pressure reducing, and pressure redistributing devices utilized in the recipient's chair or wheelchair, excluding egg crate cushions;

(B) Pressure relieving device(s) for bed, to include pressure relieving, pressure reducing and pressure redistributing devices, utilized in the recipient's bed, excluding egg crate mattresses;

(C) Turning/repositioning program, to include a continuous, consistent program for changing the recipient's position and realigning the body. There must be a specific approach that is organized, planned, documented, monitored, and evaluated;

(D) Nutrition or hydration intervention to manage skin problems, to include dietary measures received by the recipient and ordered for the purpose of preventing or treating specific skin conditions;

(E) Ulcer care, to include any intervention for treating ulcers due to circulatory problems and/or pressure and/or open lesions;

(F) Surgical wound care, to include any intervention for treating or protecting any type of surgical wound;

(G) Application of dressings (with or without topical medications) other than to feet; and

(H) Applications of ointments/medications (other than to feet), to include ointments or medications used to treat a skin condition.

(13) Foot Problems and Care. Check for the presence of foot problems and care to the feet supported by documentation in the clinical record. The foot problem(s) and the care provided, including signs and symptoms of infection, description of the open lesion(s), and application of dressing, must be documented as observed during a seven-day look back period.

(14) Activity Pursuit Patterns. Check all appropriate periods when recipient was awake all or most of the time with no more than a total of a one-hour nap during any such period. The clinical record must support the period(s) of a typical day when the recipient was awake all or most of the time as observed during a seven-day look back period.

(15) Medications. For injections, code from zero to seven the number of days that the recipient received any type of medication, antigen, or vaccine, by subcutaneous, intramuscular or intradermal injection. Do not include medications ordered but not given. This category does not include intravenous (IV) fluids or IV medications. The look back period for this item is seven days.

(16) Special Treatments and Procedures.

(A) For Special Treatments, check any treatments provided during the look back period. The clinical record must have documentation of administration of any treatment(s) the recipient received during the look back period, as it occurred. Do not code services that were provided solely in conjunction with a surgical or diagnostic procedure and the immediate post-operative or post-procedure recovery period. If the treatment was administered outside the facility during the look back period, documentation of the treatment administered must be documented and included in the clinical record. The look back period is 14 days.

(B) For Therapies, code the total number of days and the total number of minutes (for at least 15 minutes a day) that therapy was administered to a resident during the look back period. Code the total number of actual minutes the particular therapy was provided. Record therapies that occurred after admission/readmission to the nursing facility, were ordered by a physician, and were performed by a qualified therapist[;] who meets state credentialing requirements (i.e., qualified therapists or their assistants as contemplated by RAI User's Manual Chapter P.3.b) or, in some instances, under such person's direct supervision. Include only medically necessary therapies furnished af-

ter admission to the nursing facility. The time should include the actual treatment time, not the time waiting or writing reports. The therapist's initial evaluation time may not be counted, but subsequent evaluations conducted as part of the treatment process may be counted. Therapy evaluations, treatments, sessions, and minutes must be documented in the clinical record, each day, as they occur. The look back period is seven days.

(C) For Nursing Rehabilitation/Restorative Care, code between zero and seven the number of days on which the technique, procedure, or activity was practiced for a total of at least 15 minutes during each 24-hour period during the look back period. This includes nursing interventions that assist or promote the recipient's ability to attain his or her maximum functional potential, but does not include procedures or techniques carried out by or under the direction of a qualified therapist(s), as identified in the Special Treatments, Procedures, and Programs section of the MDS. The nursing rehabilitation and/or restorative care must meet all of the following additional criteria. The look back period for items described in this subparagraph is seven days.

(i) Measurable objectives and interventions must be documented in the care plan and in the clinical record as observed during the look back period.

(ii) Evidence of periodic evaluation by licensed nurse must be present in the clinical record.

(iii) Nurse assistants/aides must be trained in the techniques that promote recipient involvement in the activity.

(iv) The activities must be carried out or supervised by identified members of the nursing staff. There must be documentation, including minutes, in the clinical record for the nursing rehabilitation and/or restorative care program as observed during the look back period. This does not include groups with more than four recipients per identified supervising helper or caregiver. There must be documented evidence that services provided in a group setting were provided to a group of four or less.

(D) For Physician visits, code the number of days the physician examined the recipient over a 14-day look back period (or since admission if less than 14 days ago). Documentation of the physician's evaluation must be included in the clinical record.

(E) For Physician Orders, code the numbers of days on which physician orders were changed. Include written, telephone, fax, or consultation orders for new or altered treatment. Do not include order renewals without change. If no order changes exist, code zero.

§371.214. *Resource Utilization Group Classification System.*

(a) The Resource Utilization Group (RUG-III) 34-group classification system has seven major classification groups. The groups represent the recipient's relative direct care resource requirements.

(b) The Activities of Daily Living (ADL) score is based on the recipient's care needs that are provided by the nursing facility staff. The ADL score is used to determine a recipient's placement in a RUG-III category and is based on the recipient's care needs provided by the nursing facility staff. The score is incorporated into acuity measurements established under the RUG-III recipient classification methodology. The clinical record must support items claimed for Medicaid reimbursement on the Minimum Data Set (MDS).

(c) The state-specific Long-Term Care Medicaid Information Section is a part of the MDS assessment Resident Assessment Instrument (RAI) in Texas and must be completed for Medicaid reimbursement. The Long-Term Care Medicaid Information Section must include the last name and license number of the registered nurse (RN) assessment coordinator.

(d) The Basic Tracking Form must include:

(1) the [The] signature and title of each licensed nurse or health care professional completing any section of the MDS assessment for Medicaid reimbursement; and

(2) the [The] section(s) and completion date(s) corresponding to the signature of the nurse or health care professional.

(e) Each individual signing the signature section on the Basic Tracking Form is certifying that the information entered on the MDS assessment is accurate. A facility that submits false or inaccurate information is subject to sanctions under Subchapter G of this chapter (relating to Administrative Actions and Sanctions) [§371.1643 of this title (relating to Use of Sanctions)].

(f) If the nursing facility recipient is a hospice recipient, the nursing facility must comply with the requirements of 40 TAC §19.1926 (relating to Medicaid Hospice Services) and maintain in the recipient's clinical record[.] copies of the completed Texas Medicaid Hospice Program Recipient Election/Cancellation/Discharge Notice (Form 3071), and the DADS Medicaid/Medicare Hospice Program Physician Certification of Terminal Illness (Form 3074).

(1) The nursing facility must acknowledge a recipient's admission to hospice services on the Special Treatments, Procedures, and Programs section when completing an MDS full, comprehensive, or quarterly assessment.

(2) An MDS assessment indicating that a recipient has elected hospice services is not [will not be] processed until the Texas Medicaid Hospice Program Recipient Election/Cancellation/Discharge Notice (Form 3071), and the DADS Medicaid/Medicare Hospice Program Physician Certification of Terminal Illness (Form 3074) are received by the Texas Medicaid Claims Administrator [MCA].

(3) When a recipient is admitted to hospice and there has not been a significant change in condition, a significant change in status assessment does not have to be completed. The recipient's next scheduled assessment may be used.

(g) Each nurse's license number submitted on the MDS assessment, Long-Term Care Medicaid Information Section, is [will be] validated with the Texas Board of Nursing or [will be validated] as applicable as a nurse compact license with the licensing state. An MDS assessment is [will be] rejected for Medicaid reimbursement if an invalid or delinquent license number is submitted on the MDS assessment, Long-Term Care Medicaid Information Section.

(h) Nursing facility staff must complete the HHSC-approved MDS training in accordance with this subsection.

(1) The nursing facility RN Assessment Coordinator must complete the HHSC-approved online MDS training course prior to completing an MDS assessment for Medicaid payment. All other staff completing the MDS assessment for Medicaid payment are encouraged to take the MDS Training prior to completing the MDS assessment.

(2) The nursing facility RN Assessment Coordinator must repeat the MDS online training every two years. A certificate of completion is [will be] issued at the conclusion of the training.

(3) If the nursing facility RN Assessment Coordinator does not complete the MDS training every two years as required by HHSC, the license number of the RN Assessment Coordinator is not [will not be] accepted into the state database and the MDS assessment is [will be] rejected by the Medicaid claims administrator.

(i) An admission assessment, a quarterly assessment, significant change in status assessment, annual assessment, significant cor-

rection to a prior quarterly assessment, or a significant correction to a prior annual assessment establishes a RUG-III group.

(1) A significant change in status assessment, which requires a comprehensive MDS with Resident Assessment Protocols [(RAPs)], must be completed by the end of the 14th calendar day following determination that a significant change has occurred.

(2) A significant change in status assessment resets the schedule for the next annual assessment.

(j) Permanent medical necessity is determined by DADS [the Texas Department of Aging and Disability Services (DADS)] in accordance with 40 TAC §19.2403 (relating to Medical Necessity Determination).

(k) When correcting errors in an MDS assessment, the nursing facility staff must use the MDS Correction Policy in Chapter 5 of the Minimum Data Set, Resident Assessment Instrument User's Manual, published by CMS [the Centers for Medicare and Medicaid Services (CMS)].

(1) Documentation must be maintained in the clinical record to support the corrected MDS assessment form and be available for review by the OIG [HHSC-OIG] staff during MDS utilization reviews.

(2) The Correction Request Form attestation of accuracy of signatures must contain the RN assessment coordinator's and Director of Nursing's [DON's] signatures, and the date the correction was completed.

(3) A correction to a RUG reclassification error identified during an on-site [onsite] review is considered an assessment error as described in subsection (r)(2) of this section. This does not negate the facility's responsibility to make quality of care corrections pursuant to the CMS MDS Correction Policy referenced in this section.

(l) The MDS assessment establishes the rate(s) at which the Texas Medicaid program pays a nursing facility[;] or hospice provider for the facility's hospice residents[;] to support the care the nursing facility's residents receive and any information on the MDS RAI is [shall be] considered part of each corresponding claim for Medicaid reimbursement.

(m) Prior to entering a nursing facility for review, the OIG [HHSC-OIG] identifies a population of paid claims from which a sample is [will be] drawn.

(1) The population is defined as claims associated with RUG classifications:

(A) paid to the nursing facility, or hospice provider for the facility's hospice residents, for a specified time period; and

(B) that meet certain criteria, such as dollar or claim volume, as determined by the OIG [HHSC-OIG].

(2) The OIG [HHSC-OIG will identify] the population of paid claims, along with their related RUG classifications and MDS assessment claim forms, from which a statistically valid random sample is [will be] drawn for review. The sample generated is [will be] a statistically valid random sample generated at a minimum confidence level of 90 percent [90%] and a maximum precision of ten percent [10%]. Related extrapolations are [will be] done at the lower limit of the applicable confidence interval.

(n) Utilization reviews are [will be] conducted in accordance with this subsection.

(1) An OIG [HHSC-OIG] nurse reviewer conducts [will conduct] an unannounced on-site [onsite] MDS utilization review

of a nursing facility at least every 15 months. The frequency of unannounced on-site [onsite] reviews is [will be] determined by the accuracy of the MDS assessment(s) and the facility's error rate.

(2) The unannounced on-site [onsite] review period begins when an OIG [HHSC-OIG] nurse reviewer presents an entrance letter to the facility, and ends when the OIG [HHSC-OIG] nurse reviewer informs the facility that the unannounced on-site [onsite] review is completed. The unannounced on-site [onsite] review period is subject to the provisions in subparagraphs (A) - (D) of this paragraph. The unannounced on-site [onsite] review period does not include the exit conference, which is described in paragraph (3) of this subsection.

(A) The nursing facility shall provide the OIG [HHSC-OIG] nurse reviewer initial access to clinical records and resources the OIG [HHSC-OIG] nurse reviewer determines are necessary to initiate the unannounced on-site [onsite] review process within two hours of entrance to the nursing facility. Although the facility is not required to produce all records within two hours, documentation to be reviewed must continue to be made available to the OIG [HHSC-OIG] nurse reviewer during the unannounced on-site [onsite] review period. If the facility indicates that necessary records or resources are located off-site or otherwise unavailable for immediate retrieval, and the facility can substantiate this fact, the OIG grants [HHSC-OIG will grant] an extension to the two-hour initial production of records requirement.

(B) The nursing facility, upon the OIG [HHSC-OIG] nurse reviewer request, must provide the signed and notarized Records Affidavit described in subsection (q)(4) of this section for each MDS assessment for which copies of clinical record documentation are provided to the nurse reviewer, attesting that the facility used its best efforts to obtain all relevant records, and that the documentation provided to the OIG [HHSC-OIG] nurse reviewer is as complete a compilation as was possible during the unannounced on-site [onsite] review period. If the nursing facility refuses to provide the required Records Affidavit, the nursing facility must state the refusal in writing and attach the statement to the records provided to the nurse reviewer.

(C) The nursing facility must ensure an assigned staff member knowledgeable of the MDS and clinical record is available at the facility to the OIG [HHSC-OIG] nurse reviewer during the entire unannounced on-site [onsite] review.

(D) When the OIG [HHSC-OIG] nurse reviewer identifies an item coded on the assessment that cannot [can not] be substantiated or does not accurately reflect the recipient's status during the applicable look back period, the OIG [HHSC-OIG] nurse reviewer notifies [will notify] the assigned nursing facility staff and requests [request] supporting documentation.

(i) The nursing facility must provide the requested supporting documentation to validate the coded items to the OIG [HHSC-OIG] during the unannounced on-site [onsite] review period and prior to the exit conference.

(I) If the unannounced on-site [onsite] review period is more than one day, the nursing facility must provide the requested information during regular business hours to the OIG [HHSC-OIG] reviewer by the end of the day the documentation was requested, provided[: Provided], however, that the facility will [shall] be allowed a minimum of six business hours in which to provide requested information.

(II) Nothing in this provision shall be construed to affect the timing of an exit conference or require the reviewer to incorporate an overnight stay near the facility. It shall be the facility's responsibility to submit the supplemental records to the reviewer's place of business. The reviewer's exit conference conclusions and er-

ror rates may change after reviewing the supplemental records. Any such changes are ~~will be~~ communicated to the provider within one business day.

(III) If a facility cannot produce or make available the requested information, the facility must provide a written statement explaining why the information cannot be provided as requested. The submission of a written statement does not negate the ~~OIG's [HHSC-OIG's]~~ authority to take enforcement action under Subchapter G of this chapter ~~(relating to Legal Action Relating to Providers of Medical Assistance)~~.

(ii) Lack of documentation to validate the items claimed on the MDS as described in this paragraph may be the basis for an error and RUG III group reclassification.

(iii) Lack of documentation, inconsistent documentation that misrepresents the patient's actual condition at the time it is documented, or altered documentation, which does not follow generally accepted error correction guidelines such as the MDS Correction Policy in Chapter 5 of the Minimum Data Set, may be the basis for an error and adjustment in the RUG-III group. The error or adjustment is ~~will be~~ made based on a review of the clinical record documentation provided for the look-back period of the MDS assessment.

(3) The ~~OIG [HHSC-OIG]~~ nurse reviewer ~~holds [will hold]~~ an exit conference with nursing facility staff.

(A) The exit conference is ~~will be~~ held with the nursing facility staff at the conclusion of the ~~unannounced on-site [onsite]~~ review period. Hospice staff is encouraged to attend to discuss the review findings of the MDS assessments for hospice recipients for whom the representative provided hospice services.

(B) The ~~OIG [HHSC-OIG]~~ nurse reviewer ~~provides [will provide]~~ the nursing facility representative(s) in a leadership position(s) (e.g., the administrator, ~~Director of Nursing [DON]~~, charge nurse) formal written notification of all MDS validation findings during the exit process.

(i) If a hospice representative is present at the exit conference, written notification is ~~will be~~ provided only on recipients to whom they provided services.

(ii) If the hospice representative is not present during the exit conference, the ~~OIG provides [HHSC-OIG will provide]~~ formal written notification of all RUG-III changes within 15 calendar days of the exit conference.

(iii) If the nursing facility disagrees with the HHSC RUG-III determination or assessment of errors, the nursing facility may submit a request for reconsideration as provided in subsection (q) of this section.

(o) The ~~OIG [HHSC-OIG]~~ may sanction any provider or person as defined in ~~§371.1 [§371.1604]~~ of this title (relating to Definitions), including a managed care organization or subcontractor, pursuant to Subchapter G of this chapter that:

(1) fails to grant immediate access upon reasonable request to:

(A) the ~~OIG [HHSC-OIG]~~;

(B) the ~~OAG's [Attorney General's]~~ Medicaid Fraud Control Unit or Civil Fraud Division;

(C) any state or federal agency authorized to conduct compliance, regulatory, or program integrity functions on the provider, person, or the services rendered by the provider or person; or

(D) any agent or consultant of any agency or division within an agency described in subparagraph (A) of this paragraph;

(2) fails to allow the ~~OIG [HHSC-OIG]~~ or any other federal or state agency, division, agent, or consultant, as described in paragraph (1) of this subsection to conduct any duties that are necessary to the performance of their statutory functions; or

(3) fails to provide to the ~~OIG [HHSC-OIG]~~ or any other federal or state agency, division, agent, or consultant, as described in paragraph (1) of this subsection, upon request and as requested, for the purpose of reviewing, examining, and securing custody of records, access to, disclosure of, and custody of:

(A) copies or originals of any records, documents, or other requested items, as determined necessary by the ~~OIG [HHSC-OIG]~~ or those specified in paragraph (1) of this subsection to perform statutory functions;

(B) any records the provider or person is required to maintain;

(C) any records necessary to verify items or services furnished and delivered under Medicaid, any other ~~HHS [health and human services]~~ program, or any state health care program to determine whether payment for those items or services is due or was properly made; or

(D) information that includes, without limitation:

(i) clinical patient records;

(ii) other records pertaining to the patient;

(iii) any other records of services provided to Medicaid or other ~~HHS [health and human services]~~ program recipients and payments made for those services;

(iv) documents related to diagnosis, treatment, service, lab results, charting, billing records, invoices, documentation of delivery of items, equipment, or supplies, and radiographs, and all requirements of Subchapter G, Division 2, of this chapter ~~(relating to Grounds for Enforcement) [§371.1617(a)(2) of this title (relating to Program Violations)]~~;

(v) business and accounting records with backup support documentation, statistical documentation, computer records and data, patient sign-in sheets, and schedules; or

(vi) any records necessary to fulfill its duty under the Improper Payments Information Act of 2002, Public Law 107-300, 116 Stat. 2350 (November 26, 2002) requiring state agencies take action to reduce improper payments. The term "improper payment" means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements, including any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, any payment for services not received, or any payment that does not account for credit for applicable discounts.

(p) A facility that uses an electronic clinical record system and electronic submissions ~~must [shall]~~ comply with this subsection.

(1) A nursing facility that elects to submit electronic or digital signatures on MDS assessments is required to have a policy in effect on the date of transmission that ensures it ~~has [they have]~~ proper security measures to protect against the use of an electronic or digital signature by anyone other than the individual to whom the electronic or digital signature belongs. The policy must also ensure that clinical

records are made available to the OIG [~~HHSC-OIG~~] and others who are authorized by law.

(2) In order to receive Medicaid reimbursement, a nursing facility that utilizes a clinical record system that [~~which~~] is entirely electronic must maintain a hard copy of all MDS assessments in the recipient's clinical record. The hard copy of an MDS assessment must include the signatures, title, and date of all individuals completing the MDS.

(q) The OIG conducts [~~HHSC-OIG will conduct~~] a reconsideration review upon receipt of a written request for reconsideration.

(1) The reconsideration request must be sent in the form of a letter. The letter must describe in detail the reason a reconsideration review is requested for each specified assessment error. A copy of each signed affidavit executed during the unannounced on-site [~~onsite~~] review for which reconsideration is requested must be attached to the letter. The reconsideration request must be submitted in the order outlined in the reconsideration request requirements provided to the nursing facility staff during the exit conference[;] and must include all of the information required for a reconsideration request.

(2) The reconsideration request must be mailed to the OIG [~~HHSC-OIG~~] Utilization Review [~~UR~~] unit at the address indicated on the exit documentation provided to facility staff at the exit conference.

(A) The reconsideration request must be postmarked on or before the 15th calendar day after the date of the exit conference, provided, however, that if the 15th calendar day falls on a Sunday or national holiday as defined in Texas Government Code [~~Annotated~~] §662.003(a), the request must be postmarked on the next following business day.

(B) A reconsideration request that does not meet the requirements of this paragraph is not [~~will not be~~] granted.

(3) An MDS assessment error that is not identified in the request is not [~~will not be~~] reconsidered.

(4) A nursing facility may submit additional clinical records along with a timely request for reconsideration review. Any such additional records must be accompanied by a notarized Fact and Records Affidavit that properly authenticates the documents as true and correct duplicates of business records pursuant to TEX. R. EVID. 803(6) and TEX. R. EVID.[;] 902(10). Additionally, the Fact Affidavit must specify: why the records were not produced during the unannounced on-site [~~onsite~~] review, when the records were obtained, where the records were located, who located the records, and the circumstances under which the records were obtained. If recipient medical record documentation that was not provided during the unannounced on-site [~~onsite~~] review is submitted for reconsideration, the weight to be given any supplemental documentation remains [~~shall remain~~] within the discretion of the reviewer.

(5) If the reconsideration review establishes that the OIG [~~HHSC-OIG~~] has changed an MDS RUG-III group in error, the OIG directs [~~HHSC-OIG will direct~~] the Texas Medicaid claims administrator to correct the error retroactively.

(6) If the provider disagrees with the reconsideration determination, the provider may request a formal appeal as described in Chapter 357, Subchapter I of this title (relating to Hearings Under the Administrative Procedure Act).

(7) The RUG-III group and the associated per diem rate specified in the reconsideration determination remain in effect during the formal appeal process.

(r) The OIG recovers [~~HHSC-OIG will recover~~] overpayments based on unannounced on-site [~~onsite~~] review findings associated with an administrative or assessment error in accordance with this subsection.

(1) An administrative error occurs if a requirement in subsections (c) and (d) of this section are not met, or the Long-Term Care Medicaid Information Section or Basic Tracking Form is not made available to the OIG [~~HHSC-OIG~~] during regular business hours of the unannounced on-site [~~onsite~~] review period and prior to the exit conference.

(A) If the unannounced on-site [~~onsite~~] review period is more than one day, the nursing facility must provide the requested information to the OIG [~~HHSC-OIG~~] reviewer by the end of the day information is requested, during regular business hours.

(B) If a facility cannot produce or make available the requested information, the facility must provide a written statement explaining why the information cannot be provided as requested. The submission of a written statement does not negate the OIG's [~~HHSC-OIG's~~] authority to take enforcement action under Subchapter G of this chapter.

(C) An administrative error may be reconsidered as described in subsection (q) of this section.

(2) An assessment error is a RUG reclassification resulting in an overpayment or underpayment of an MDS assessment claim(s) identified during a utilization review of a facility.

(A) During the MDS assessment utilization review of a facility, the OIG identifies [~~HHSC-OIG will identify~~] each assessment error (e.g., overpayment amount or underpayment amount of an MDS assessment claim) from the population as that term is described in subsection (m) of this section.

(B) Following the unannounced on-site [~~onsite~~] review of the sampled MDS assessment claim forms, an assessment error rate is [~~will be~~] calculated as follows:  
Figure: 1 TAC §371.214(r)(2)(B) (No change.)

(C) The OIG processes [~~HHSC-OIG will process~~] all RUG reclassifications identified as a result of the unannounced on-site [~~onsite~~] utilization review.

(i) The OIG recovers [~~HHSC-OIG will recover~~] from the facility any overpayment(s) associated with an MDS assessment claim. The recovered amount is a debt owed by the facility to the Texas Medicaid program. The facility is [~~will be~~] reimbursed for any underpayment(s) identified.

(ii) To calculate any overpayment, the OIG extrapolates [~~HHSC-OIG will extrapolate~~] to the population and the extrapolation is [~~will be~~] applied only to the RUG classifications found in error. An adjustment equal to the net value of the identified overpayment(s) and underpayment(s) is [~~will be~~] made. Any net overpayments [~~will~~] constitute a debt owed by the facility/provider, as applicable, to the Texas Medicaid program. Net underpayments are [~~will be~~] reimbursed to the facility/provider, as applicable. The OIG Utilization Review extrapolates to the population in all cases of overpayment, and the extrapolation is applied only to the RUG classifications found in error.

~~{(f)} For Utilization Reviews conducted on September 1, 2008 through August 31, 2009, HHSC-OIG Utilization Review will extrapolate to the population only when the error rate exceeds 25%.~~

~~{(H)} For Utilization Reviews conducted on September 1, 2009 through February 28, 2010, HHSC-OIG Utilization~~

Review will extrapolate to the population only when the error rate exceeds 20%.]

~~[(III) For Utilization Reviews conducted on March 1, 2010 through August 31, 2010, HHSC-OIG Utilization Review will extrapolate to the population only when the error rate exceeds 15%.]~~

~~[(IV) For Utilization Reviews conducted on or after September 1, 2010, HHSC-OIG Utilization Review will extrapolate to the population in all cases of overpayment as set forth in clause (ii) of this subparagraph and the extrapolation will be applied only to the RUG classifications found in error.]~~

~~(iii) An error rate greater than 25 percent [25%] or suspected program violation described in Subchapter G, Division 2, of this chapter, results [§371.1617 of this chapter (relating to Program Violations), will result] in a referral for investigation to the OIG [HHSC-OIG] Medicaid Program Integrity [(MPI)] Division. This referral is [will be] made part of the state's method for identification, investigation and referral for fraud under Chapter 357, Subchapter M, of this title (relating to Fraud or Abuse Involving Medical Providers) and Chapter 371, Subchapter G of this title (relating to Administrative Actions and Sanctions [Legal Action Relating to Providers of Medical Assistance]).~~

~~(D) An assessment error is subject to reconsideration in accordance with subsection (q) of this section.~~

~~(i) If the facility timely requests reconsideration of the unannounced on-site [onsite] review results, the assessment error rate is [will be] based on the results of the reconsideration.~~

~~(ii) If the facility does not timely request reconsideration of the unannounced on-site [onsite] review, the assessment error rate is [will be] based on the results of the unannounced on-site [onsite] review.~~

~~(s) Suspected fraudulent documentation, such as medical or clinical records that appear to have been altered, falsified, or fabricated, results [will result] in a referral for investigation to the OIG [HHSC-OIG] Medicaid Program Integrity [(MPI)] Division. This referral is [will be] made part of the state's method for identification, investigation, and referral for fraud under Chapter 357, Subchapter M, of this title.~~

#### *§371.216. Waiver of Extrapolation.*

~~(a) The OIG [inspector general] may waive the calculation of an overpayment by extrapolation, as described in §371.214(r)(2) of this subchapter (relating to Resource Utilization Group Classification System), to any or all of the Resource Utilization Group (RUG) classifications found in error.~~

~~(b) A provider must request a waiver of extrapolation in writing on or before the 15th calendar day after receipt of the final notice of overpayment. The provider's request for waiver of extrapolation must include sufficient evidence to demonstrate good cause for the waiver. The OIG [Office of the Inspector General] may request additional evidence or documentation from the provider or other informational sources in evaluating the request.~~

~~(c) The OIG [inspector general] is vested with the sole discretion to evaluate the provider's showing of good cause and to determine whether waiver of extrapolation is warranted.~~

~~(d) The decision to grant, deny, or modify a request for waiver of extrapolation is not subject to administrative or judicial review.~~

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 15, 2016.

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Karen Ray

Chief Counsel

Texas Health and Human Services Commission

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For further information, please call: (512) 424-6900

## SUBCHAPTER E. PROVIDER DISCLOSURE AND SCREENING

**1 TAC §§371.1001, 371.1005, 371.1007, 371.1009, 371.1011, 371.1013, 371.1015**

### Legal Authority

The amendments are proposed under Texas Government Code §531.102(a-2), which requires the Executive Commissioner to work in consultation with the Office of Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program.

The amendments implement Texas Government Code Chapter 531, as amended by S.B. 207. No other statutes, articles, or codes are affected by the proposal.

### *§371.1001. Applicability.*

(a) This subchapter describes the disclosure requirements for applications and screening criteria used by the OIG [HHSC Office of Inspector General (HHSC-OIG)] in making a recommendation for an enrollment determination.

(b) This subchapter applies to:

(1) all applicants for enrollment as a provider in the Medicaid program or CHIP [the Children's Health Insurance Program]; and

(2) if requested by an HHS [a health and human services] agency, applicants for enrollment with an HHS [a health and human services] agency program.

### *§371.1005. Disclosure Requirements.*

(a) An applicant must disclose in its enrollment application the identity of any person or entity as requested by HHSC.

(b) The applicant's disclosures must identify every person whose identity must be disclosed pursuant to the Affordable Care Act, Title 42 of the Code of Federal Regulations, or state statute or administrative rule, as amended. Such disclosures include ~~[but are not limited to]~~ owners, certain subcontractors, creditors, managers, and agents.

(c) An applicant must disclose in its enrollment application every person that previously had an ownership or control interest in the applicant but whose interest was transferred to another person, if the person's former interest was transferred to an immediate family member or to a member of the person's household and the person's former

interest was transferred within one year before or at any time after receiving notice of any potential adverse actions by a governmental entity against the person or against a provider for which the person has or had an ownership or control interest.

(d) An applicant must disclose in the enrollment application all information required by state or federal law or regulation, and all additional information requested by HHSC or the OIG [HHSC-OIG], in its discretion, during the provider screening and enrollment process.

(e) If any information required to be disclosed under this section changes during the processing of an enrollment application, the applicant or provider must disclose that information pursuant to §352.21 of this title (relating to Duty to Report Changes).

(f) A failure by an applicant, provider, or person to meet any of the disclosure requirements specified in this section constitutes a material non-disclosure of relevant information.

(g) The OIG [HHSC-OIG] may use information submitted by another HHS [health and human services] agency that relates to information required to be disclosed in lieu of requiring another submission of the same information by the applicant.

#### §371.1007. *Screening Levels.*

(a) The OIG [HHSC-OIG] uses a screening level of "Limited," "Moderate," or "High" risk, assigned in accordance with §352.9 of this title (relating to Screening Levels) to determine the verifications and further screening required under §371.1009 of this subchapter (relating to Verifications Required for Each Screening Level).

(b) Case-by-case recommendation of screening levels. For any enrollment application, the OIG [HHSC Office of Inspector General] may, in its sole discretion and on a case-by-case basis, recommend that HHSC assign a higher or lower screening level in accordance with §352.9(b) of this title if the OIG [HHSC-OIG] determines in its discretion that the applicant may pose an increased risk of committing fraud, waste, or abuse or may demonstrate unfitness to provide or bill for medical assistance items or services. The OIG [HHSC-OIG] may make such a recommendation after considering all circumstances, including the applicant's criminal, regulatory, and administrative sanction history, as well as the following, if applicable:

(1) The applicant or any person required to be disclosed in the enrollment application is under a payment suspension based on a credible allegation of fraud.

(2) The applicant or any person required to be disclosed in the enrollment application has failed to repay any overpayments incurred under Medicaid, CHIP, or other HHS [health and human services] programs.

(3) The applicant or any person required to be disclosed in the enrollment application was excluded from participation in Medicaid, CHIP, or other HHS [health and human services] program during the ten years before the date of the enrollment application.

(4) The applicant is seeking enrollment as a provider type that was subject to a state or federal temporary moratorium, if the moratorium was lifted within six months before the date of the enrollment application.

#### §371.1009. *Verifications Required for Each Screening Level.*

(a) For an applicant or provider assigned a screening level of "Limited," the OIG [HHSC-OIG] verifies the accuracy and completeness of the information in or related to the enrollment application and 42 C.F.R. §455.450(a)(1), information about the applicant contained in state or federal records, including criminal history records, and any additional information requested of the applicant by the OIG [HHSC-OIG].

(b) For an applicant assigned a screening level of "Moderate," the OIG [HHSC-OIG]:

(1) verifies all items described in subsection (a) of this section; and

(2) performs at least one unscheduled and unannounced pre- and post-enrollment site visit, as described in subsection (d) of this section and in accordance with §352.9 of this title (relating to Screening Levels), if applicable, as described in subsection (d) of this section.

(c) For an applicant or provider assigned a screening level of "High," HHSC or the OIG [HHSC-OIG] performs:

(1) all the verifications described in subsections (a) and (b) of this section; and

(2) a fingerprint-based criminal history check, in the form and manner prescribed by state or federal law, of each person that is an individual and has an ownership or control interest as defined in §371.1005 of this subchapter (relating to Disclosure Requirements) in the applicant.

(d) An unscheduled and unannounced pre- or post-enrollment site visit conducted in accordance with subsections (b) and (c) of this section verifies compliance with state and federal law, rule, and policy governing the Medicaid and CHIP programs. Documents compiled, subpoenaed, or maintained by the OIG [HHSC-OIG] in connection with a site visit are confidential pursuant to Texas Government Code §531.1021(g) and (h).

(e) The OIG [HHSC-OIG], in its sole discretion, may accept previously submitted fingerprints if an individual has been subjected to a fingerprint-based criminal history check by a licensing or regulatory authority or by another state's Medicaid, CHIP, or medical assistance program and the results are made available to HHSC.

(f) As provided in 42 C.F.R. §455.452, the OIG may establish provider screening methods in addition to or more stringent than those required by applicable federal regulations. The OIG may require a fingerprint-based criminal history check when required to do so under State law or because of the level of screening based on risk of fraud, waste, or abuse as determined for that category of provider.

(g) For the requirements outlined above, the OIG may rely on validated screenings as provided by 42 C.F.R. §455.410.

#### §371.1011. *Recommendation Criteria.*

(a) A felony or misdemeanor conviction, as defined in 42 C.F.R. §1001.2, under Texas law, the laws of another state, or federal law, may affect a provider's and/or person's ability to participate.

(b) ~~[(a)]~~ The OIG [Except as provided by subsection (b) of this section, HHSC-OIG] may recommend denial of an enrollment application of the applicant or a person required to be disclosed in accordance with §371.1005 of this subchapter (relating to Disclosure Requirements) on the basis of information revealed through a background [criminal history] check on the applicant, provider, or a person required to be disclosed. A background check may include:

(1) information concerning the licensing status of the health care professional;

(2) information contained in the criminal history record information check performed in accordance with Texas Government Code §531.1032;

(3) a review of federal databases;

(4) the pendency of an open investigation by the OIG; and

(5) any other reason that the OIG determines appropriate.

(c) ~~[(b)]~~ On a case-by-case basis, the OIG [HHSC-OIG] may recommend approval of an enrollment application despite the existence of a criminal history. The case-by-case recommendation for approval is ~~[will be]~~ made by considering the following circumstances:

(1) the number of criminal convictions as defined in 42 C.F.R. §1001.2;

(2) the nature and seriousness of the crime;

(3) whether the individual or entity has completed the sentence, punishment, or other requirements that were imposed for the crime and, if so, the length of time since completion;

(4) in the case of an individual, the age of the individual at the time the crime was committed;

(5) whether the crime was committed in connection with the individual's or entity's participation in Medicaid or other HHS [health and human services] programs;

(6) the extent of the individual's or entity's rehabilitation efforts and outcome;

(7) the conduct of the individual or entity, and the work history of the individual, both before and after the crime;

(8) the relationship of the crime to the individual or entity's fitness or capacity to remain a provider or become a provider;

(9) whether approving the individual or entity would offer the individual or entity the opportunity to engage in further criminal activity;

(10) the extent to which the individual or entity provides relevant information or otherwise demonstrates that approval should be granted; and

(11) any other circumstances that HHSC determines are relevant to the individual or entity's eligibility.

(d) ~~[(e)]~~ The OIG [HHSC-OIG] may recommend permanent denial of an enrollment application if:

(1) the applicant, provider, or a person required to be disclosed has been convicted, as defined in 42 C.F.R. ~~[CFR]~~ §1001.2, of an offense arising from a fraudulent act under Medicaid or other HHS [health and human services] programs; and

(2) that fraudulent act resulted in injury to an elderly person, a person with a disability, or a person younger than 18 years of age.

(e) ~~[(d)]~~ The OIG [HHSC-OIG] may recommend denial of an enrollment application if it determines in its discretion that the applicant may pose an increased risk for committing fraud, waste, or abuse or may demonstrate unfitness to provide or bill for medical assistance items or services. In addition to the applicant's criminal, regulatory, and administrative sanction history, the OIG considers [HHSC-OIG will consider] all applicable circumstances, including the following, if applicable:

(1) the applicant, a person required to be disclosed, or a person with an ownership or control interest in the provider did not submit complete, timely, and accurate information, failed to cooperate with any provider screening methods, or refused to permit access for a site visit;

(2) the applicant or a person required to be disclosed has failed to repay overpayments to Medicaid, CHIP, or other HHS [health or human services] programs;

(3) the applicant, provider, or a person required to be disclosed pursuant to §371.1005 of this subchapter, has been suspended or prohibited from participating, excluded, terminated, or debarred from participating in any state Medicaid, CHIP or other HHS [health and human services] agency program;

(4) the applicant, provider, or a person required to be disclosed has participated in Medicaid or CHIP program and failed to bill for medical assistance or refer clients for medical assistance within the 12-month period prior to submission of the enrollment application;

(5) the applicant, provider, or a person required to be disclosed has falsified any information on the enrollment application; and

(6) The OIG [HHSC-OIG] is unable to verify the identity of the applicant, provider, or a person required to be disclosed.

*§371.1013. Provider Enrollment Recommendations.*

(a) The OIG [HHSC-OIG] makes a recommendation on each enrollment application submitted for review in accordance with the requirements of this subchapter (relating to Provider Disclosure and Screening) and Chapter 352 of this title (relating to Medicaid and Children's Health Insurance Program Provider Enrollment), or other rule, as applicable. The recommendation is at the sole discretion of the OIG [HHSC-OIG], and is not subject to administrative review or reconsideration.

(b) In making its enrollment recommendation, the OIG [HHSC-OIG] may consider any relevant circumstance or factor as it applies to the applicant, provider, or any person required to be disclosed in the enrollment application in accordance with this subchapter and Chapter 352 of this title, if applicable.

(c) Upon making a recommendation on a complete application, the OIG [HHSC-OIG] informs HHSC of its recommendation. HHSC ~~makes~~ the final enrollment decision after considering:

(1) the OIG's [HHSC-OIG's] recommendation;

(2) any conditions for approval recommended by the OIG [HHSC-OIG];

(3) the availability of access to care; and

(4) any other relevant facts or circumstances.

*§371.1015. Types of Provider Enrollment Recommendations.*

(a) The OIG [HHSC-OIG] may make the following types of recommendations regarding an enrollment application:

(1) Approval. If an enrollment application is recommended for approval, the recommendation is for a time-limited period of participation as specified in the provider agreement or notification of the enrollment decision. The prospective provider must complete and submit the provider agreement before enrollment is granted.

(2) Conditional approval. An enrollment application may be recommended for conditional approval with conditions as specified in the notification of the enrollment recommendation. The conditions may consist of the imposition of any one or more administrative actions or sanctions as specified in Subchapter G of this chapter (relating to Administrative Actions and Sanctions) or in other Medicaid or CHIP policy or rule.

~~[(3) Abatement. An enrollment application may be abated and the recommendation delayed for up to six months from the date of submission of the completed enrollment application.]~~

(3) ~~[(4)]~~ Denial. If an enrollment application is denied, HHSC sends [will send] a written notice of the decision by certified

mail to the address of record on the enrollment application. The reason or reasons for denial are as specified in the written notice. If the denial is based upon a pending investigation, charge, or other legal proceeding, the applicant or provider is [will be] ineligible to reapply until such investigation or proceeding is finally resolved.

(b) If an enrollment application is [abated or] denied based upon the OIG's [~~HHSC-OIG's~~] recommendation, an applicant may request an informal desk review by the OIG [~~HHSC-OIG~~] of the recommendation within 20 calendar days from the date of the notice of [abatement or] denial as follows.

(1) The request for an informal desk review must be made in writing and must be submitted in accordance with the instructions in the notice.

(2) The request should state the basis for disagreement with the enrollment recommendation, include any documentary evidence, and describe any mitigating circumstances that would support a reconsideration of the initial enrollment recommendation.

(3) Upon conclusion of the resulting informal desk review, the OIG notifies [~~HHSC-OIG will notify~~] HHSC of its final recommendation. HHSC sends [~~will send~~] a written notice of the final enrollment decision to the address of record on the enrollment application.

(4) The final enrollment recommendation is not subject to administrative review or reconsideration.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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## 1 TAC §371.1002, §371.1003

### Legal Authority

The repeals are proposed under Texas Government Code §531.102(a-2), which requires the Executive Commissioner to work in consultation with the Office of Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program.

The repeals implement Texas Government Code Chapter 531, as amended by S.B. 207. No other statutes, articles, or codes are affected by the proposal.

§371.1002. *Minimum Collection Goal.*

§371.1003. *Definitions.*

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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## SUBCHAPTER F. INVESTIGATIONS

### 1 TAC §§371.1301, 371.1305, 371.1307, 371.1309, 371.1311

#### Legal Authority

The amendments and new rule are proposed under Texas Government Code §531.102(a-2), which requires the Executive Commissioner to work in consultation with the Office of Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program.

The amendments and new rule implement Texas Government Code Chapter 531, as amended by S.B. 207. No other statutes, articles, or codes are affected by the proposal.

§371.1301. *Purpose.*

(a) This subchapter provides [Pursuant to §531.033 and §531.102 of the Texas Government Code, the Executive Commissioner is authorized to adopt rules relating to the investigation of a fraud, waste, or abuse complaint filed with the Texas Health and Human Services Commission's Office of Inspector General. The purpose of this chapter is to provide] procedures for the investigation of complaints or allegations to [that will] promote their just and efficient disposition.

(b) This subchapter [chapter] governs the investigation of all jurisdictional complaints or allegations before the OIG [~~Commission's Office of Inspector General~~].

§371.1305. *Preliminary Investigation [and Report].*

(a) The OIG may receive and investigate complaints related to fraud, waste, or abuse within HHSC or an HHS agency. The OIG prioritizes complaints for purposes of determining the order in which complaints are investigated, taking into account the seriousness of the allegations made in a complaint. The OIG may consider the following factors when opening cases and prioritizing cases for the efficient management of the OIG's workload:

- (1) the highest potential for recovery or risk to the State;
- (2) the history of noncompliance with applicable law and regulations;
- (3) identified fraud trends;

(4) internal affairs investigations according to the seriousness of the threat to recipient or public safety or the risk to program integrity in terms of the amount or scope of fraud, waste, or abuse posed by the allegation that is the subject of the investigation;

(5) acts or the failure to act that potentially threatens the public health or may result in physical harm to the public; and

(6) the potential for or actual physical destruction of state property, including the loss, theft and destruction of State assets, property, benefits, or equipment.

(b) ~~[(a)]~~ The ~~OIG~~ assesses complaints received by the ~~OIG~~ from any source to determine within 30 days of receipt ~~[will determine]~~ whether it has:

(1) sufficient indicators of fraud, waste, or abuse; and

(2) jurisdiction ~~[sufficient information and whether it has jurisdiction within 30 days of receipt of a complaint or allegation of fraud, waste, or abuse; within 30 days of OIG having reason to believe that fraud or abuse has occurred; or within 30 days of OIG having identified possible questionable practices].~~

(c) If the ~~OIG~~ has jurisdiction and sufficient information to justify ~~[initiate]~~ an investigation, the ~~OIG~~ completes ~~[will conduct]~~ a preliminary investigation within 45 days of receipt of the complaint to determine whether there is sufficient basis to warrant a full investigation. The ~~OIG~~ may also collaborate with federal or other state authorities in conducting audits or investigations and in taking enforcement measures in response to program violations.

(1) After completing its preliminary investigation, the ~~OIG~~ may, at its discretion, initiate settlement discussions of an administrative case with the person who is the subject of the investigation. If the matter cannot reasonably be settled or if the ~~OIG~~ determines that further investigation is required before the propriety of settlement or other enforcement can be evaluated, the ~~OIG~~ may conduct a full investigation.

(2) If, at any point during its investigation, the ~~OIG~~ determines that an overpayment resulted without wrongdoing, the ~~OIG~~ may refer the matter for routine payment correction by HHSC's fiscal agent or an operating agency or may offer a payment plan.

(d) The ~~OIG~~ may also consider the following factors in determining whether to open a full investigation:

(1) the nature of the program violation;

(2) evidence of knowledge and intent;

(3) the seriousness of the program violation;

(4) the extent of the violation;

(5) prior noncompliance issues;

(6) prior imposition of sanctions, damages, or penalties;

(7) willingness to comply with program rules;

(8) efforts to interfere with an investigation or witnesses;

(9) recommendations of peer review groups;

(10) program violations within Medicaid, Medicare, Titles V, XIX, XX, CHIP, and other HHS programs;

(11) pertinent affiliate relationships;

(12) past and present compliance with licensure and certification requirements;

(13) history of criminal, civil, or administrative liability; and

(14) any other relevant information or analysis the ~~OIG~~ deems appropriate.

(e) Once the preliminary investigation is completed, the ~~OIG~~ reviews the allegations of fraud, waste, abuse, or questionable practices, and all facts and evidence relating to the allegation and prepares a preliminary report before the allegation of fraud or abuse proceeds to a full investigation. The preliminary report documents the following:

(1) the allegation that is the basis of the report;

(2) the evidence reviewed;

(3) the procedures used to conduct the preliminary investigation;

(4) the findings of the preliminary investigation; and

(5) whether a full investigation is warranted.

~~[(b) Once the preliminary investigation is completed, OIG will review the allegations of fraud, abuse, or questionable practices, and all facts and evidence relating to the allegation and will prepare a preliminary report before the allegation of fraud or abuse will proceed to a full investigation. The preliminary report will document the following:]~~

~~[(1) the allegation that is the basis of the report;]~~

~~[(2) the evidence reviewed;]~~

~~[(3) the procedures used to conduct the preliminary investigation, if available;]~~

~~[(4) the findings of the preliminary investigation; and]~~

~~[(5) whether a full investigation is warranted.]~~

~~[(e) OIG will also consider the factors listed in §371.1603(f)(1) of this chapter (relating to Legal Basis and Scope).]~~

(f) ~~[(d)]~~ The ~~OIG~~ maintains ~~[OIG will maintain]~~ a record of all allegations of fraud, waste, or abuse against a provider containing the date each allegation was received or identified and the source of the allegation, if available. This record is confidential under Texas Government Code §531.1021(g) and subject to Texas Government Code §531.1021(h).

*§371.1307. Full Investigation.*

(a) The ~~OIG~~ begins a full investigation within 30 days of completing the preliminary investigation if it determines that a full investigation is warranted.

(b) A full investigation must be completed within 180 days unless the ~~OIG~~ determines that more time is needed to complete the investigation.

(c) If the ~~OIG~~ determines that more time is needed to complete the investigation, the ~~OIG~~ must notify the provider who is the subject of the investigation indicating that the investigation will exceed 180 days and specifying the reasons the ~~OIG~~ is unable to complete the investigation within the 180-day time period. However, the ~~OIG~~ is not required to notify the provider if the ~~OIG~~ determines that notice would jeopardize the investigation.

(d) Within 30 days of completion of the preliminary investigation, the ~~OIG~~ refers ~~[OIG will refer]~~ the case to the state's Medicaid fraud control unit if a provider is suspected of fraud, waste, or abuse involving criminal conduct or if the ~~OIG~~ learns or has reason to suspect that a provider's records are being withheld, concealed, destroyed, fabricated, or in any way falsified. This referral does ~~[will]~~ not preclude the ~~OIG~~ from continuing its investigation of the provider.

§371.1309. *Training of Investigators.*

Investigators who investigate Medicaid providers for potential fraud, waste, or abuse [with] receive annual training on notice, service, due process, and any additional regulations or policies that may affect the OIG investigatory process.

§371.1311. *Role of the OIG and SIUs.*

(a) An MCO is required by §353.502 of this title (relating to Managed Care Organization's Plans and Responsibilities in Preventing and Reducing Waste, Abuse, and Fraud) and §370.501 of this title (relating to Purpose) to establish and maintain an SIU to investigate allegations of fraud, waste, or abuse for all services in the MCO plan. If an MCO suspects possible fraud, waste, or abuse, the MCO must conduct a preliminary investigation in accordance with criteria in §353.502 and §370.501 of this title. If the preliminary investigation confirms fraud, waste, or abuse, the MCO must refer the matter to the OIG.

(b) For a potential overpayment amount less than \$100,000, the MCO pursues recovery of the overpayment.

(c) For MCO referrals to the OIG where the potential overpayment amount exceeds \$100,000, the OIG accepts the referral and conducts a preliminary investigation.

(1) The OIG evaluates the allegation(s) and evidence from the MCO-SIU for intentional deception, repeat billing pattern, or other indicators of questionable practices.

(2) The OIG determines within 30 business days whether to take additional investigative action, and notifies the referring MCO of the decision.

(d) If the preliminary investigation determines a full investigation is warranted, the OIG assesses the provider's billing activity in fee-for-service Medicaid and other MCOs in which the provider is credentialed.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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**1 TAC §371.1303**

Legal Authority

The repeal is proposed under Texas Government Code §531.102(a-2), which requires the Executive Commissioner to work in consultation with the Office of Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program.

The repeal implements Texas Government Code Chapter 531, as amended by S.B. 207. No other statutes, articles, or codes are affected by the proposal.

§371.1303. *Definitions.*

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**SUBCHAPTER G. ADMINISTRATIVE  
ACTIONS AND SANCTIONS**

**DIVISION 1. GENERAL PROVISIONS**

**1 TAC §§371.1601, 371.1603, 371.1609, 371.1611, 371.1613,  
371.1615, 371.1617, 371.1619**

Legal Authority

The amendments are proposed under Texas Government Code §531.102(a-2), which requires the Executive Commissioner to work in consultation with the Office of Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program.

The amendments implement Texas Government Code Chapter 531, as amended by S.B. 207. No other statutes, articles, or codes are affected by the proposal.

§371.1601. *Applicability.*

(a) Unless otherwise provided, this subchapter applies to all administrative actions and sanctions imposed by the OIG and arising out of an investigation of fraud, waste, or abuse.

~~[(b) If an investigation, utilization review, or audit procedure is conducted on a person whose program area is regulated by another health and human services (HHS) agency, the substantive rules governing that program area also apply.]~~

~~[(c) This subchapter supersedes any other HHS agency rule regarding enforcement involving fraud, waste, or abuse.]~~

~~(b) [(d)] This subchapter does not apply to system recoupments or other administrative or clerical corrections.~~

~~[(e) An investigation pending on September 1, 2013, is governed by this subchapter as it existed on that date, unless by mutual agreement of the parties.]~~

§371.1603. *Legal Basis and Scope.*

[(a) The statutory authority for this subchapter is provided by:]

[(1) Texas Human Resources Code Chapters 32 and 36;]

[(2) Texas Government Code Chapter 531;]

[(3) Title 42, United States Code; and]

[(4) Title 42, Code of Federal Regulations.]

[(b) OIG is responsible for:]

[(1) preventing, detecting, auditing, inspecting, reviewing, and investigating fraud, abuse, overpayments, and waste in the provision and delivery of Medicaid and all other state-administered HHS programs and services that are wholly or partly federally funded;]

[(2) minimizing the opportunity for fraud, abuse, overpayments, and waste within Medicaid and other HHS programs;]

[(3) protecting recipients of federally funded programs; and]

[(4) ensuring compliance with state law relating to the provision of health and human services.]

(a) [(e)] The OIG may take administrative enforcement measures against a person or an affiliate of a person based upon an investigation or finding, including an audit finding, in the Medicaid or other HHS programs. Administrative enforcement measures may include:

(1) making referrals for further investigation or action;

(2) taking an administrative action;

(3) imposing a sanction;

(4) assessing damages, penalties, costs related to an administrative appeal, and investigative and administrative costs; or

(5) denying the enrollment of a person for participation in the Medicaid program.

(b) [(d)] When the OIG receives information regarding a possible program violation or possible fraud, abuse, overpayment, or waste, the OIG conducts [~~will conduct~~] an investigation pursuant to Subchapter [~~subchapter~~] F of this chapter (relating to Investigations). If, at any point during its investigation, the OIG determines that an overpayment resulted without wrongdoing, the OIG may refer the matter for routine payment correction by the agency's fiscal agent or an operating agency or may offer a payment plan.

[(e)] When OIG conducts a risk analysis, creates an audit plan, or receives a request to conduct an audit service or agreed-upon procedure, OIG may initiate an audit service, singly or in combination with an investigation. OIG may also collaborate with other federal or state authorities in conducting audit services and enforcing audit findings and questioned costs.]

[(f)] OIG may take administrative actions, sanctions, or both against a person or an affiliate of a person who commits a program violation.]

[(1) In determining whether to open a full scale investigation or administer appropriate administrative actions and sanctions, OIG will consider:]

[(A) the nature of the program violation;]

[(B) evidence of knowledge and intent;]

[(C) the seriousness of the program violation;]

[(D) the extent of the violation;]

[(E) prior non-compliance issues;]

[(F) prior imposition of sanctions, damages, or penalties;]

[(G) willingness to comply with program rules;]

[(H) efforts to interfere with an investigation or witnesses;]

[(I) recommendations of peer review groups;]

[(J) program violations within Medicaid, Medicare, Titles V, XIX, XX, CHIP, and other HHS programs;]

[(K) pertinent affiliate relationships;]

[(L) past and present compliance with licensure and certification requirements;]

[(M) history of criminal, civil, or administrative liability. The lack of a prior record is considered neutral; and]

[(N) any other relevant information or analysis deemed appropriate by OIG.]

[(2) Administrative enforcement measures include:]

[(A) making referrals for further investigation or action;]

[(B) taking an administrative action;]

[(C) imposing a sanction;]

[(D) assessing damages, penalties, costs related to an administrative appeal, and investigative and administrative costs; or]

[(E) abating, denying, or postponing a decision to enroll a person for participation in the Medicaid program.]

[(3) OIG will determine by prima facie evidence that a person or affiliate has committed a program violation prior to taking administrative enforcement measures. Upon a credible allegation of fraud, however, OIG may impose the sanction of payment hold before establishing prima facie evidence.]

[(A) The medical director employed by OIG ensures 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 OIG imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.]

[(B) The dental director employed by OIG ensures 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 OIG imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.]

[(g) OIG has authority to settle any administrative issue or case. All settlement negotiations are confidential according to the protections in the Texas Government Code.]

(c) [(h)] At the OIG's sole discretion, overpayments may be collected in a lump sum or through installments. The OIG determines a reasonable length of time for a [OIG may collect recoupments by deducting them incrementally from prospective or retrospective payments owed to the person. A] payment plan based on [will be for a reasonable length of time as determined by OIG considering] the circumstances of each individual case.

(d) [(i)] Nothing in these rules is intended to prevent concurrent administrative, civil, or criminal investigation and action. Subject to express statutory limitations, the OIG may proceed with recoupment

or other administrative enforcement concurrently with judicial prosecution of the same matter.

(e) ~~[(f)]~~ An OIG case remains open until:

- (1) the investigation is complete;
- (2) the case is settled;
- (3) the OIG makes an administrative determination that closes the case for lack of evidence or appropriate administrative enforcement; or
- (4) all administrative remedies have been exhausted.

(f) In determining the appropriate administrative action or sanction, including the amount of any administrative penalty to assess, the OIG considers:

- (1) the seriousness of the violation;
- (2) the prevalence of errors by the provider;
- (3) the financial or other harm to the state or recipients; and
- (4) any aggravating or mitigating factors the OIG determines appropriate.

(g) The following may be considered as aggravating factors that warrant more severe or restrictive action by the OIG. Aggravating factors may include:

- (1) harm to one or more patients;
- (2) the severity of patient harm;
- (3) one or more violations that involve more than one patient;
- (4) economic harm to any individual or entity and the severity of such harm;
- (5) increased potential for harm to the public;
- (6) attempted concealment of the act constituting a violation;
- (7) intentional, premeditated, knowing, or grossly negligent act constituting a violation;
- (8) prior similar violations;
- (9) previous disciplinary action by a licensing board, any government agency, peer review organization, or health care entity;
- (10) violation of a licensing board or government agency order; or
- (11) other relevant circumstances increasing the seriousness of the misconduct.

(h) The following may be considered as mitigating factors that warrant less severe or restrictive action by the OIG. The provider shall have the burden to present evidence regarding any mitigating factors that may apply in the particular case. Mitigating factors may include:

- (1) self-reported and voluntary admissions of violation(s);
- (2) implementation of remedial measures to correct or mitigate harm from the violation(s);
- (3) acknowledgment of wrongdoing and willingness to cooperate with the OIG, as evidenced by acceptance of a settlement agreement;
- (4) rehabilitative potential;

(5) prior community service and present value to the community;

(6) other relevant circumstances reducing the seriousness of the misconduct; or

(7) other relevant circumstances lessening responsibility for the misconduct.

(i) Any administrative penalties assessed are determined as provided in §371.1715 of this chapter (relating to Damages and Penalties).

§371.1609. *Notice and Service.*

(a) Service of notice.

(1) When required by this subchapter, the OIG provides written notice by:

(A) hand delivery, in which case notice is presumed to be received on the date of delivery;

(B) certified mail with return receipt requested, in which case notice is presumed to be received on the date of the signature of the addressee or its agent on the return receipt or on the delivery date as reflected in the records of the United States Postal Service if the return receipt is unsigned or certified mail is unclaimed;

(C) registered mail, in which case notice is presumed to be received on the date of delivery as reflected in the records of the United States Postal Service;

(D) fax with confirmation page, in which case notice is presumed to be received on the date of the confirmation of the fax; or

(E) regular mail plus one of the other methods enumerated in subparagraphs (A) - (D) of this paragraph.

(2) Notice may be delivered to the subject of the OIG action, any affiliate of the subject, the subject's authorized representative, or any adult at the subject's address of record. Receipt by any of these persons is ~~will be~~ effective as against the provider or person subject to the OIG action.

(3) Notice provided in any manner as provided for in this section constitutes prima facie evidence of proper notice of agency action.

(b) Contents of Notice. The OIG notices~~;~~ generally~~;~~ will include, as applicable:

(1) a description of the action or potential action being taken, including any financial amounts at issue;

(2) the basis of the action or potential action;

(3) the effect of the action or potential action;

(4) the duration of the action;

(5) a statement regarding the person's due process rights and the right to submit additional evidence or information for consideration, if applicable; and

(6) any additional information required by statute or this subchapter.

(c) Documents sent to the OIG are considered received by the OIG only when received by 5:00 p.m. on a business day. A document received after 5:00 p.m. on a business day is considered received on the next business day.

§371.1611. *Due Process.*

(a) The OIG affords to any provider or person against whom it imposes sanctions the administrative due process remedies applicable to administrative sanctions as set forth in this subchapter.

(b) The imposition of administrative actions as defined in §371.1701 of this subchapter (relating to Administrative Actions) does not give rise to due process remedies.

§371.1613. *Informal Resolution Process.*

(a) A person who is served a notice of intent to impose a sanction or notice of a payment hold may request an informal resolution meeting (IRM) to discuss the issues identified by the OIG in the notice.

(b) A written request for an IRM must:

(1) be sent by certified mail to the address specified in the notice letter;

(2) arrive at the address specified in the notice of intent to impose the sanction no later than:

(A) for a payment hold, ten [~~10~~] days after service on the person of the notice of payment hold<sub>2</sub>[-];

(B) for any sanction other than a payment hold or notice of recoupment of overpayment or debt, 30 days after service on the person of the notice<sub>2</sub> or[-];

(C) for a notice of recoupment or overpayment or debt, a person may request an IRM any time prior to the issuance of the final notice<sub>2</sub>[-];

(3) include a statement as to the specific issues, findings, and/or legal authority in the notice letter with which the person disagrees, and, in the case of a payment hold, why an IRM would be beneficial for the resolution of the case;

(4) state the basis for the person's contention that the specific issues or findings and conclusions of the OIG are incorrect; and

(5) be signed by the person or an attorney for the person. No other person or party may request an IRM for or on behalf of the subject of the sanction.

(c) On timely request for an initial IRM:

(1) For [~~for~~] any sanction other than a payment hold, the OIG schedules [~~OIG shall schedule~~] the IRM and gives [~~give~~] notice of the time and place of the meeting.

(2) For [~~for~~] a request based on a payment hold, the OIG decides [~~OIG shall decide~~] whether to grant the provider's request for an IRM and, if the OIG decides to grant the IRM, the OIG schedules [~~OIG shall schedule~~] the IRM and notice of the time and place of the meeting.

(d) A person may also submit to the OIG any documentary evidence or written argument regarding whether the sanction is warranted. Documentary evidence or written argument that may be submitted is not necessarily controlling upon the OIG, however.

(e) A written request for an IRM may be combined with a request for an administrative hearing, if a person is entitled to such hearing, and if it meets the requirements of this subchapter. If both an IRM and an administrative hearing have been requested by a person entitled to both, the informal resolution process shall run concurrently with the administrative hearing process, and the administrative hearing process may not be delayed on account of the informal resolution process.

(f) Upon written request of a provider, the OIG provides [~~OIG will provide~~] for a recording of an IRM at no expense to the provider who requested the meeting. The recording of an IRM is [~~will be~~] made available to the provider who requested the meeting. The OIG does

[~~OIG shall~~] not record an IRM unless the OIG receives a written request from a provider.

(g) Notwithstanding Texas Government Code §531.1021(g), an IRM is confidential, and any information or materials obtained by the OIG, including the OIG's employees or agents, during or in connection with an IRM, including a recording, are privileged and confidential and may not be subject to disclosure under Chapter 552, Texas Government Code, or any other means of legal compulsion for release, including disclosure, discovery, or subpoena.

§371.1615. *Appeals.*

(a) A person who is served with final notice of a sanction may appeal the imposition of the sanction.

(b) Request for hearing.

(1) A request for an administrative hearing at HHSC Appeals Division or at SOAH on a final notice of overpayment, must be received in writing by the OIG no later than 30 days after the date the person is served the final notice.

(2) A request for an administrative hearing at HHSC Appeals Division on a Final Notice of Contract Cancellation, Final Notice of Exclusion, or Notice of Final Assessment of Administrative Penalties must be received in writing by the OIG no later than 15 days after the date the person is served the notice.

(3) A request for an expedited administrative hearing at SOAH on a payment hold must be received in writing by the OIG no later than ten [~~10~~] days after the date the person is served the notice.

(4) A written request for an administrative hearing must:

(A) be sent by certified mail to the address specified in the notice letter;

(B) timely arrive at the address specified in the final notice; and

(C) be signed by the person or an attorney for the person. No other person or party may request a hearing for or on behalf of the subject of the sanction.

(5) Other than a final notice of overpayment or payment hold, an administrative hearing for a final notice of a sanction is [~~will be~~] held at the HHSC Appeals Division.

(6) The costs for an administrative hearing held at SOAH is [~~will be~~] borne by the OIG, but a provider is responsible for the provider's own costs incurred in preparing for the hearing.

(7) All other costs incurred by either party, including attorney's fees, transcript copies, expert fees, and deposition costs, is [~~will be~~] the responsibility of the party incurring those costs.

(8) The OIG contacts [~~OIG will contact~~] the HHSC Appeals Division or SOAH to request that the hearing be docketed. The OIG files [~~OIG will file~~] a docketing request for a payment hold hearing with SOAH not later than the third [~~3rd~~] day after the hearing is requested.

(c) If a person who has been served notice of a final sanction or notice of a payment hold fails to timely request an administrative hearing, the sanction becomes [~~will become~~] final and unappealable.

§371.1617. *Finality and Collections.*

(a) Unless otherwise provided in this subchapter, a sanction becomes final upon any of the following events:

(1) expiration of 30 calendar days after service [~~receipt~~] of the notice of final sanction [~~or notice of a payment hold~~] if no [~~timely~~]

request for appeal of imposition of the sanction is received by the OIG by the 30th calendar day after service [OIG];

(2) execution of a settlement agreement with the OIG; or

(3) a final order entered by the Executive Commissioner or his designee after an administrative [contested case] hearing.

(b) The effect of a final sanction resulting in recoupment, [restricted reimbursement], assessment of damages, penalties, recoupment of audit overpayments, or other financial recovery is to create a final debt in favor of the State [of Texas]. Within 30 days after the date on which the sanction becomes final, the person must:

(1) pay the amount of the overpayment, assessment of damages, penalties, or other costs;

(2) negotiate and execute a payment plan, the terms of which are granted at the sole discretion of the OIG; or

(3) file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty.

(c) If a final payment plan agreement is not executed by all parties or full restitution is not received within 30 calendar days after finality, the debt is [will be] delinquent and one or more vendor holds may be placed on the provider's payment claims and account by HHSC, the Medicaid/CHIP division, the state Comptroller, the OAG Collection Division, or any other state agency with authority to interrupt payments in satisfaction of a debt to the state.

(d) The OIG may, at its sole discretion, agree to suspend any vendor holds pending negotiations of payment plan terms.

(e) When a debt is delinquent, the OIG may collect funds owed. Collection methods may include:

(1) placing the person on prepayment or postpayment hold. Funds withheld by a payment hold may be used to satisfy any portion of an unpaid assessment of overpayments, damages, or penalties;

(2) using a collection agency;

(3) collecting from Medicare for Medicaid debts;

(4) requesting the State Comptroller to place a hold on all state voucher revenue for the person from all state agencies;

(5) requesting the OAG's Collection Division to file suit in district court or engage in other collection efforts;

(6) requesting the OAG to seek an injunction prohibiting the person from disposing of an asset(s) identified by the OIG as potentially subject to recovery due to the person's fraud, waste, or abuse;

(7) applying any funds derived from forfeited asset(s), after offsetting any expenses attributable to the sale of those assets; and

(8) receiving and reporting credit information on a person with outstanding debts.

*§371.1619. Award for Reporting Medicaid Fraud, Waste, Abuse, or Overcharges.*

(a) The OIG may grant an award to a person who reports activity that constitutes fraud, waste, or abuse of funds in the Medicaid program or reports overcharges in the program if the OIG determines that the disclosure results in the recovery of a damage or penalty imposed under §32.039, Texas Human Resources Code, and described in this subchapter. Unless the person is the original source of the information as defined in §36.113(b), Texas Human Resources[;] Code, the OIG may not grant an award to a person in connection with a report if:

(1) The OIG or the OAG had independent knowledge of the activity;

(2) The OIG or the OAG had an open complaint or investigation on the provider or person;

(3) the state or any agent of the state was a party to civil or criminal proceedings in which the allegations were disclosed;

(4) the allegations were disclosed in a legislative or administrative report, hearing, audit, or investigation; or

(5) the allegations were disclosed by the news media.

(b) A person who brings an action under Chapter 36, Subchapter C, Texas Human Resources Code is not eligible for an award under this section.

(c) A person who makes a report under this section must make known at the time of the report of the complaint that they are reporting the potential fraud, waste, or abuse in accordance with this section.

(d) The OIG determines, at its discretion, the amount of an award. The award may not exceed five percent [5%] of the amount of the administrative damage or penalty collected under this subchapter that resulted from the person's disclosure. In determining the amount of the award, the OIG considers how important the disclosure was in ensuring the fiscal integrity of the program. The OIG may also consider whether the individual participated in the fraud, waste, abuse, or overcharge.

(e) The OIG pays an award made under this section only after collecting the funds to be awarded. Recovery of funds, including overpayments, damages and penalties, and any other collections from the provider or person committing the fraud, waste, or abuse, is applied in the following order:

(1) the overpayment;

(2) refund of the federal share of any overpayment, damages, or penalties;

(3) the OIG's method of finance [OIG's "method of finance"] from the collected damages and penalties;

(4) the OIG's investigative costs from the collected damages and penalties;

(5) other costs of recovery from the collected damages and penalties;

(6) an award from the collected damages and penalties; and

(7) any other accounts receivable against the person or provider.

(f) The priority of application and distribution of the collected funds under subsection (e) of this section may be altered, at the discretion of the OIG, due to state or federal statute or other policy determinations.

(g) The OIG calculates awards based on the collected state general revenue portion of the penalties and damages. If HHSC [the Commission] enters into global or national settlements where the federal government or other agencies receive a portion of the amount of damages or penalties, the award is [only] calculated only on the remaining state general revenue share collected.

(h) The OIG does not award a distribution unless the OIG has met its ["method of finance"] threshold for the biennium, as defined in the General Appropriations Act, from damages and penalties collected under this subchapter.

(i) The person reporting a complaint has no discretion or authority over the [an] OIG decision to allow a payment plan or to decide the terms of the payment plan.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 15, 2016.

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Karen Ray

Chief Counsel

Texas Health and Human Services Commission

Earliest possible date of adoption: February 28, 2016

For further information, please call: (512) 424-6900



## 1 TAC §371.1607

### Legal Authority

The repeal is proposed under Texas Government Code §531.102(a-2), which requires the Executive Commissioner to work in consultation with the Office of Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program.

The repeal implements Texas Government Code Chapter 531, as amended by S.B. 207. No other statutes, articles, or codes are affected by the proposal.

### §371.1607. Definitions.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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Karen Ray

Chief Counsel

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## DIVISION 2. GROUNDS FOR ENFORCEMENT

### 1 TAC §§371.1651, 371.1653, 371.1655, 371.1657, 371.1659, 371.1663, 371.1665, 371.1667, 371.1669

### Legal Authority

The amendments are proposed under Texas Government Code §531.102(a-2), which requires the Executive Commissioner to work in consultation with the Office of Inspector General

to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program.

The amendments implement Texas Government Code Chapter 531, as amended by S.B. 207. No other statutes, articles, or codes are affected by the proposal.

### §371.1651. Provider Eligibility.

A person is subject to administrative actions or sanctions if the person:

(1) is suspended, terminated, or otherwise sanctioned by Medicare, Medicaid, another HHS program, CHIP, or any state or federally funded health care program;

(2) is affiliated with a person who has been suspended, terminated, or otherwise prohibited from participating in Medicare, Texas Medicaid, CHIP, or other HHS program;

(3) is a provider and any person with an ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or Title XXI program in the last ten [40] years;

(4) is a person with an ownership or control interest in a provider or is an agent or managing employee of the provider and fails to:

(A) disclose or submit timely and accurate information, including fingerprints if required by federal or state rule, statute, regulation, or published policy; or

(B) cooperate with any and all screening methods required during the provider screening process under statute or regulation;

(5) is a provider, has an ownership or control interest in a provider, or is an agent or managing employee of a provider and fails to:

(A) submit timely and accurate information, including fingerprints if required by CMS or state rule; and

(B) cooperate with any and all screening methods required during the provider screening process as provided by statute, rule, or regulation;

(6) is a provider or person with an ownership interest in the provider and fails to timely submit sets of fingerprints during the provider screening process as required by rule, statute, or other regulation;

(7) fails to permit access to any and all provider locations for unannounced or announced on-site visits or inspections during the provider screening process as required by rule, statute, or other regulation;

(8) falsifies any information provided on a provider enrollment application;

(9) is a provider whose identity CMS or the OIG is unable to verify;

(10) has a criminal history that would result in denial of a provider enrollment application pursuant to rule;

(11) fails to disclose or omits any material fact on a provider enrollment application;

(12) fails to meet standards required for licensure or loses licensure, as finally determined by the licensing authority, when such licensure is required by state or federal law, administrative rule, provider agreement, or provider manual for participation in the Medicaid or other HHS program;

(13) fails to fully and accurately make any disclosure required by the Social Security Act §1124 or §1126;

(14) fails to identify or disclose in the provider screening process for any HHS program:

(A) all persons with a direct or indirect ownership or control interest, as defined by 42 C.F.R. [CFR] §455.101;

(B) all information required to be disclosed in accordance with state administrative rule, 42 C.F.R. [CFR] Part 1001, or other by statute, rule, or regulation;

(C) all agents or subcontractors of the provider:

(i) if the provider or a person with an ownership interest in the provider has an ownership interest in the agent or subcontractor; or

(ii) if the provider engages in a business transaction with the agent or subcontractor that meets the criteria specified by 42 C.F.R. [CFR] §455.105;

(15) makes a false statement, misrepresentation or omission of a pertinent fact on, or fails to fully or correctly complete or execute a provider enrollment application, provider agreement or amendment, reinstatement request or any document requested as a prerequisite for Medicaid or other HHS program participation; or

(16) fails to timely correct, supplement, or update information on a provider enrollment application, provider agreement or amendment, reinstatement request, or any document requested as a prerequisite for continued Medicaid or other HHS program participation, including:

(A) change of mailing address;

(B) fax number;

(C) loss or forfeiture of corporate charter; or

(D) change in ownership.

§371.1653. *Claims and Billing.*

A person is subject to administrative actions or sanctions if the person submits, or causes to be submitted, a claim for payment by the Medicaid or other HHS program:

(1) for an item or service for which the person knew or should have known the claim or cost report was false or fraudulent;

(2) for an item or service that was not provided as claimed;

(3) for an item or service that requires prior authorization, prior order, or prescription, where prior authorization, prior order, or prescription was not properly obtained, including where prior authorization, prior order, or prescription requirements were met by misrepresentation or omission;

(4) for an item or service that requires the name and National Provider Number of the supervising, ordering, or referring person for prior authorization, where the correct name and National Provider Number of the supervising, ordering, or referring person were not provided;

(5) based on a code that would result in greater payment than the code applicable to the item or service that was actually provided;

(6) for an item or service that was not coded, bundled, or billed in accordance with standards required by statute, regulation, contract, Medicaid or other HHS program policy or provider manual, and that, if used, has the potential of increasing any individual or state provider payment rate or fee;

(7) for an item or service that was not reimbursable by, permitted by, or associated with the Medicaid or other HHS program, including an item or service substituted without authorization by the Medicaid or other HHS program and a prescription drug substituted without authorization by an HHS program;

(8) for any order or prescription in which a false statement, misrepresentation, or omission of pertinent facts was made by the ordering or prescribing person on a claim, attachments to a claim, medical record, documentation used to adjudicate a claim for payment or to support representations on cost reports, used by the provider to show the medical necessity, or on documents used to establish fees, daily payment rates, or vendor payments;

(9) for an item or service where the charges for that item or service exceed ~~are in excess of~~ the usual and customary fee the person charges to the public, privately insured persons, or private-pay persons for the same item or service, including a claim submitted under Title XVIII (Medicare);

(10) for an item or service where the charges or costs for that item or service were discounted for the public, privately insured persons, or private-pay persons for the same item or service, including a claim submitted under Title XVIII (Medicare);

(11) for an item or service that is furnished, prescribed, or otherwise ordered or presented by a person that is excluded, terminated, or otherwise prohibited from participation in an HHS program or any state or federally funded health care program, except an order or prescription that was:

(A) written before the exclusion or termination of a physician or other practitioner legally authorized to write a prescription; and

(B) delivered within 30 days of the effective date of such exclusion or termination;

(12) for a home health service for which no in-person evaluation of the recipient was performed within the 12-month period preceding the date of the order or other authorization for the home health service;

(13) for durable medical equipment for which the physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse-midwife that ordered or otherwise authorized the durable medical equipment has failed to certify on the order or authorization that he or she conducted an in-person evaluation of the recipient within the 12-month period preceding the date of the order or other authorization;

(14) for an item or service for which the provider knowingly made, used, or caused the making or use of a false record or statement material to an obligation to pay or transmit money or property to this state under the Medicaid program, or knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to this state under the Medicaid program;

(15) for an item or service that constitutes a violation of §32.039(b) or §36.002 [sections §32.039(b) or 36.002] of the Texas Human Resources Code;

(16) for an item or service rendered to a child who was not accompanied by an authorized adult or who was accompanied by the provider or its affiliate to treatment; or

(17) for damages, costs, or penalties collected or assessed by the OIG.

§371.1655. *Program Compliance.*

A person is subject to administrative actions or sanctions if the person:

(1) is excluded or terminated for cause on or after January 1, 2011, under Title XVIII of the Social Security Act or under the Medicaid program or CHIP of any other state;

(2) commits an act for which sanctions, damages, penalties, or liability could be or are assessed by the OIG;

(3) fails to repay overpayments or other assessments after receiving written notice of the overpayment or of delinquency by the OIG or any HHS program or HHS agency;

(4) fails to repay overpayments within 60 calendar days of self-identifying or discovering an overpayment that was made to the person by the Medicaid, CHIP or other HHS program;

(5) fails to comply, when required for participation in Medicaid or other HHS program or award, with financial record and supporting document retention requirements designed to ensure that a person's claims or costs may be reviewed objectively for accuracy and validity. Such requirements include compliance with:

(A) United States Office of Management and Budget (OMB) [~~OMB~~] circulars;

(B) generally accepted accounting principles (GAGAS);

(C) state or federal law; or

(D) contractual requirements;

(6) fails to comply, when required for participation in Medicaid or other HHS program or award, with standards or requirements related to allowable and valid expenses and costs, including requirements related to cost allocation methodologies and the correct application of cost allocation methodologies. Such standards include compliance with:

(A) OMB circulars;

(B) GAGAS;

(C) state or federal law; or

(D) contractual requirements;

(7) fails to establish an effective compliance program for detecting criminal, civil, and administrative violations, that promotes quality of care, contains appropriate protection for whistleblowers, and contains the core elements identified in the federal sentencing guidelines for corporations or established by the United States Secretary of Health and Human Services;

(8) fails to ensure that items or services furnished personally by, at the direction of, or on the prescription or order of an excluded person are not billed to the Titles V, XIX, XX, or CHIP programs after the effective date of the person's exclusion, whether the exclusion was imposed directly or through an MCO, or through an individual or a group billing number;

(9) fails to comply with Medicaid or other HHS program policy, a published medical assistance or other HHS program bulletin, a policy notification letter, a provider policy or procedure manual, a contract, a statute, a rule, a regulation, or an interpretation previously published or sent to the provider by an operating agency or the Commission, including statutes or standards governing occupations;

(10) fails to comply with the terms of Medicaid or other HHS program contract, provider enrollment application, provider agreement or amendment, assignment agreement, the provider certification on Medicaid or other HHS program claim form or rules or regulations published by the Commission or the medical assistance program or other HHS operating agency;

(11) enrolls as a provider as a corporation and loses or forfeits its corporate charter, and fails to obtain reinstatement retroactive to the time of the original loss or forfeiture;

(12) was found liable in a court judgment, assumed liability for repaying an overpayment in a settlement agreement or was convicted of a violation relating to performance of a provider agreement or program violation of Medicare, Texas Medicaid, other HHS program, or any other state's Medicaid program;

(13) fails to comply with any provision of the Texas Human Resources Code Chapter 32 or 36, the Texas Government Code, the Texas Health and Safety Code, or any rule or regulation issued under those codes;

(14) fails to abide by applicable federal and state law regarding persons with disabilities or civil rights;

(15) fails to correct deficiencies in provider operations, medical care, billing, records management, or reporting after receiving written notice of them from an operating agency, the Commission, or their authorized agents;

(16) defaults on repayments of scholarship obligations or items relating to health profession education made or secured, in whole or in part, by the United States Department of Health and Human Services [HHS] or the state when all reasonable steps have been taken to secure repayment;

(17) fails to notify and reimburse the relevant operating agency or the Commission or their agents for services paid by Medicaid or other HHS program if the provider also receives reimbursement from a liable third party;

(18) requests from a third party liable for payment of the services or items provided to a recipient under Medicaid or other HHS program, any payment other than as authorized by 42 C.F.R. [CFR] §447.20;

(19) unless otherwise allowed by law, solicits recipients or causes recipients to be solicited, through offers of transportation or otherwise, for the purpose of delivering to those recipients health care items or services or solicits for treatment or treats a child who was not accompanied by an authorized adult or who was accompanied by the provider or its affiliate to treatment;

(20) fails to include within any subcontracts for services or items to be delivered within Medicaid all information that is required by 42 C.F.R. [CFR] §434.10(b);

(21) fails, as a hospital, to comply substantially with a corrective action required under 42 U.S.C. §1395ww(f)(2)(B) [the Social Security Act, §1886(f)(2)(B)];

(22) commits an act described as grounds for exclusion under 42 U.S.C. §1320a-7(a) [in the Social Security Act, §1128A]

(civil monetary penalties for false claims) or 42 U.S.C. §1320a-7(b) [§H28B] (criminal liability for health care violations);

(23) could be excluded for any reason for which the Secretary of the United States [U.S.] Department of Health and Human Services or its agent could exclude such person under 42 U.S.C. §1320a-7(a) (mandatory exclusion), 42 U.S.C. §1320a-7(b) (permissive exclusion), or 42 C.F.R. Part [CFR Parts] 1001 or 1003;

(24) prevents, obstructs, impedes, or attempts to impede the OIG or any other federal or state agency, division, agent, or consultant from conducting any duties that are necessary to the performance of their official functions;

(25) fails to screen all employees and contractors for exclusions from the Medicaid or other HHS program on a monthly basis and to confirm that no employees or contractors are excluded individuals or entities;

(26) fails to document that the provider and its employees and contractors are not excluded;

(27) fails to immediately inform the OIG after identification of an excluded employee;

(28) fails to immediately inform the OIG when the provider takes any action against an employee or contractor, including suspension actions, settlement agreements, and situations where an individual or entity voluntarily withdraws from the program to avoid a formal sanction;

(29) fails to refund Medicaid for funds spent, if any, for an excluded person's salary, expenses, or fringe benefits paid during the period of exclusion if those funds were reflected or calculated into a cost report or any other document used by the state to determine an individual payment rate, a statewide payment rate, or a fee;

(30) commits any act or omission described in:

(A) 42 C.F.R. [CFR] §1001.801 (failure of health maintenance organizations [HMOs] and Competitive Medical Plans [CMPs] to furnish medically necessary items or services);

(B) 42 C.F.R. [CFR] §1001.901 (false or improper claims);

(C) 42 C.F.R. [CFR] §1001.951 (fraud and kickbacks and other prohibited activities);

(D) 42 C.F.R. [CFR] §1001.1001 (exclusion of entities owned or controlled by a sanctioned person);

(E) 42 C.F.R. [CFR] §1001.1051 (exclusion of individuals with ownership or control interest in sanctioned entities);

(F) 42 C.F.R. [CFR] §1001.1101 (failure to disclose certain information);

(G) 42 C.F.R. [CFR] §1001.1501 (default of health education loan or scholarship obligations);

(H) 42 C.F.R. [CFR] §1001.1601 (violations of the limitations on physician charges); or

(I) 42 C.F.R. [CFR] §1001.1701 (billing for services of assistant at surgery during cataract operations); or

(31) commits or conspires to commit a violation of §32.039(b) [section 32.039(b)] of the Texas Human Resources Code.

§371.1657. Unallowable Fiscal Gain.

A person is subject to administrative actions or sanctions if the person:

(1) requests payment from a recipient for services or items delivered within the Medicaid or other HHS program when payment for the services was recouped by Medicaid or another HHS program for any reason;

(2) requests payment from recipients for services or items furnished [by], directed [by], ordered, or prescribed by an excluded person without first:

(A) informing the recipient, before delivery of the item or service, that those services are not reimbursable by the Medicaid or other HHS program; and

(B) obtaining and retaining, before delivery of the item or service, a written signed consent from the recipient indicating that the recipient understands he or she is responsible for payment for the services and that the services or items are still desired;

(3) misapplies, misuses, embezzles, converts, steals, or fails to promptly release upon a valid request, or fails to keep detailed receipts of expenditures relating to any funds or other property in trust for a Medicaid or other HHS program recipient;

(4) causes or permits the embezzlement, misuse, misapplication, improper withholding, conversion, or misappropriation of Medicaid or Medicaid-related funds:

(A) while the Medicaid provider is bankrupt, in receivership, or insolvent;

(B) rendering the Medicaid provider insolvent by such act; or

(C) deepening or contributing to the insolvency of the Medicaid provider by such act;

(5) requests payment from a recipient for services or items delivered within the Medicaid or other HHS program for any amount that exceeds the amount Medicaid or other HHS program paid for such services or items, with the exception of any cost-sharing authorized by the program;

(6) markets, offers, supplies, or sells confidential information, including recipient names, Medicaid recipient identification numbers, and other recipient information, for a use that is not expressly authorized by a Medicaid or other HHS program;

(7) discloses a recipient's protected health information to any person in exchange for direct or indirect remuneration, except that a person may disclose a recipient's protected health information:

(A) to a covered entity as defined by §181.001 of the Texas Health and Safety Code or to a covered entity as that term is defined by §602.001 of the Texas Insurance Code for the purpose of:

(i) treatment;

(ii) payment;

(iii) health care operations; or

(iv) performing an insurance or health maintenance organization function as described by §602.053 of the Texas Insurance Code; or

(B) as otherwise authorized by state or federal law.

§371.1659. Compliance with Health Care Standards.

A person is subject to administrative actions or sanctions if the person:

(1) engages in any negligent or abusive practice that results in death, injury, or substantial probability of death or injury to a recipient;

(2) fails to provide an item or service to a recipient in accordance with accepted medical community standards or standards required by statute, regulation, or contract, including statutes and standards that govern occupations;

(3) furnishes or orders services or items for a recipient under the Medicaid or other HHS program that substantially exceed a recipient's needs, are not medically necessary, are not provided economically or are of a quality that fails to meet professionally recognized standards of health care;

(4) is the subject of a voluntary or involuntary action taken by a licensing or certification agency or board, which action is based upon the agency or board's receipt of evidence of noncompliance with licensing or certification requirements;

(5) has its license to provide health care revoked, suspended, or probated by any state's licensing or certification authority, or surrenders a license or certification while a formal disciplinary proceeding is pending before any state's licensing or certification authority;

(6) fails to abide by applicable statutes and standards governing providers;

(7) fails to comply with the security, privacy, marketing, disclosure, notification, business associate and breach requirements of HIPAA [the Health Insurance Portability and Accountability Act (HIPAA)] and regulations promulgated under HIPAA or the Texas Medical Records Privacy Act in chapter 181 of the Texas Health and Safety Code and regulations promulgated under that Act;

(8) fails to timely provide notice of electronic disclosure to a recipient for whom the person creates or receives protected health information that is subject to electronic disclosure;

(9) electronically discloses or permits the electronic disclosure of a recipient's protected health information to any person without a separate, documented authorization from the recipient or the recipient's legally authorized representative for each disclosure, unless the disclosure is:

(A) to a covered entity as defined by §181.001 of the Texas Health and Safety Code or to a covered entity as that term is defined by §602.001 of the Texas Insurance Code for the purpose of:

(i) treatment;

(ii) payment;

(iii) health care operations; or

(iv) performing an insurance or health maintenance organization function as described by §602.053 of the Texas Insurance Code; or

(B) as otherwise authorized by state or federal law;

(10) employs any treatment modality that has been declared unsafe or ineffective by the Food and Drug Administration [(FDA)], CMS, the Public Health Service [(PHS)], or other state or federal agency with regulatory authority; or

(11) fails to comply with eligibility or meaningful use or other standards of the Health Information Technology for Economic and Clinical Health [(HITECH)] Act incentive programs and regulations promulgated under the Act.

§371.1663. *Managed Care.*

A person is subject to administrative action or sanctions if the person:

(1) is an MCO or an MCO provider and fails to provide a health care benefit, service, or item that the MCO or MCO provider is

required to provide according to the terms of its contract with an operating agency, its fiscal agent, or other contractor [~~contract~~] to provide health care services to Medicaid or HHS program recipients;

(2) is an MCO or MCO provider and fails to provide to an individual a health care benefit, service, or item that the MCO or MCO provider is required to provide by state or federal law, regulation, or program rule;

(3) is an MCO and engages in actions that indicate a pattern of wrongful denial, excessive delay, barriers to treatment, authorization requirements that exceed professionally recognized standards of health care, or other wrongful avoidance of payment for a health care benefit, service or item that the organization is required to provide under its contract with an operating agency;

(4) is an MCO and engages in actions that cause a delay in making payment for a health care benefit, service or item that the organization is required to provide under its contract with an operating agency, and the delay results in processing or paying the claim on a date later than that allowed by the MCO's contract;

(5) is an MCO or MCO provider and engages in fraudulent activity or misrepresents or omits material facts in connection with the enrollment in the MCO's managed care plan of an individual eligible for medical assistance or in connection with marketing the organization's services to an individual eligible for medical assistance;

(6) is an MCO or MCO provider and receives a capitation payment, premium, or other remuneration after enrolling a member in the MCO's managed care plan whom [~~who~~] the MCO knows or should have known is not eligible for medical assistance;

(7) is an MCO or MCO provider and discriminates against MCO-enrollees or prospective MCO-enrollees in any manner, including marketing and disenrollment, and on any basis, including, without limitation, age, gender, ethnic origin, or health status;

(8) is an MCO or MCO provider and fails to comply with any term of a contract with a Medicaid or other HHS program or operating agency or other contract to provide health care services to Medicaid or HHS program recipients and the failure leads to patient harm, creates a risk of fiscal harm to the state, or results in fiscal harm to the state;

(9) is an MCO or an MCO provider and fails to provide, in the form requested, to the relevant operating agency or its authorized agent upon written request, accurate encounter data, accurate claims data, or other information contractually or otherwise required to document the services and items delivered by or through the MCO to recipients;

(10) is an MCO or an MCO provider and files a cost report or other report with the Medicaid or other HHS program that violates any of the cost report violations in §371.1665 of this division (relating to Cost Report Violations);

(11) is an MCO or MCO provider and misrepresents, falsifies, makes a material omission, or otherwise mischaracterizes any facts on a request for proposal, contract, report, or other document with respect to the MCO's ownership, provider network, credentials of the provider network, affiliated persons, solvency, special investigative unit, plan for detecting and preventing fraud, waste, or [~~and~~] abuse, or any other material fact;

(12) is an MCO or MCO provider and fails to maintain the criteria and conditions supporting an application and grant of a waiver to HHSC, or fails to demonstrate the results that were contemplated, based upon representations by the MCO or provider in its proposal submissions or contract negotiations when the waiver was granted, if the

failure is related to representations made by the MCO in its proposal, readiness review, contract, marketing materials, audit management responses, or other written representation submitted to the state, and the failure leads to patient harm, creates a risk of fiscal harm to the state, or results in fiscal harm to the state;

(13) is an MCO or MCO provider and misrepresents, falsifies, makes a material omission, or otherwise mischaracterizes any facts on a patient assessment or any other document that would have the effect of increasing the MCO's capitation or reimbursement rate, would increase incentive payments or premiums, would decrease the amount of capitation at risk, or would decrease the experience rebate owed to the Medicaid program;

(14) is an MCO or MCO provider and fails to simultaneously [~~immediately and contemporaneously~~] notify the OIG and the OAG in writing of the discovery of fraud, waste, or abuse in the Medicaid or CHIP program;

(15) is an MCO and fails to ensure that any payment recovery efforts in which the MCO engages are in accordance with applicable law, contract requirements, or [~~and~~] other applicable procedures established by the Executive Commissioner or the OIG;

(16) is an MCO and engages in payment recovery of an amount sought that exceeds \$100,000 and that is related to fraud, waste, or abuse in the Medicaid or CHIP program:

(A) without first [~~immediately and contemporaneously~~] notifying the OIG and the OAG in writing of the discovery of fraud, waste, or abuse in the Medicaid or CHIP program;

(B) within ten [40] business days after notifying the [~~notification of~~] OIG or the OAG of the discovery of fraud, waste, or abuse in the Medicaid or CHIP program; or

(C) after receipt of a notice from the OIG or the OAG indicating that the MCO is not authorized to proceed with recovery efforts;

(17) is an MCO and fails to timely submit an accurate monthly [a quarterly] report to the OIG detailing the amount of money recovered after any and all payment recovery efforts engaged in as a result of the discovery of fraud, waste, or abuse in the Medicaid or CHIP program;

(18) notwithstanding the terms of any contract, is an MCO or MCO provider and fails to timely comply with the requirements of the Texas Medicaid Managed Care program or with the terms of the MCO contract with HHSC [~~the Commission~~] or other contract to provide health care services to Medicaid or HHS program recipients, and the failure leads to patient harm, creates a risk of fiscal harm to the state, or results in fiscal harm to the state;

(19) is an MCO or MCO provider and engages in marketing services in violation of §531.02115 [~~section 531.02115~~] of the Texas Government Code, the program rules or contract and has not received prior authorization from the program for the marketing campaign;

(20) is an MCO or an MCO provider and fails to use prior authorization and utilization review processes to reduce authorizations of unnecessary services and inappropriate use of services; [~~or~~]

(21) is an MCO or MCO provider and commits or conspires to commit a violation of §32.039(b) [~~section 32.039(b)~~] of the Texas Human Resources Code; [~~-~~]

(22) is an MCO and fails to implement or release a payment hold as directed by the OIG or to report accurate payment hold amounts to the OIG;

(23) is an MCO and fails to comply with any provision in Chapter 353, Subchapter F of this title (relating to Special Investigative Units) or Chapter 370, Subchapter F of this title (relating to Special Investigative Units); or

(24) is an MCO and releases information pertaining to an OIG investigation of a provider.

§371.1665. Cost Report Violations.

A person is subject to administrative actions or sanctions if the person:

(1) reports costs of non-covered or non-chargeable health care or administrative services, supplies, equipment, or other unallowable expenses in a cost report;

(2) incorrectly apportions or allocates costs in a cost report;

(3) reports costs of unallowable health care or administrative services, supplies, or equipment as allowable costs in a cost report;

(4) reports costs of health care services, supplies, or equipment that were not delivered to the recipient;

(5) reports costs of administrative services, supplies, or equipment that were not actually incurred;

(6) engages in an arrangement between providers and employees, related parties, independent contractors, suppliers, and/or others that appear to be designed to overstate the costs to the program through any device (such as commissions or fee splitting) or to siphon off or conceal illegal profits;

(7) reports costs in a cost report that were not incurred, that were incurred at a discount or lesser cost than that which was reported, or that were attributable to non-program activities, other enterprises, or personal expenses;

(8) manipulates or falsifies statistics that result in overstatement of costs or avoidance of recoupment, including incorrectly reporting square footage, hours worked, revenues received, or units of service delivered;

(9) claims bad debts without first attempting to collect payment;

(10) depreciates assets that have been fully depreciated or sold, or uses an incorrect basis for depreciation;

(11) affiliates with, retains, or employs a person excluded from participation in Medicare, Medicaid, or other HHS program and includes the salary, fringe, overhead, or any other costs associated with the excluded person within a cost report or any documents used to determine a person's payment rate, a statewide payment rate, or a fee;

(12) reports a cost above the cost actually paid to a related party;

(13) reports a damage, cost, or penalty collected by the OIG as an allowable expense in a cost report;

(14) minimizes or understates profits on a cost report;

(15) manipulates or understates profits on a cost report in a manner that reduces the experience rebate that would have been owing to the state;

(16) manipulates or falsifies supporting documentation related to a cost report, including the use of market data rather than actual expenses; or

(17) manipulates or falsifies any cost report supporting documentation including medical loss statistics, annual statements, encounter data, cash disbursement journal entries, or annual reports.

§371.1667. *Records and Documentation.*

A person is subject to administrative actions or sanctions if the person:

(1) fails to make, maintain, retain, or produce adequate documentation according to Medicaid or other HHS policy, state or federal law, rule or regulation, or contract for a minimum period of:

(A) five years from the date of service or until all audit questions, administrative hearings, investigations, court cases, or appeals are resolved;

(B) six years or until all audit questions, administrative hearings, investigations, court cases, or appeals are resolved if the person is a Freestanding Rural Health Clinic; and

(C) ten years or until all audit questions, administrative hearings, investigations, court cases, or appeals are resolved if the person is a hospital-based Rural Health Clinic;

(2) fails to provide originals or complete and correct copies of records or documentation as requested upon reasonable request by a requesting agency [Requesting Agency]; or

(3) fails to grant immediate access to the premises, records, documentation, or any items or equipment determined necessary by the OIG to complete its official functions related to a fraud, waste, or abuse investigation upon request by a requesting agency [Requesting Agency]. Failure to grant immediate access may include, but is not limited to, the following:

(A) failure to allow the OIG or any requesting agency [Requesting Agency] to conduct any duties that are necessary to the performance of their official functions;

(B) failure to provide to the OIG or a requesting agency [Requesting Agency], upon request and as requested, for the purpose of reviewing, examining, and securing custody of records, access to, disclosure of, and custody of copies or originals of any records, documents, or other requested items, as determined necessary by the OIG or a requesting agency [Requesting Agency] to perform official functions;

(C) failure to produce or make available records within 24 hours of a request for production, for the purpose of reviewing, examining, and securing custody of records upon reasonable request, as determined by the OIG or a requesting agency [Requesting Agency] except where the OIG or a requesting agency [Requesting Agency] reasonably believes that requested documents are about to be altered or destroyed or that the request may be completed at the time of the request and/or in less than 24 hours;

(D) failure to grant access to a person's premises at the time of a reasonable request;

(E) failure to provide access to records at the time of a request, for the purpose of reviewing, examining, and securing custody of records upon reasonable request, when the OIG or a requesting agency [Requesting Agency] has reason to believe that:

(i) requested documents are about to be altered or destroyed; or

(ii) in the opinion of the OIG or a requesting agency [Requesting Agency], the request could be met at the time of the request or in less than 24 hours;

(F) failure to relinquish custody of records and documents as directed by the OIG or a requesting agency [Requesting Agency];

(G) failure to complete a records affidavit, business records affidavit, evidence receipt, or patient record receipt, at the

direction of the OIG or a requesting agency [Requesting Agency] and to attach these documents to the records or documentation requested; or

(4) fails to make, maintain, retain, or produce documentation sufficient to demonstrate compliance with any federal or state law, rule, regulation, contract, Medicaid or other HHS policy, or professional standard in order to:

(A) participate in the Medicaid or other HHS program;

(B) support a claim for payment;

(C) verify delivery of services or items provided;

(D) establish medical necessity, medical appropriateness, or adherence to the professional standard of care related to services or items provided;

(E) determine appropriate payment for items or services delivered in accordance with established rates;

(F) confirm the eligibility of a person to participate in the Medicaid or other HHS program;

(G) demonstrate solvency of risk-bearing providers;

(H) support a cost or expenditure;

(I) verify the purchase and actual cost of products, items, or services; or

(J) establish compliance with applicable state and federal regulatory requirements.

§371.1669. *Self-Dealing.*

A person is subject to administrative actions or sanctions if the person:

(1) rebates or accepts a fee or a part of a fee or charge for a Medicaid or other HHS program patient referral;

(2) solicits recipients or causes recipients to be solicited, through offers of transportation or otherwise, for the purpose of claiming payment related to those recipients;

(3) knowingly offers to pay or agrees to accept, directly or indirectly, overtly or covertly, any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered by a state health care regulatory agency or HHS agency;

(4) knowingly offers to pay or agrees to accept, directly or indirectly, overtly or covertly, any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered by a state health care regulatory agency, subject to the exceptions enumerated in Chapter 102, Texas Occupations Code;

(5) solicits or receives, directly or indirectly, overtly or covertly, any remuneration, including any kickback, bribe, or rebate, in cash or in kind for referring an individual to a person for the furnishing of, or for arranging the furnishing of, any item or service for which payment may be made, in whole or in part, under the Medicaid or other HHS program, provided that this paragraph does not prohibit the referral of a patient to another practitioner within a multispecialty group or university medical services research and development plan (practice plan) for medically necessary services;

(6) solicits or receives, directly or indirectly, overtly or covertly, any remuneration, including any kickback, bribe, or rebate, in cash or in kind for purchasing, leasing, or ordering, or arranging for or recommending the purchasing, leasing, or ordering of, any good,

facility, service, or item for which payment may be made, in whole or in part, under the Medicaid or other HHS program;

(7) offers or pays, directly or indirectly, overtly or covertly, any remuneration, including any kickback, bribe, or rebate, in cash or in kind to induce a person to refer an individual to another person for the furnishing of, or for arranging the furnishing of, any item or service for which payment may be made, in whole or in part, under the Medicaid or other HHS program, provided that this paragraph does not prohibit the referral of a patient to another practitioner within a multispecialty group or university medical services research and development plan (practice plan) for medically necessary services;

(8) offers or pays, directly or indirectly, overtly or covertly, any remuneration, including any kickback, bribe, or rebate, in cash or in kind to induce a person to purchase, lease, or order, or arrange for or recommend the purchase, lease, or order of, any good, facility, service, or item for which payment may be made, in whole or in part, under the Medicaid or other HHS program;

(9) provides, offers, or receives an inducement in a manner or for a purpose not otherwise prohibited by this section or §102.001, Texas Occupations Code, to or from a person, including a recipient, provider, employee or agent of a provider, third-party vendor, or public servant, for the purpose of influencing or being influenced in a decision regarding:

(A) selection of a provider or receipt of a good or service under the Medicaid or other HHS program;

(B) the use of goods or services provided under the Medicaid or other HHS program; or

(C) the inclusion or exclusion of goods or services available under the Medicaid program;

(10) is a physician and refers a Medicaid or other HHS program recipient to an entity with which the physician has a financial relationship for the furnishing of designated health services, payment for which would be denied under Title XVIII (Medicare) pursuant to [§1877 and §1903(s) of the Social Security Act, codified at] 42 U.S.C. §1395nn, §1396b(s) (Stark I, II, and III), the federal Anti-Kickback Statute, the Affordable Care Act, or other state or federal law prohibiting self-dealing or self-referral;

(11) engages in marketing services in violation of §531.02115 of the Texas Government Code, program rules, or contract and has not received prior authorization from the program for the marketing campaign; or

(12) fails to disclose documentation of financial relationships necessary to establish compliance with §1877 and §1903(s) of the Social Security Act or 42 C.F.R. §§411.350 - .389 [§§411.350-389] (Stark I, II, and III), the federal Anti-Kickback Statute, the [The] Affordable Care Act, or other state or federal law prohibiting self-dealing or self-referral.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 15, 2016.

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Karen Ray

Chief Counsel

Texas Health and Human Services Commission

Earliest possible date of adoption: February 28, 2016

For further information, please call: (512) 424-6900



### DIVISION 3. ADMINISTRATIVE ACTIONS AND SANCTIONS

**1 TAC §§371.1701, 371.1703, 371.1705, 371.1707, 371.1709, 371.1711, 371.1715, 371.1717, 371.1719**

#### Legal Authority

The amendments are proposed under Texas Government Code §531.102(a-2), which requires the Executive Commissioner to work in consultation with the Office of Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program.

The amendments implement Texas Government Code Chapter 531, as amended by S.B. 207. No other statutes, articles, or codes are affected by the proposal.

#### §371.1701. Administrative Actions.

(a) The OIG may impose one or more administrative actions if it determines that the person committed an act for which a person is subject to administrative actions or sanctions, including the following:

- (1) commits a program violation;
- (2) commits an act for which sanctions, damages, penalties, or liability could be or are assessed by the OIG;
- (3) commits an act that amounts to fraud, abuse, overpayment, or waste in relation to Medicaid or an HHS program or service; or
- (4) is affiliated with a person who commits an act described in paragraphs (1) - (3) of this subsection.

(b) An administrative action may be taken in conjunction with or independently of other enforcement measures, and is not a prerequisite to the imposition of a sanction or other enforcement measure.

(c) Administrative actions include:

- (1) transferring a person to a closed-end contract or agreement for a specified period of time or to a provisional or probationary contract or agreement with modified terms and conditions;
- (2) attendance at education sessions;
- (3) prior authorization of selected services (failure to submit and receive prior authorization prior to the service being rendered or billed would result in denial of the claim);
- (4) prepayment review of all claims or certain specific claims or services of a person;
- (5) conducting post-payment review of all claims or certain specific claims or services of a person after payment;

(6) attendance at informal or formal person corrective action meetings;

(7) requiring submission of additional documentation or justification for a claim, as deemed advisable by the OIG, as a condition precedent to payment of the claim;

(8) oral, written, or personal educational contact with the person;

(9) requiring a person to post a surety bond or provide a letter of credit, as provided in §371.23 of this chapter (relating to Surety Bond);

(10) serving a subpoena to compel the production of a witness or of relevant evidence;

(11) reinstatement; and

(12) referral for additional review or investigation of any person suspected of committing fraud, waste, or abuse. Such referrals include the following entities:

(A) all cases of suspected Medicaid fraud or patient abuse or neglect to the OAG Medicaid Fraud Control Unit or Civil Medicaid Fraud Division for investigation;

(B) peer review outside HHSC [~~the Commission~~] or operating agency;

(C) the appropriate state licensing board;

(D) the United States Department of Health and Human Services, including for action under the Civil Monetary Penalties Law (the Social Security Act, §1128);

(E) other federal or state law enforcement agencies for fraud investigation and criminal fraud prosecution;

(F) other federal or state agencies for civil fraud prosecution and imposition of civil damages or penalties or recovery of overpayments and administrative penalties and damages through judicial means;

(G) a collection agency, the OAG, or any other collection authority, for recovery of overpayments, administrative penalties and damages or other debts established by the OIG;

(H) credit bureaus for failure to pay all imposed recoupments and damages and penalties; and

(I) any other entity determined to be advisable or necessary by the OIG [~~to perform its official functions~~].

(d) The OIG provides written notice of the administrative actions described in subsection (c)(1) - (11) of this section to persons who are the subject of administrative actions. The notice includes [~~will include~~]:

(1) a description of the administrative action;

(2) the general basis for the administrative action; and

(3) a description of what the person must do to comply with the administrative action.

(e) An administrative action does not give rise to due process, additional notice, or hearing requirements.

#### §371.1703. *Termination of Enrollment or Cancellation of Contract.*

(a) The OIG may terminate the enrollment or cancel the contract of a person by debarment, suspension, revocation, or other deactivation of participation, as appropriate. The OIG may terminate or cancel a person's enrollment or contract if it determines that the person

committed an act for which a person is subject to administrative actions or sanctions.

(b) When the OIG establishes the following by prima facie evidence, the OIG must terminate or cancel the enrollment or contract from the Medicaid program or any other HHS program of:

(1) a provider or any person with an ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or CHIP program in the last ten years;

(2) a provider that is terminated or revoked for cause, excluded, or debarred under Title XVIII of the Social Security Act or under the Medicaid program or CHIP program of any other state;

(3) a provider that fails to permit access to any and all provider locations for unannounced or announced on-site inspections required during the provider screening process as provided by rule;

(4) a provider when any person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely and accurate information, including fingerprints if required by CMS or state rule, and cooperate with any and all screening methods required during the provider screening process as provided by rule, statute, rule, or regulation;

(5) a provider that fails to submit sets of fingerprints in a form and manner to be provided by rule;

(6) a person that fails to repay overpayments under the Medicaid program or CHIP;

(7) a person that owns, controls, manages, or is otherwise affiliated with and has financial, managerial, or administrative influence over a provider who has been suspended or prohibited from participating in Medicare, Medicaid, or CHIP;

(8) a provider that fails to identify or disclose in the provider screening process for any HHS program:

(A) all persons with a direct or indirect ownership or control interest, as defined by 42 C.F.R. [~~CFR~~] §455.101;

(B) all information required to be disclosed in accordance with 42 C.F.R. [~~CFR~~] §1001.1101, 42 C.F.R. [~~CFR~~] chapter 455, or other by statute, rule, or regulation; or

(C) all agents or subcontractors of the provider:

(i) if the provider or a person with an ownership interest in the provider has an ownership interest in the agent or subcontractor; or

(ii) if the provider engages in a business transaction with the agent or subcontractor that meets the criteria specified by 42 C.F.R. [~~CFR~~] §455.105; or

(9) a provider that has been excluded or debarred from participation in a state or federally funded health care program as a result of:

(A) a criminal conviction or finding of civil or administrative liability for committing a fraudulent act, theft, embezzlement, or other financial misconduct under a state or federally funded health care program; or

(B) a criminal conviction for committing an act under a state or federally funded health care program that caused bodily injury to:

(i) a person who is 65 years of age or older;

(ii) a person with a disability; or

(iii) a person under 18 years of age.

(c) When the OIG establishes the following by prima facie evidence, the OIG may terminate or cancel the enrollment or contract from Medicaid, CHIP, [the medical assistance program] or any other HHS program of:

(1) a provider if a criminal history check reveals a prior criminal conviction;

(2) a provider that has failed to bill for medical assistance or refer clients for medical assistance within a 12-month period;

(3) a provider that has been excluded or debarred from participation in any federally funded health care program not described in subsection (b)(2) of this section;

(4) a provider that has falsified any information on its application for enrollment as determined by the OIG;

(5) a provider whose identity on an application for enrollment cannot be verified by the OIG;

(6) a person that commits a program violation;

(7) a person that is affiliated with a person who commits a program violation;

(8) a person that commits an act for which sanctions, damages, penalties, or liability could be or are assessed by the OIG; or

(9) a person whose contract [that] may be cancelled [terminated] for any other reason specified by statute or regulation.

(d) Exceptions.

(1) The OIG need not terminate participation if the person or provider voluntarily resigned from participation under Title XVIII of the Social Security Act or under the Medicaid program or CHIP program of any other state, and the resignation was not in lieu of or to avoid exclusion, termination, or any other sanction.

(2) The OIG need not terminate participation based on a conviction described in subsection (b)(1) of this section, a termination described in subsection (b)(2) of this section, or a failure to allow access described in subsection (b)(3) of this section if the OIG:

(A) determines that termination is not in the best interests of the Medicaid program; and

(B) documents that determination and the rationale in writing.

(e) Notice. Notice of termination includes:

(1) a description of the termination;

(2) the basis for the termination;

(3) the effect of the termination;

(4) the duration of the termination;

(5) whether re-enrollment will be required after the period of termination; and

(6) a statement of the person's right to request an informal resolution meeting or an administrative hearing regarding the imposition of the termination unless the termination is required under 42 C.F.R. §455.416.

(f) Due process.

(1) After receiving a notice of termination, a person has a right to the informal resolution process in accordance with §371.1613

of this subchapter (relating to Informal Resolution Process) unless the termination is required under 42 C.F.R. §455.416.

(2) A person may request an administrative hearing after receipt of a final notice of termination in accordance with §371.1615 of this subchapter (relating to Appeals) unless the termination is required under 42 C.F.R. §455.416. The OIG must receive the written request for a hearing no later than the 15 days after the date the person receives the notice.

(g) Scope and effect of termination.

(1) A person's enrollment agreement or contract is [will be] nullified on the effective date of the termination.

(2) Once a person's enrollment agreement or contract is terminated or cancelled [person has been terminated], no items or services furnished are [will be] reimbursed by the Medicaid or other HHS program during the period of termination or cancellation.

(3) Following termination [When the termination period expires], the person must [may need to] re-enroll in order to participate as a provider in the Medicaid or other HHS program, if the person was terminated for any grounds in subsection (b) or (c)(1) - (3) of this section. Re-enrollment requires [will require] the provider to meet all applicable screening requirements, including the payment of any application fees. [Re-enrollment will be required if the person was terminated for any grounds in subsection (b) or (c)(1) - (3) of this section.]

(4) A person may be terminated from participation in the Medicare program and in the Medicaid program of every other state as a result of the termination.

(5) If, after the effective date of the termination or cancellation, a [terminated] person submits or causes to be submitted claims for services or items furnished within the period of termination or cancellation, the person may be liable to repay any submitted claims or subject to civil monetary penalty liability under §1128A(a)(1)(D), and criminal liability under §1128B(a)(3) of the Social Security Act in addition to sanctions or penalties by the OIG.

(6) The termination or cancellation may, as determined by the OIG, [will] become immediately effective and final on the date reflected on the notice of cancellation [termination] in the following circumstances:

(A) [OIG determines that] the person subject to termination or cancellation may be placing at risk the health or safety of persons receiving services under Medicaid [at risk];

(B) the person who is subject to termination or cancellation fails:

(i) to grant immediate access to the OIG or to a requesting agency [Requesting Agency] upon reasonable request;

(ii) to allow the OIG or a requesting agency [Requesting Agency] to conduct any duties that are necessary to the performance of their official functions; or

(iii) to provide to the OIG or a requesting agency [Requesting Agency] as requested copies or originals of any records, documents, or other items, as determined necessary by the OIG or the requesting agency [Requesting Agency].

(7) If the person timely filed a written request for an administrative hearing, the effective date of termination is the date the hearing officer's or administrative law judge's decision to uphold the termination becomes final; however, if the administrative law judge upholds a termination for grounds described in paragraph (6) of this subsection,

the effective date is [will be] made retroactive to the date of the notice of termination.

(8) Unless otherwise provided in this section, the termination becomes [will become] final as provided in §371.1617(a) of this subchapter (relating to Finality and Collections).

(h) Reinstatement.

(1) The OIG may reinstate a provider's enrollment if the OIG finds:

(A) good cause to determine that it is in the best interest of the medical assistance program; and

(B) the person has not committed an act that would require revocation of a provider's enrollment or denial of a person's application to enroll since the person's enrollment was revoked.

(2) The OIG must support a determination made under this section with written findings of good cause for the determination.

§371.1705. *Mandatory Exclusion.*

(a) The OIG must exclude from participation in Titles V, XIX, XX, and CHIP programs, as applicable, any person if it determines that the person:

(1) has been excluded from participation in Medicare or any other federal health care programs;

(2) is a provider whose health care license, certification, or other qualifying requirement to perform certain types of service is revoked, suspended, voluntarily surrendered, or otherwise terminated such that the provider is unable to legally perform their profession due to loss of their license, certification, or other qualifying requirement;

(3) has been convicted of a criminal offense related to the delivery of an item or service under Medicare or a state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program;

(4) has been convicted, under federal or state law, of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct:

(A) in connection with the delivery of a health care item or service, including the performance of management or administrative services relating to the delivery of such items or services; or

(B) with respect to any act or omission in a health care program (other than Medicare and a State health care program) operated by, or financed in whole or in part, by any federal, state or local government agency;

(5) has been convicted, under federal or state law, of a felony relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance, as defined under federal or state law. This applies to a person that:

(A) is, or has ever been, a health care practitioner, person, or supplier;

(B) holds, or has held, a direct or indirect ownership or control interest (as defined in §1124(a)(3) of the Social Security Act) in an entity that is a health care person or supplier, or is, or has ever been, an officer, director, agent or managing employee (as defined in §1126(b) of the Social Security Act) of such an entity; or

(C) is or has ever been, employed in any capacity in the health care industry;

(6) is an MCO or other entity furnishing services under a waiver approved under §1915(b)(1) of the Social Security Act that has an affiliate relationship with a person, and that person:

(A) has been convicted:

(i) of an offense that is a ground for mandatory exclusion under this section;

(ii) of an offense under federal or state law consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct:

(I) in connection with the delivery of a health care item or service;

(II) with respect to any act or omission in a health care program (other than those specifically described in paragraph (1) of this subsection) operated by or financed in whole or in part by any federal, state, or local government agency; or

(III) relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any federal, state, or local government agency;

(iii) of an offense under federal or state law in connection with the interference with or obstruction of any investigation related to:

(I) an offense that is a ground for mandatory exclusion under this section; or

(II) the use of funds received, directly or indirectly, from any federal health care program;

(iv) of an offense under federal or state law for acts that took place after January 1, 2010, in connection with the interference with or obstruction of any audit related to:

(I) an offense that is a ground for mandatory exclusion under this section; or

(II) the use of funds received, directly or indirectly, from any federal health care program;

(v) has had civil money penalties or assessments imposed under §1128A of the Social Security Act (federal false claims); or

(vi) has been excluded from participation in Medicare or any of the state health care programs or CHIP; and

(B) that person:

(i) has an ownership interest in the entity;

(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note or other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceeds five [~~5~~] percent of the total property and assets of the entity;

(iii) is an officer or director of the entity, if the entity is organized as a corporation;

(iv) is a partner in the entity, if the entity is organized as a partnership;

(v) is an agent of the entity;

(vi) is a managing employee, that is, a person (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the entity or

part thereof, or directly or indirectly conducts the day-to-day operations of the entity or part thereof; or

(vii) was formerly described in clauses (i) - (vi) of this subparagraph, but is no longer so described because of a transfer of ownership or control interest to an immediate family member or a member of the person's household in anticipation of or following a conviction, assessment of a civil monetary penalty, or imposition of an exclusion;

(7) is an individual and has an ownership or control interest or a substantial contractual relationship in or is an officer or managing employee of a sanctioned entity, and who knew or should have known of an action that constituted the basis for a conviction or mandatory exclusion of the sanctioned entity; or

(8) is convicted, pleads guilty or pleads nolo contendere to an offense arising from a fraudulent act under the Medicaid program, which results in injury to a person age 65 or older, a person with a disability, or a person younger than 18 years of age.

(b) The OIG may exclude a person without sending prior notice of intent to exclude in the following circumstances:

(1) The OIG determines that the person is subject to mandatory exclusion under subsection (a) of this section and the person may be placing the health and/or safety of persons receiving services under an HHS program at risk; or

(2) a person who is subject to mandatory exclusion under subsection (a) of this section fails:

(A) to grant immediate access to the OIG or to a requesting agency [Requesting Agency] upon reasonable request;

(B) to allow the OIG or a requesting agency [Requesting Agency] to conduct any duties that are necessary to the performance of their official functions; or

(C) to provide to the OIG or a requesting agency [Requesting Agency] as requested copies or originals of any records, documents, or other items, as determined necessary by the OIG or the requesting agency [Requesting Agency].

(c) When the OIG issues a final notice of exclusion, the notice includes the requirements and procedures for reinstatement. [Notice.]

~~[(1) Except as provided in subsection (b) of this section, when~~ OIG proposes to exclude any person on mandatory grounds, it gives written notice of its intent to exclude, which will include:]

~~[(A) the basis for the potential exclusion;]~~

~~[(B) the potential effect of the exclusion; and]~~

~~[(C) whether~~ OIG also proposes to cancel any agreement held by the person to be excluded.]

~~[(2) When~~ OIG makes a final determination to exclude a person on mandatory grounds or when the exclusion is based upon the grounds described in subsection (b) of this section, OIG issues a final notice of exclusion, which will include:]

~~[(A) a description of the final exclusion;]~~

~~[(B) the basis of the final exclusion;]~~

~~[(C) the effect of the final exclusion;]~~

~~[(D) the duration of the final exclusion;]~~

~~[(E) the earliest date on which~~ OIG will consider a request for reinstatement;]

~~[(F) the requirements and procedures for reinstatement; and]~~

~~[(G) a statement of the person's right to request a formal administrative appeal hearing regarding the exclusion.]~~

(d) Due process.

(1) After receiving a notice of intent to exclude, a person has a right to the informal resolution process in accordance with §371.1613 of this subchapter (relating to Informal Resolution Process) unless the exclusion is required under subsection (a)(1) of this section or under 42 C.F.R. §1001.101.

(2) A person may request an administrative appeal hearing in accordance with §371.1615 of this subchapter (relating to Appeals) after receipt of a final notice of exclusion unless the exclusion is required under subsection (a)(1) of this section or under 42 C.F.R. §1001.101. The OIG must receive the written request for an appeal no later than 15 days after the date the person receives final notice.

(3) When the exclusion is based on the existence of a criminal conviction;[,] a civil fraud finding;[,] a civil judgment imposing liability by federal, state, or local court;[,] a determination by another government agency or board;[,] any other prior determination;[,] or provisions within a settlement agreement, [the basis for the underlying determination is not reviewable and] the individual or entity subject to exclusion may not collaterally attack the underlying determination, either on substantive or procedural grounds, in an administrative appeal.

(e) Scope and effect of exclusion.

(1) [The period of exclusion begins on the effective date.] An exclusion becomes effective on the following:

(A) the date the person's health care services or items became ineligible for federal financial participation as described in subsection (a)(1) of this section;

(B) the effective date the person lost its [their] license, certification, or other qualifying requirement as described in subsection (a)(2) of this section;

(C) the date of the criminal judgment of conviction or date of order the person received for deferred adjudication or pre-trial diversion as described in subsection (a)(3) - (5) and (8) of this section;

(D) the date of the criminal judgment of conviction, or effective date of the assessment of civil monetary penalties or exclusion as described in subsection (a)(6) of this section;

(E) the effective date of final determination of liability pursuant to Texas Human Resources Code §32.039(c) as described in subsection (a)(8) of this section;

(F) the date of [reflected on] the final notice of exclusion if the exclusion is based on a health or safety risk as described in subsection (b)(1) of this section;

(G) the date of the original request for records if the exclusion is based on failure to provide access as described in subsection (b)(2) of this section; or

[(H) if the exclusion is upheld at an administrative hearing, the effective date is made retroactive to the applicable effective date described in this section.]

~~[(H) unless otherwise provided, twenty (20) days after the person's receipt of the final notice of exclusion if the provider does not timely file a written request for an appeal that satisfies the requirements of §371.1615 of this subchapter; or]~~

~~{(1) if the person timely filed a written request for appeal, the date the hearing officer's or administrative law judge's decision to uphold the exclusion becomes final; however, if the administrative law judge upholds an exclusion, the effective date will be made retroactive to the applicable effective date described in this paragraph.}~~

(2) An exclusion remains in effect for the period indicated in the final notice of exclusion. The person is not eligible to apply for reinstatement or reenrollment as a provider until the exclusion period has elapsed. The minimum length of exclusion is determined as follows:

(A) The minimum length of exclusion is the federally mandated exclusion period plus one additional year if the exclusion is based upon a conviction as described in subsection (a)(3), (4), or (5) of this section.

(B) An MCO is ~~is~~ ~~[will be]~~ excluded for the same period as the related person was excluded, as described in subsection (a)(6) of this section.

(C) An individual is ~~is~~ ~~[will be]~~ excluded for the same period as the sanctioned entity in which the individual held an ownership, control interest, or substantial contractual relationship as described in subsection (a)(7) of this section.

(D) The exclusion is effective for ten years if the exclusion is based upon an assessment of civil monetary penalties pursuant to Texas Human Resources Code §32.039(c) arising out of injury to a person who is 65 years of age or older, a person with a disability, or a person under 18 years of age as described in subsection (a)(8) of this section.

(E) The exclusion is effective for three years if the exclusion is based upon an assessment of civil monetary penalties pursuant to Texas Human Resources Code §32.039(c).

(F) The exclusion is permanent if the exclusion is based upon a criminal conviction for committing a fraudulent act under the Medicaid program that results in injury to a person who is 65 years of age or older, a person with a disability, or a person under 18 years of age as described in subsection (a)(8) of this section.

(G) Unless otherwise provided, the length of exclusion is ~~is~~ ~~[will be]~~ determined by the ~~OIG~~ in its discretion. ~~The~~ ~~OIG~~ ~~considers~~ ~~[OIG will consider]~~ the factors enumerated in §371.1305(c) of this chapter (relating to Preliminary Investigation and Report) ~~[§371.1603(f)(1) of this subchapter (relating to Legal Basis and Scope)]~~ in determining the length of exclusion.

(3) Unless a person is ~~first~~ reinstated and ~~then~~ re-enrolled as a provider in the Texas Medicaid program, no payment is ~~is~~ ~~[will be]~~ made by the Medicaid program for any item or service furnished or requested by an excluded person on or after the effective date of exclusion.

(4) An excluded person is prohibited from:

(A) personally or through a clinic, group, corporation, or other association or entity, billing or otherwise requesting or receiving payment for any Title V, XVIII ~~[VIII]~~, XIX, XX, or CHIP program for items or services provided on or after the effective date of the exclusion;

(B) providing any service under the Medicaid program, whether or not the excluded person directly requests Medicaid program payment for such services;

(C) assessing care or ordering or prescribing services, directly or indirectly, to Title V, XIX, XX, or CHIP recipients after the effective date of the person's exclusion; and

(D) accepting employment by any person whose revenue stream includes funds from a Title V, XVIII ~~[VIII]~~, XIX, XX, or CHIP program.

(5) If, after the effective date of an exclusion, an excluded person submits or causes to be submitted claims for services or items furnished within the period of exclusion, the person may be subject to civil monetary penalty liability under §1128A(a)(1)(D), and criminal liability under §1128B(a)(3) of the Social Security Act in addition to sanctions or penalties by the ~~OIG~~.

(6) In accordance with federal and state requirements, when the ~~OIG~~ excludes a person, the ~~OIG~~ may notify each state agency administering or supervising the applicable state health care program, as well as the appropriate state or local authority or agency responsible for licensing or certifying the person excluded. If issued, notification includes ~~[will include]~~:

(A) the facts, circumstances, and period of exclusion;

(B) a request that appropriate investigations be made and any necessary sanctions or disciplinary actions be imposed in accordance with applicable law and policy; and

(C) a request that the state or local authority or agency fully and timely inform the ~~OIG~~ with respect to any actions taken in response to the ~~OIG's~~ request.

(7) The ~~OIG~~ notifies the public of all persons excluded.

(8) A person who has been excluded from the Texas Medicaid or CHIP program is ~~is~~ ~~[will be]~~ excluded from the Medicaid and/or CHIP program in every other state and from the Medicare program pursuant to each program's applicable state or federal authority. When exclusion from the Texas Medicaid and/or CHIP program is based on the person's exclusion from Medicare, or from another state's Medicaid or CHIP program, the prohibitions enumerated in paragraph (4) of this subsection may apply.

*§371.1707. Permissive Exclusion.*

(a) The ~~OIG~~ may exclude from participation in Titles V, XVIII ~~[VIII]~~, XIX, XX, or CHIP programs any person if it determines that the person:

(1) commits a program violation;

(2) is affiliated with a person who commits a program violation;

(3) commits an act for which damages, penalties, or liability could be or are assessed by the ~~OIG~~;

(4) is a person not enrolled as a provider whose health care license, certification, or other qualifying requirement to perform certain types of service is revoked, suspended, voluntarily surrendered, or otherwise terminated such that the provider is unable to legally perform their profession due to loss of their license, certification, or other qualifying requirement;

(5) could be excluded for any reason for which the Secretary of the United States ~~[U.S.]~~ Department of Health and Human Services, its Office of Inspector General, or its agents could exclude such person under 42 U.S.C. §1320a-7(b) or 42 C.F.R. Part ~~[CFR Parts]~~ 1001 or 1003;

(6) is found liable for any violation under subsection (c) of Texas Human Resources Code §32.039 that resulted in injury to a person who is 65 years of age or older, a person with a disability, or a person younger than 18 years of age;

(7) is found liable for any violation under subsection (c) of Texas Human Resources Code §32.039 that did not result in injury to a

person 65 years of age or older, a person with a disability, or a person younger than 18 years of age; or

(8) has been excluded from participation in Medicare or any other federal health care programs.

(b) The OIG may exclude a person without sending prior notice of intent to exclude in the following circumstances:

(1) The OIG determines that the person is or may be placing the health and/or safety of persons receiving services under an [a] HHS program at risk;

(2) a person fails:

(A) to grant immediate access to the OIG or to a requesting agency [Requesting Agency] upon reasonable request;

(B) to allow the OIG or a requesting agency [Requesting Agency] to conduct any duties that are necessary to the performance of their official functions; or

(C) to provide to the OIG or a requesting agency [Requesting Agency] as requested copies or originals of any records, documents, or other items, as determined necessary by the OIG or the requesting agency [Requesting Agency];

(3) the person engages in acts that violate 42 C.F.R. [CFR] §1001.1401 (hospital's failure to comply with corrective action plan required by the Centers for Medicare and Medicaid Services);

(4) the person engages in acts that violate 42 C.F.R. [CFR] §1001.1501 (default on health education loan or scholarship obligations);

(5) the person engages in acts that violate 42 C.F.R. [CFR] §1001.901 (false or improper claims);

(6) the person engages in acts that violate 42 C.F.R. [CFR] §1001.951 (fraud and kickbacks and other prohibited activities);

(7) the person engages in acts that violate 42 C.F.R. [CFR] §1001.1601 (violations of the limitations on physician charges);

(8) the person engages in acts that violate 42 C.F.R. [CFR] §1001.1701 (billing for services of assistant at surgery during cataract operations); or

(9) the person has been excluded from the Medicaid program and obtains a new provider number without [first] completing the reinstatement and re-enrollment process as required by §371.1719 of this division (relating to Recoupment of Overpayments Identified by Audit).

(c) When the OIG issues a final notice of exclusion, the final notice states: [Notice.]

(1) Except as provided in subsection (b) of this section, OIG will issue a notice of intent to exclude when it proposes to exclude any person on permissive grounds. The notice of intent to exclude will include:

~~[(A) the basis for the potential exclusion;]~~

~~[(B) the potential effect of the exclusion; and]~~

~~[(C) whether OIG also proposes to cancel any agreement held by the person to be excluded.]~~

(2) When OIG makes a final determination to exclude the person or when the exclusion is based upon the grounds enumerated in subsection (b) of this section, OIG issues a final notice of exclusion, which will state:

~~[(A) a description of the final exclusion;]~~

~~[(B) the basis of the final exclusion;]~~

~~[(C) the effect of the final exclusion;]~~

~~[(D) the duration of the final exclusion;]~~

~~[(E) the earliest date on which OIG will consider a request for reinstatement;]~~

(1) ~~[(F)]~~ the requirements and procedures for reinstatement;

(2) ~~[(G)]~~ whether the OIG will also cancel any agreement held by the person to be excluded; and

(3) ~~[(H)]~~ a statement of the person's right to request a formal administrative appeal hearing regarding the exclusion.

~~[(d) Due process.]~~

~~[(1) After receiving a notice of intent to exclude, a person has a right to the informal resolution process in accordance with §371.1613 of this subchapter (relating to Informal Resolution Process).]~~

~~[(2) A person may request an administrative appeal hearing in accordance with §371.1615 of this subchapter (relating to Appeals) after receipt of a final notice of exclusion. OIG must receive the written request for an appeal no later than the 15th calendar day after the date the person receives final notice.]~~

~~[(d) [(e)] Scope and effect of exclusion.~~

(1) ~~[(The period of exclusion begins on the effective date.)]~~ An exclusion becomes effective on the following:

(A) the date of ~~[(reflected on)]~~ the final notice of exclusion, if the exclusion is based on a health or safety risk as described in subsection (b)(1) of this section;

(B) the date of the original request for records, if the exclusion is based on failure to provide access as described in subsection (b)(2) of this section;

~~[(C) unless otherwise provided, 30 days after the person's receipt of the final notice of exclusion if the provider does not timely file a written request for an appeal that satisfies the requirements of §371.1615 of this subchapter; or]~~

~~[(D) [(D)] [if the person timely filed a written request for appeal, the date the hearing officer or administrative law judge upholds the decision to exclude; however,] if the exclusion is upheld at an administrative hearing [law judge upholds an exclusion] based upon subsection (b)(1) of this section, the effective date is [will be] made retroactive to the date of the final notice;] and~~

~~[(D) if the exclusion is upheld at an administrative hearing [judge upholds an exclusion] based upon subsection (b)(2) of this section, the effective date is [will be] made retroactive to the date of the original request for records.~~

(2) An exclusion remains in effect for the period indicated in the final notice of exclusion. The person is not eligible to apply for reinstatement or re-enrollment as a provider until the exclusion period has elapsed.

(3) Unless a person is [first] reinstated and [then] re-enrolled as a provider in the Texas Medicaid program, no payment is [will be] made by the Medicaid program for any item or service furnished or requested by an excluded person on or after the effective date of exclusion.

(4) An excluded person is prohibited from:

(A) personally or through a clinic, group, corporation, or other association or entity, billing or otherwise requesting or receiving payment from any Title V, XVIII [VHH], XIX, XX, or CHIP programs for items or services provided on or after the effective date of the exclusion;

(B) providing any service pursuant to the Medicaid program, whether or not the excluded person directly requests Medicaid program payment for such services;

(C) assessing care or ordering or prescribing services, directly or indirectly, to Title V, XVIII, XIX, XX, or CHIP recipients after the effective date of the person's exclusion; and

(D) accepting employment by any person whose revenue stream includes funds from a Title V, XVIII [VHH], XIX, XX, or CHIP program.

(5) If, after the effective date of an exclusion, an excluded person submits or causes to be submitted claims for services or items furnished within the period of exclusion, the person may be subject to civil monetary penalty liability under §1128A(a)(1)(D) and criminal liability under §1128B(a)(3) of the Social Security Act in addition to sanctions or penalties by the OIG.

(6) In accordance with federal and state requirements, when the OIG excludes a person, the OIG may notify each state agency administering or supervising the applicable state health care program, as well as the appropriate state or local authority or agency responsible for licensing or certifying the person excluded. If issued, notification includes [~~will include~~]:

(A) the facts, circumstances, and period of exclusion;

(B) a request that appropriate investigations be made and any necessary sanctions or disciplinary actions be imposed in accordance with applicable law and policy; and

(C) a request that the state or local authority or agency fully and timely inform the OIG with respect to any actions taken in response to the OIG's request.

(7) The OIG notifies the public of all persons excluded.

(8) A person who has been excluded from the Texas Medicaid or CHIP program is [~~will be~~] excluded from the Texas Medicaid and/or CHIP program in every other state and from the Medicare program pursuant to each program's applicable state or federal authority. When exclusion from the Texas Medicaid and/or CHIP program is based on the person's exclusion from Medicare, or from another state's Medicaid or CHIP program, the prohibitions enumerated in paragraph (4) of this subsection may apply.

#### §371.1709. *Payment Hold.*

(a) Subject to subsections (c) and (d) of this section, the OIG imposes [~~OIG shall impose~~] a payment hold against a provider only:

(1) to compel the production records or documents;

(2) when requested by the state's Medicaid Fraud Control Unit; or

(3) upon the determination a credible allegation of fraud exists.

(b) The OIG may elect not to impose a payment hold, to discontinue [~~not continue~~] a payment hold, to impose a payment hold only in part, or to convert a payment hold imposed in whole to one imposed only in part, for any of the good cause exceptions enumerated in 42 C.F.R. §455.23 and in Texas Government Code §531.102(g)(8) [~~and in 42 C.F.R. §455.23~~].

(c) The OIG may not impose a payment hold on claims for reimbursement submitted by a provider for medically necessary services for which the provider has obtained prior authorization from the commission or a contractor of the commission unless the OIG has evidence that the provider has materially misrepresented documentation relating to those services.

(d) Unless the OIG receives a request from a law enforcement agency to temporarily withhold notice pursuant to 42 C.F.R. §455.23, the OIG shall provide notice as required by 42 C.F.R. [CFR] §455.23(b) and Texas Government Code §531.102(g).

(e) Scope and effect of payment hold.

(1) Once a person is placed on payment hold, payment of Medicaid claims for specific procedures or services is [~~will be~~] limited or denied as long as the payment hold is in effect.

(2) After a payment hold is terminated for any reason, the OIG may retain the funds accumulated during the payment hold to offset any overpayment, criminal restitution, penalty or other assessment, or agreed-upon amount that may result from ongoing investigation of the person, including any payment amount accepted by the prosecuting authorities made in lieu of a prosecution to reimburse the Medicaid or other HHS program.

(3) The payment hold may be terminated or partially lifted for the reasons outlined in 42 C.F.R. [CFR] §455.23 or Texas Government Code §531.102(g)(8).

#### §371.1711. *Recoupment of Overpayments and Debts.*

(a) The OIG recovers overpayments made to providers within the Medicaid or other HHS programs, whether the overpayment resulted from error by the provider, the claims administrator, or an operating agency, misunderstanding, or a program violation.

(b) Application. The OIG may recoup from any person if it determines that the person committed an act for which a person is subject to administrative actions or sanctions, including the following:

(1) commits a program violation that leads to the payment of an overpayment;

(2) has failed to pay a debt owed to Medicare or to any Medicaid program as the result of fraudulent or abusive actions by a person participating in such program;

(3) is affiliated with a person who commits a program violation that leads to the payment of an overpayment;

(4) commits an act for which sanctions, damages, penalties, or liability could be or are assessed by the OIG; or

(5) who causes or receives an overpayment.

(c) Notice includes [~~will 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, information relating to the extrapolation methodology used as part of the investigation, and the methods used to determine the overpayment or debt in sufficient detail so that the extrapolation results may be demonstrated to be statistically valid and are fully reproducible;

(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 option to seek informal resolution, the provider's right to seek a formal administrative appeal hearing, or ~~[that] the provider's option to [provider may] seek both.~~

(d) The person who is the subject of a recoupment of overpayment or recoupment of a debt is responsible for payment of all overpayment amounts or debts assessed.

§371.1715. *Damages and Penalties.*

(a) ~~[Application.]~~ The ~~OIG~~ may assess administrative damages, penalties, or both against a person pursuant to §32.039, Texas Human Resources Code. ~~[any person if it determines that the person committed an act for which a person is subject to administrative actions or sanctions, including the following:]~~

~~[(1) presents or causes to be presented to OIG or its fiscal agent, a claim that contains a statement or representation the person knows or should know to be false;]~~

~~[(2) commits an act of self-dealing in violation of §371.1669 of this subchapter (relating to Self-Dealing);]~~

~~[(3) commits a managed care violation prohibited by §371.1663 of this subchapter (relating to Managed Care);]~~

~~[(4) fails to maintain adequate documentation to support a claim for payment in accordance with the requirements specified by rule or policy of Medicaid or Texas Medicaid Managed Care program policy; or]~~

~~[(5) engages in any other conduct that OIG has defined as a program violation.]~~

(b) When determining whether or not a person is prohibited from providing or arranging to provide health care services under the Medicaid program, the OIG considers the following:

(1) the person's knowledge of the violation;

(2) the likelihood that education provided to the person would be sufficient to prevent future violations;

(3) the potential impact on availability of services in the community served by the person; and

(4) any other reasonable factor identified by the OIG.

~~[(b) Exceptions:]~~

~~[(1) Unless the provider submitted information to OIG for use in preparing a voucher that the provider knew or should have known was false or failed to correct information that the provider knew or should have known was false when provided an opportunity to do so, this section does not apply to a claim based on the voucher if OIG calculated and printed the amount of the claim on the voucher and then submitted the voucher to the provider for the provider's signature.]~~

~~[(2) Subsection (a)(2) of this section does not prohibit a person from engaging in generally accepted business practices, including:]~~

~~[(A) conducting a marketing campaign;]~~

~~[(B) providing token items of minimal value that advertise the person's trade name;]~~

~~[(C) providing complimentary refreshments at an informational meeting promoting the person's goods or services;]~~

~~[(D) providing a value-added service if the person is an MCO; or]~~

~~[(E) other conduct specifically authorized by law, including conduct authorized by federal safe harbor regulations (42 CFR §1001.952).]~~

(c) The OIG gives notice of a preliminary penalty report and of its final assessment of penalties to the person charged with committing the violation, pursuant to §32.039, Texas Human Resources Code. ~~[Notice.]~~

~~[(1) Notice of preliminary report. If after an examination of the facts OIG determines by prima facie evidence that a person commits a violation that subjects the person to assessment of damages or penalties, OIG may issue a preliminary report stating the facts on which it based its conclusion, its proposal that administrative damages or penalty under this section be imposed, and stating the amount of the proposed damages or penalty. OIG will issue notice of the preliminary report to the person subject to the assessment.]~~

~~[(2) Content of the notice of preliminary report. The notice of preliminary report will include:]~~

~~[(A) a brief summary of the facts forming the basis for the assessment;]~~

~~[(B) a statement of the amount of the proposed damages or penalty; and]~~

~~[(C) a statement of the person's right to an informal resolution meeting (IRM) of the alleged violation, the amount of the damages or penalty, or both the alleged violation and the amount of the damages or penalty.]~~

~~[(3) Notice of final assessment. The notice of final assessment of damages or penalty includes:]~~

~~[(A) a brief summary of the facts forming the basis for the assessment;]~~

~~[(B) a statement of the amount of the damages or penalty;]~~

~~[(C) a statement of the effect of the assessment; and]~~

~~[(D) a statement of the person's right to an appeal of the alleged violation, the amount of the damages or penalty, or both the alleged violation and the amount of the damages or penalty.]~~

(d) Due process.

(1) After service ~~[receipt]~~ of a notice of preliminary report, a person has a right to request an informal review not later than the tenth day after service of the notice ~~[the informal resolution process in accordance with §371.1613 of this subchapter (relating to Informal Resolution Process)].~~

(2) After service of a final notice of assessment of penalties, a ~~[A]~~ person may request an administrative appeal hearing ~~[in accordance with §371.1615 of this subchapter (relating to Appeals) after receipt of a notice of final assessment. OIG must receive the written request for an appeal] no later than ten [15] days after the date of service of the notice ~~[the person receives the notice of final assessment].~~~~

~~[(e) Scope and effect of assessment of damages and penalties.]~~

~~[(1) A person who violates subsection (a)(1) - (3) of this section is liable for:]~~

~~[(A) damages equal to the amount paid, if any, as a result of the violation and interest on that amount determined at the rate provided by law for legal judgments and accruing from the date on which the payment was made; plus]~~

{(B) an administrative penalty of an amount not to exceed twice the amount paid, if any, as a result of the violation, plus;}

{(i) an administrative penalty of an amount not less than \$5,500 or more than \$15,000 for each violation that results in injury to a person who is 65 years of age or older, a person with a disability, or a person younger than 18 years of age; or}

{(ii) an administrative penalty of an amount not more than \$11,000 for each violation that does not result in injury to a person who is 65 years of age or older, a person with a disability, or a person younger than 18 years of age.}

{(2) A person who violates subsection (a)(4) or (a)(5) of this section is liable for;}

{(A) the amount paid in response to the claim for payment; or}

{(B) the payment of an administrative penalty in an amount not to exceed \$500 for each violation, as determined by OIG;}

{(3) Additionally, a person against whom damages or penalties have been assessed may be responsible for OIG's and other HHS program's costs related to the investigation that resulted in the assessment and the costs of any administrative hearing arising out of the assessment.}

{(4) In determining the amount of administrative damages or penalties to be assessed, OIG considers;}

{(A) the seriousness of the violation;}

{(B) whether the person had previously committed a violation; and}

{(C) the amount necessary to deter the person from committing future violations.}

{(5) The assessment of damages or penalty will become final as provided in §371.1617(a) of this subchapter (relating to Finality and Collections).}

#### §371.1717. Reinstatement.

(a) [A person who has been excluded from Medicaid or any state health care program by OIG may be reinstated by OIG.] A person excluded from the Medicaid program, Titles V, XVIII, XIX, XX, CHIP, or any other HHS program may submit to the OIG [Inspector General] a written request for reinstatement at any time after the period of exclusion has ended. The request for reinstatement must establish good cause for granting reinstatement.

(b) The OIG may require the requestor to furnish specific information and authorization for the OIG to obtain information from private health insurers, peer review bodies, probation officers, professional associates, investigative agencies, and others as may be necessary to determine whether reinstatement should be granted.

(c) The request for reinstatement may be approved, abated, postponed, or denied by the OIG. The OIG grants [OIG will grant] reinstatement only if it is reasonably certain that the types of actions that formed the basis for the original exclusion have not recurred and will not recur. In making this determination, the OIG considers [OIG will consider]:

(1) the conduct of the provider or person before and after the date of the notice of exclusion;

(2) whether all fines, damages, penalties, and any other debts due and owing to any federal, state, or local government have been paid, or satisfactory arrangements have been made that fulfill these obligations;

(3) the accessibility of other health care to the recipient population that would be served by the person who has been excluded;

(4) the person's previous conduct, including conduct during participation in the Titles V, XVIII, XIX, XX[, and V], CHIP, and any HHS programs in any state, or any conduct or action for which a sanction could have been taken, as described in this subchapter;

(5) any previous criminal convictions of the person regardless of its relation to Titles V, XVIII, XIX, XX, [V,] CHIP, or other HHS programs;

(6) whether the person complies with or has made satisfactory arrangements to fulfill the applicable conditions of participation or supplier conditions for coverage under the statutes and regulations;

(7) whether the person has, during the period of exclusion, submitted claims, or caused claims to be submitted or payment to be made by the Medicaid program or any state health care program, for items or services the excluded party furnished, ordered or prescribed, including health care administrative services; [and]

(8) whether a person has, during the period of exclusion, submitted claims or caused claims to be submitted or payments to be made by the Medicaid program or any state health care program for items or services furnished, ordered, or prescribed, including administrative and management services or salary, during the period of exclusion and before reinstatement has been granted and re-enrollment completed; and

(9) [(8)] any other factors or circumstances deemed by the OIG to be relevant to the determination of reinstatement.

(d) If an entity, association, or affiliation seeks reinstatement, and any affiliate of that entity, as defined by §371.1607 of this subchapter (relating to Definitions), was also excluded on grounds arising out of the same program violations, the OIG may approve reinstatement of the entity, association, or affiliation if the OIG [it] determines that the excluded principal for the entity or association:

(1) has terminated its [his or her] ownership or control interest in the entity;

(2) is no longer an officer, director, agent, consultant, managing employee, or bears any other title with the same duties, ownership, or control of the entity; or

(3) has been reinstated in accordance with this section.

(e) Notice.

(1) Approval of request for reinstatement. If the OIG approves the request for reinstatement, the OIG provides [OIG will provide] written notice to the excluded person and enters [will enter] the fact of that person's reinstatement into the OIG exclusion database. The OIG must support a determination granting reinstatement after termination with written findings that support the decision. The notice of approval includes [will include]:

(A) any conditions precedent to reinstatement and the date by which they must be satisfied;

(B) any limiting conditions on the person's continued participation in the Medicaid program;

(C) the provider's obligations to re-enroll as a Medicaid provider; and

(D) the effective date of reinstatement.

(2) Denial of request for reinstatement. If the OIG denies a [the] request for reinstatement, it gives [will give] written notice to the requesting person, which includes [will include]:

- (A) notice of the denial; and
- (B) a description of the person's right to ~~to~~ a desk review.

(3) Desk review results. After concluding a desk review, ~~the~~ OIG issues written notice to the provider which includes ~~[OIG will send the provider written notice, which will include]:~~

(A) notice of approval of reinstatement as specified in paragraph (1) of this subsection; or

(B) notice the request was denied and that a subsequent request for reinstatement will not be considered until at least one year after the date of denial.

(f) Due process.

(1) The excluded person may submit a request for a desk review of a denial of reinstatement. The request must be received by the ~~OIG~~ within 30 calendar days of receipt of the notice of denial. The request must include any documentary evidence and written argument against the continued exclusion. Upon timely receipt of a request for desk review, the ~~OIG reviews~~ [OIG will review] the evidence and argument and notify the person of the results.

(2) The denial of reinstatement is an administrative action, not a sanction. A reinstatement decision does not give rise to additional due process or notice requirements.

(3) A determination with respect to reinstatement is not subject to administrative or judicial review. ~~[An administrative law judge or judge may not require reinstatement of an individual or entity in accordance with this section. The determination is subject only to informal resolution meeting by OIG.]~~

(g) Scope and effect of reinstatement.

(1) ~~Reinstatement is not effective unless the~~ OIG approves ~~[will not be effective until OIG grants]~~ the request and provides notice under this section. Reinstatement is ~~[will be]~~ effective as provided in the notice. The provider may apply for re-enrollment on or after the effective date of reinstatement.

(2) An excluded person may not be granted a contract or provider agreement in the Medicaid program unless and until:

- (A) reinstatement is approved by the ~~OIG~~;
- (B) the exclusion status is removed; and
- (C) the person re-enrolls and is admitted as a provider.

(3) If a person circumvents or attempts to circumvent the reinstatement and reenrollment requirements specified in subsections (a), (b), and (e) of this section and receives or uses another ~~[a new]~~ Medicaid program provider number before being reinstated, the person may be excluded without prior notice. The person may also be subject to recoupment of all of the Medicaid provider payments made to that provider number and imposition of administrative penalties.

(4) If a person submits claims or causes claims to be submitted or payments to be made by the programs for items or services furnished, ordered or prescribed, including administrative and management services or salary, during the period of exclusion and before reinstatement has been granted and re-enrollment completed, the ~~OIG~~ may deny reinstatement on that basis. This section applies regardless of whether a person has obtained a program provider number or equivalent, either as an individual or as a member of a group, prior to being reinstated. The person is subject to imposition of recoupment of any payments made and administrative penalties.

*§371.1719. Recoupment of Overpayments Identified by Audit.*

(a) The ~~OIG~~ may recoup an overpayment if the overpayment was identified in an audit that found claims or cost reports resulted in money paid in excess of what the person is or was entitled to receive under an HHS program, contract, or grant. This section does not include overpayments identified by a Recovery Audit Contractor (RAC) pursuant to 42 C.F.R. ~~[CFR]~~ §455.506.

(b) Audit procedures.

(1) An audit conducted by the ~~OIG~~ or its contractor must:

(A) be conducted and reported in accordance with Generally Accepted Governmental Auditing Standards (GAGAS) or other appropriate standards recognized by the United States Government Accountability Office;

(B) limit the period covered by an audit to five years;

(C) notify the person, and the person's corporate headquarters if the person is incorporated, of the impending audit not later than the seventh day before the date the site visit, if any, begins, except when an element of surprise is critical to the audit objective, such as surprise audits, cash counts, or fraud-related procedures; and

(D) permit the person to produce, for consideration, documentation to address any exception found during an audit not later than the tenth ~~[10th]~~ calendar day after the date the exit conference, if any, is completed, or by a later date as specified by the auditor.

(2) If an exit conference is conducted after the site visit, the auditor must allow the person to:

(A) orally respond to questions by the auditor; and

(B) orally comment on the initial findings of the auditor.

(c) Notice.

(1) Point of contact. A person may designate a specific address and individual point of contact to receive all correspondence related to the audit by sending the designated individual's contact information to the auditor and to the ~~OIG~~ Sanctions unit. The ~~OIG begins~~ [OIG will begin] sending all notices and correspondence to the designated point of contact within 30 calendar days after receiving the designation.

(2) Draft audit report. After the field work is completed, the ~~OIG~~ or its auditor delivers ~~[will deliver]~~ written notice of a draft audit report in accordance with §371.1609 of this subchapter (relating to Notice and Service ~~[Notice, Service, and Subpoena Authority]~~).

(3) Revised draft audit report and additional revisions. The auditor may elect whether to issue a revised draft audit report or to issue a final report. The auditor may revise the draft audit report as needed to incorporate the management responses and reconsideration of any initial findings. A revised draft audit report is ~~[will be]~~ delivered to the person in accordance with §371.1609 of this subchapter.

(A) The auditor, in its discretion, may consider additional management or HHS agency staff responses to the revised draft audit report and make additional revisions.

(B) If additional revisions are made that modify the basis or rationale for determining that an overpayment exists or that increase the overpayment amount, the ~~OIG~~ or its auditor provides ~~[will provide]~~ written notice of the revised draft audit report.

(4) Notice of final audit report. The ~~OIG~~ or its auditor delivers written notice of a final audit report in accordance with §371.1609 of this subchapter. The final audit report must include:

(A) a statement of the auditor's compliance with GAGAS;

(B) the management response, which may be summarized;

(C) the final determination of overpayment amount;

(D) reconsideration results and the revisions of any initial findings; and

(E) a recitation of the person's rights and obligations as set forth in subsections (d) and (e) of this section.

(5) Notice of appeal results. After the conclusion of any appeal hearing, the OIG delivers [~~OIG will deliver~~] written notice of the appeal results in accordance with §371.1609 of this subchapter. The written notice identifies [~~will identify~~] the final overpayment amount.

(d) Due process.

(1) Draft audit report. A person who is the subject of a draft audit report may request an informal appeal, may make a written management response, or both. The OIG or its auditor, as designated in the notice letter, must receive a written request for the informal appeal or written management response no later than the 30th calendar day after the date the person receives the draft audit report, or by the date specified by the auditor, whichever is earlier. The informal appeal, if requested, consists [~~will consist~~] of a desk review by the auditing division or entity at the OIG or its auditor.

(2) Revised draft audit report. If the person is the subject of a revised draft audit report that modifies the basis or rationale for determining that an overpayment exists or that increases the overpayment amount, the person may request an informal appeal, may make a written management response, or both. The OIG or its auditor, as designated in the notice letter, must receive a written request for the informal appeal or written management response no later than the 30th calendar day after the date the person receives the revised draft audit report, or by the date specified by the auditor, whichever is earlier. The informal appeal, if requested, consists [~~will consist~~] of a desk review by the auditing division or entity at the OIG or its auditor.

(3) Response to final audit report. A person who receives a final audit report must respond in one of the following ways:

(A) The person can refund the overpayment within 60 calendar days after receipt of the final audit report.

(B) The person can timely request and execute a final payment plan agreement that has been approved by the OIG. A written request for a final payment plan agreement must be received by the OIG within 15 [~~fifteen (15)~~] calendar days after the person received the final audit report. The request must be signed by the person or its attorney and contain a statement that the person agrees not to dispute the findings of the final audit report for purposes of the overpayment recoupment sanction at issue and waives its right to an appeal of any findings for which a payment plan agreement is sought.

(i) The request for a final payment plan agreement is not binding upon the OIG. A resolution is not final until the person and the OIG execute a written final payment plan agreement.

(ii) A request for a final payment plan agreement does not abate the imposition of a final debt in accordance with subsection (e) of this section.

(iii) The OIG may agree to toll the repayment obligation deadline pending negotiations of payment plan terms. The OIG sends [~~OIG will send~~] written notice to the person of any decision to toll the repayment obligations or to discontinue further payment plan negotiations.

(iv) The OIG retains discretion to determine when payment plan negotiations have been exhausted.

(C) The person can timely request an administrative hearing appeal. To request an appeal of the final audit report, the person must file a written request for an appeal, which must be received by the OIG within 15 calendar days after receipt of the final audit report. The request must:

(i) be signed by the person or its attorney;

(ii) contain a statement as to the specific issues, findings, or legal authority in the final audit report being challenged, and the basis for the person's contention that the specific issues or findings and conclusion are incorrect; and

(iii) with respect to any audit findings that are not being challenged [~~on appeal~~], indicate whether the person intends to remit payment within 60 calendar days or whether the person seeks a payment plan in accordance with this section. Recoupment of overpayments at issue on appeal is not [~~will not be~~] initiated by the OIG until the appeal has been finally determined.

(4) Request for a hearing to appeal. Upon timely receipt of a proper written request for appeal, the OIG notifies [~~OIG will notify~~] the HHSC Appeals Division of the provider's hearing request. The appeal then proceeds [~~will then proceed~~] pursuant to Chapter 357, Subchapter I of this title (relating to Hearings Under the Administrative Procedure Act).

(e) Scope and effect.

(1) The effect of a final overpayment identified in an audit is to create a final debt in favor of the State of Texas.

(2) A final audit report becomes final and unappealable if a written request for an appeal is not received by the OIG within 15 [~~fifteen (15)~~] calendar days after the person's receipt of the final audit report.

(3) If a duly requested final payment plan agreement is not executed by all parties or full restitution is not received within 60 calendar days after receipt by the person of an unappealed final audit report or final disposition of an administrative appeal, one or more vendor holds may be placed on the person's payment claims and account; however, the OIG may agree to toll the imposition of any vendor holds pending negotiations of payment plan terms. The OIG sends [~~OIG will send~~] written notice to the person of any decision to toll the imposition of any vendor holds.

(4) If the person has duly requested an appeal, the contested amount of the overpayment becomes final 30 days after the person receives written notice of the appeal results. Recoupment of any overpayments at issue on appeal is not [~~will not be~~] initiated until the appeal has been finally determined.

(f) Reporting.

(1) For purposes of refunding the federal share of any questioned costs, the final audit report constitutes the State's written notice of the identified overpayment amount. The date of the written notice of overpayment accompanying a final audit report constitutes the date of discovery.

(2) If a person appeals a final audit report, the State issues [~~state will issue~~] a written notice of the identified overpayment amount at the conclusion of the appeal, and the date of that notice of final audit report constitutes [~~will constitute~~] the date of discovery.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 15, 2016.

TRD-201600188

Karen Ray

Chief Counsel

Texas Health and Human Services Commission

Earliest possible date of adoption: February 28, 2016

For further information, please call: (512) 424-6900



## 1 TAC §371.1713

### Legal Authority

The repeal is proposed under Texas Government Code §531.102(a-2), which requires the Executive Commissioner to work in consultation with the Office of Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program.

The repeal implements Texas Government Code Chapter 531, as amended by S.B. 207. No other statutes, articles, or codes are affected by the proposal.

### §371.1713. *Restricted Reimbursement.*

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 15, 2016.

TRD-201600189

Karen Ray

Chief Counsel

Texas Health and Human Services Commission

Earliest possible date of adoption: February 28, 2016

For further information, please call: (512) 424-6900



## TITLE 22. EXAMINING BOARDS

### PART 9. TEXAS MEDICAL BOARD

#### CHAPTER 177. BUSINESS ORGANIZATIONS AND AGREEMENTS

##### SUBCHAPTER E. PHYSICIAN CALL COVERAGE MEDICAL SERVICES

### 22 TAC §§177.18 - 177.20

The Texas Medical Board (Board) proposes new Subchapter E, §§177.18 - 177.20, concerning Physician Call Coverage Medical Services.

The amendment to the title of Chapter 177, Business Organizations, changes the title to include the word "Agreements," to reflect the proposed addition of new Subchapter E, concerning "Physician Call Coverage Medical Services", and in order to better describe the topic and content of Chapter 177 as a whole.

New Subchapter E, titled "Physician Call Coverage Medical Services," is added as a subchapter title in order to identify the subject matter of the rules contained in Subsection E. The subchapter's addition results from the Board's meetings with stakeholders who expressed the need for more clarity with respect to the application of the rules relating to on-call services, as it pertains to all physicians and not just those physicians practicing in the area of telemedicine.

New §177.18, relating to Purpose and Scope, is added to set forth the purpose, scope and applicability of Subchapter E, relating to the rules contained in Subchapter E and indicate that the rules pertaining to "on-call" coverage apply to all physicians, rather than just those physicians practicing in the area of telemedicine.

New §177.19, relating to Definitions, is added to define the "Act" and the "Board" as used throughout Subchapter E.

New §177.20, relating to Call Coverage Minimum Requirements, is added to set forth specific minimum requirements for each call coverage model, including expanded and limited call coverage arrangements and a description for each particular model.

Scott Freshour, General Counsel for the Board, has determined that for each year of the first five years the sections as proposed are in effect the public benefit anticipated as a result of enforcing this proposal will be a chapter title that clearly identifies the nature and substance of the rules contained therein; to clearly identify the scope of the rules contained therein, rather than having such rules remain isolated in Chapter 174, which pertains to Telemedicine; and to provide physicians with guidance and clarity as it relates to the applicability of the rules pertaining to physician call coverage agreements and requirements. Furthermore, the public benefit anticipated as a result of enforcing these sections will be to provide physicians more clarity about on-call service agreements and eliminate confusion as to the applicability of the rules and requirements surrounding on-call service agreements; to have clearly defined terms as used throughout Subchapter E; and to improve all physicians' understanding of the required elements to ensure call coverage and continuity of care to patients in Texas while protecting patient health and welfare. Furthermore, the public benefit anticipated as a result of enforcing these sections will be to allow physicians to provide call coverage for patients of another physician who is in the same or a similar specialty, while maintaining the covering and covered physicians' mutual responsibility for patients cared for through the call coverage agreements. Finally, the public benefit anticipated as a result of enforcing these sections will be to expand the ability of physicians to provide call coverage, provide clarity and improved guidance to all physicians regarding minimum requirements for call coverage agreements, and ultimately increase patients' access to quality health care in Texas.

Mr. Freshour has also determined that for the first five-year period the sections are in effect there will be no fiscal implication to state or local government as a result of enforcing the sections as proposed. The effect to individuals required to comply

with these rules as proposed will include costs associated with preparing a call coverage agreement. The effect on small or micro businesses will include costs associated with preparing a call coverage agreement. However, because the new rules will allow expanded call coverage for physicians' patients, the anticipated economic costs may be offset by potential industry growth, as it will create opportunities for new business arrangements and/or opportunities.

Comments on the proposal may be submitted to Rita Chapin, P.O. Box 2018, Austin, Texas 78768-2018 or e-mail comments to: [rules.development@tmb.state.tx.us](mailto:rules.development@tmb.state.tx.us). A public hearing will be held at a later date.

The new rules are proposed under the authority of the Texas Occupations Code Annotated, §153.001, which provides authority for the Board to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; enforce this subtitle; and establish rules related to licensure.

No other statutes, articles or codes are affected by this proposal.

§177.18. Purpose and Scope.

(a) Purpose. Pursuant to §153.001 of the Act, the Board is authorized to adopt rules relating to the practice of medicine. The purpose of this subchapter is to set forth minimum requirements relating to a physician's provision of call coverage services for another physician's established patients. Advances in technology have enabled a more expansive model of call coverage, requiring that minimum standards be adopted so as to better protect and promote the health and safety of the public while accounting for such technological advances. In setting forth these rules, the board recognizes that a call coverage model outside of the traditional office setting between physicians who are not of the same specialty and do not provide reciprocal call coverage can provide effective and safe patient care, contingent upon physicians remaining mutually responsible for meeting the standard of care for call coverage provided under an agreement, and minimum standards being in place proportionate to the level of care being provided. Such standards will allow increased access to healthcare, while maintaining accountability between physicians, in order to provide continuity and coordination of care, thereby protecting patient safety and health.

(b) Scope. This chapter applies to all physicians providing call coverage in Texas, regardless of the nature and scope of technology being used to provide care to patients through the call coverage relationship.

§177.19. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the contents clearly indicate otherwise.

(1) Act--The Texas Medical Practice Act, Texas Occupations Code Annotated, Title 3 Subtitle B.

(2) Board--Texas Medical Board.

§177.20. Call Coverage Minimum Requirements.

(a) Generally. Physicians who are in same specialty or similar specialties may provide medical services through a call coverage agreement (CCA) to established patients of a physician who requests the coverage. Physicians who enter into a CCA are contractually obligated and mutually responsible for meeting the standard of care in providing call coverage medical services to established patients through the CCA, and for documenting and relaying such documentation to the physician who requested the coverage. A record created or relayed solely by the patient to the physician who requested coverage is not sufficient to meet this burden.

(b) Expanded Call Coverage Model. For physicians who enter into a CCA and are not of the same specialty or similar specialties, or do not require that reciprocal medical call coverage services be provided to the covering physician's patients through the CCA, the CCA must be in writing and at a minimum include terms that:

(1) establish and maintain the physicians' mutual responsibility for meeting the standard of care in providing call coverage for the established patients of the physician requesting coverage;

(2) provide a list of all of the physicians that may provide the call coverage under the CCA;

(3) require that at the time of the service provided, the covering physician have access to the necessary and appropriate medical records related to the patient who is being treated under the CCA;

(4) for non-emergency care provided for a diagnosis previously made by the physician who requested call coverage, require the covering physician to furnish a written report to the physician requesting the call coverage within 7 days from the end of each call coverage period;

(5) for non-emergency care provided for an injury, illness, or disease not previously diagnosed by the physician who requested call coverage, require the covering physician to furnish a written report to the physician who requested the call coverage within 72 hours from the end of each call coverage period;

(6) for emergency care provided, require the covering physician to furnish a written report to the physician who requested call coverage within an appropriate time period according to the circumstances of the emergency situation; and

(7) require that the physician who requested the coverage make the written report provided by the covering physician a part of the patient's medical record.

(c) Limited Call Coverage Model.

(1) Physicians who are of the same specialty or similar specialties and require that reciprocal call coverage services be provided to the covering physician(s) patients, may enter into a verbal or written CCA, so long as the CCA limits such medical services to solely responding to the patient's complaint or inquiry for the purpose of determining the following:

(A) whether the patient should be referred or directed to seek immediate emergency care;

(B) whether the patient should be seen by the covering physician for further evaluation in an office setting or through telemedicine; or

(C) whether the patient should receive treatment for a condition that is limited to a 72-hour maximum requiring a follow-up visit with either the covering physician or the physician who requested the coverage.

(2) Terms of the CCA at a minimum must establish the covering and covered physicians' mutual obligation for meeting the standard of care for the covered physician's established patients and for documenting and relaying information related to the patient care provided to the covered physician within an appropriate amount of time from the conclusion of each call coverage period.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 13, 2016.

TRD-201600136

Mari Robinson, J.D.

Executive Director

Texas Medical Board

Earliest possible date of adoption: February 28, 2016

For further information, please call: (512) 305-7016



## PART 22. TEXAS STATE BOARD OF PUBLIC ACCOUNTANCY

### CHAPTER 513. REGISTRATION SUBCHAPTER B. REGISTRATION OF CPA FIRMS

#### 22 TAC §513.10

The Texas State Board of Public Accountancy (Board) proposes an amendment to §513.10, concerning Firm License.

#### Background, Justification and Summary

The amendment to §513.10 will clarify that: 1) CPA firms may be organized under the Texas Business Corporation Act and LLC law, as well as the Texas Professional Corporation Act and professional LLC law, and 2) Professional organizations must be composed entirely of licensees.

#### Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

#### Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be an understanding that CPA firm shareholders may only be CPAs.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

#### Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses; therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

#### Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on February 29, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

#### Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by this proposed amendment.

#### §513.10. Firm License.

(a) Except as provided for in §501.81(d) of this title (relating to Firm License Requirements), a firm providing attest services or using the titles CPAs, CPA Firm, Certified Public Accountants, Certified Public Accounting Firm, Auditing Firm, or a variation of any of those titles shall do so only through a licensed firm.

(b) To be eligible for a firm license, the firm must show:

(1) that a majority of the ownership of the firm, in terms of both financial interests and voting rights, belongs to individuals who hold certificates issued under this chapter or are licensed as a CPA in another state; or [and]

(2) that when the firm ownership includes professional organizations, as defined in §301.003(7) of the Texas Business Organizations Code, the professional organizations must be owned by individuals that hold a certificate issued under this chapter or are licensed in another state; and

(3) [(2)] that all attest services performed in this state are under the supervision of an individual who holds a certificate issued by the board or by another state.

(c) Financial interests shall include but shall not be limited to stock shares, capital accounts, capital contributions, and equity interests of any kind. Financial interests also include contractual rights and obligations similar to those of partners, shareholders or other owners of an equity interest in a legal entity.

(d) Voting rights shall include but shall not be limited to any right to vote on the firm's ownership, business, partners, shareholders, management, profits, losses and/or equity ownership.

(e) Interpretive comment: A licensee offering services as defined in §901.005 of the Act (relating to Findings; Public Policy; Purpose) through an unlicensed firm in accordance with §501.81(d) of this title may not use the CPA designation in the unlicensed firm's name. For example: John Smith may not use the firm name "John Smith, CPA" unless the firm is licensed by the board.

(f) Interpretive comment: §901.351(a) of the Act (relating to Firm License Required), §501.81(a) of this title and subsection (a) of this section require a firm license in order to use the title CPA except as provided for in §501.81(d) of this title.

(g) Interpretive comment: A professional organization includes a professional corporation or professional limited liability company.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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J. Randel (Jerry) Hill

General Counsel

Texas State Board of Public Accountancy

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For further information, please call: (512) 305-7842



## 22 TAC §513.11

The Texas State Board of Public Accountancy (Board) proposes an amendment to §513.11, concerning Qualifications for Non-CPA Owners of Firm License Holders.

### Background, Justification and Summary

The amendment to §513.11 will clarify that: 1) CPA firms may be organized under the Texas Business Corporation Act and LLC law, as well as the Texas Professional Corporation Act and professional LLC law, and 2) Professional organizations must be composed entirely of licensees.

### Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

### Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be an understanding that the requirements for being a non-CPA firm owner applies only to natural persons.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

### Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses; therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

### Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to

his attention at (512) 305-7854, no later than noon on February 29, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

### Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by this proposed amendment.

§513.11. *Qualifications for Non-CPA Owners of Firm License Holders.*

(a) A firm which includes non-CPA owners may not qualify for a firm license unless every non-CPA individual who is an owner of the firm:

~~[(1) is an individual;]~~

(1) ~~[(2)]~~ is actively providing personal services in the nature of management of some portion of the firm's business interests or performing services for clients of the firm or an affiliated entity;

(2) ~~[(3)]~~ is of good moral character as demonstrated by a lack of history of dishonest or felonious acts; and

(3) ~~[(4)]~~ is not a suspended or revoked licensee or certificate holder excluding those licensees that have been administratively suspended or revoked. (Administratively suspended or revoked are those actions against a licensee for Continuing Professional Education reporting deficiencies or failure to renew a license.)

(b) Each of the non-CPA individual owners who are residents of the State of Texas must also:

(1) pass an examination on the rules of professional conduct as determined by board rule;

(2) comply with the rules of professional conduct;

(3) maintain professional continuing education applicable to license holders including the Board approved ethics course as required by board rule;

(4) hold a baccalaureate or graduate degree conferred by a college or university within the meaning of §511.52 of this title (relating to Recognized Institutions of Higher Education [Colleges and Universities]) or equivalent education as determined by the board; and

(5) maintain any professional designation held by the individual in good standing with the appropriate organization or regulatory body that is identified or used in an advertisement, letterhead, business card, or other firm-related communication.

(c) A "Non-CPA Owner" includes any individual or qualified corporation who has any financial interest in the firm or any voting rights in the firm.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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General Counsel

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## CHAPTER 523. CONTINUING PROFESSIONAL EDUCATION

### SUBCHAPTER C. ETHICS RULES: INDIVIDUALS AND SPONSORS

#### 22 TAC §523.131

The Texas State Board of Public Accountancy (Board) proposes an amendment to §523.131, concerning Board Approval of Ethics Course Content.

#### Background, Justification and Summary

The amendment to §523.131 would require ethics course providers to have in their presentation and materials information on the services available to licensees from the Accountants Confidential Assistance Network (ACAN).

#### Fiscal Note

William Treacy, Executive Director of the Board, has determined that for the first five-year period the proposed amendment is in effect, there will be no additional estimated cost to the state, no estimated reduction in costs to the state and to local governments, and no estimated loss or increase in revenue to the state, as a result of enforcing or administering the amendment.

#### Public Benefit Cost Note

Mr. Treacy has determined that for the first five-year period the amendment is in effect the public benefits expected as a result of adoption of the proposed amendment will be increased exposure of the services available to CPAs and CPA applicants from ACAN.

There will be no probable economic cost to persons required to comply with the amendment and a Local Employment Impact Statement is not required because the proposed amendment will not affect a local economy.

#### Small Business and Micro-Business Impact Analysis

Mr. Treacy has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses because the amendment does not impose any duties or obligations upon small businesses or micro-businesses; therefore, an Economic Impact Statement and a Regulatory Flexibility Analysis is not required.

#### Public Comment

Written comments may be submitted to J. Randel (Jerry) Hill, General Counsel, Texas State Board of Public Accountancy, 333 Guadalupe, Tower 3, Suite 900, Austin, Texas 78701 or faxed to his attention at (512) 305-7854, no later than noon on February 29, 2016.

The Board specifically invites comments from the public on the issues of whether or not the proposed amendment will have an adverse economic effect on small businesses; if the proposed rule is believed to have an adverse effect on small businesses, estimate the number of small businesses believed to be impacted by the rule, describe and estimate the economic impact of the rule on small businesses, offer alternative methods of achieving the purpose of the rule; then explain how the Board may legally and feasibly reduce that adverse effect on small businesses considering the purpose of the statute under which the proposed rule is to be adopted, finally describe how the health, safety, environmental and economic welfare of the state will be impacted by the various proposed methods. See Texas Government Code, §2006.002(c).

#### Statutory Authority

The amendment is proposed under the Public Accountancy Act ("Act"), Texas Occupations Code, §901.151 which authorizes the Board to adopt rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by this proposed amendment.

#### §523.131. Board Approval of Ethics Course Content.

(a) The content of an ethics course designed to satisfy the four hour ethics CPE requirements of §523.130 of this chapter (relating to Ethics Course Requirements) must be submitted to the CPE committee of the board for initial approval and upon request thereafter. The primary objectives of the ethics course shall be to:

(1) encourage the licensee to become educated in the ethics of the profession;

(2) convey the intent of the board's Rules of Professional Conduct in the licensee's performance of professional accounting services, and not mere technical compliance;

(3) apply ethical judgment in interpreting the rules and provide for a clear understanding of the public interest. The public interest shall be placed ahead of self-interest, even if it means a loss of job or client;

(4) emphasize the ethical standards of the profession, as described in this section; and

(5) review and discuss the board's Rules of Professional Conduct and their implications for persons in a variety of practices, including at least one example from subparagraph (A) of this paragraph and at least one example from either subparagraph (B) or (C) of this paragraph:

(A) a licensee engaged in the client practice of public accountancy who performs attest and non-attest services, as defined in §501.52 of this title (relating to Definitions); and

(B) a licensee employed in industry who provides internal accounting and auditing services; or

(C) a licensee employed in education or in government accounting or auditing.

(b) To meet the objectives of subsection (a) of this section, a course must be four hours in length and its components should be approximately:

- (1) 25% on ethical principles and values;
- (2) 25% on ethical reasoning and dilemmas;

(3) 15% on the board's Rules of Professional Conduct with special focus on recent changes in those rules and including information on the peer assistance available to Texas CPAs, CPA candidates and accounting students with alcohol, substance abuse, depression, stress or other mental health issues through the Accountants Confidential Assistance Network (ACAN); and

(4) 35% on case studies that require application of ethical principles, values, and ethical reasoning within the context of the board's Rules of Professional Conduct.

(c) Course content shall be approved only after demonstrating, either in a live instructor format, a blended program format, or interactive (computer based) format, as defined in §523.102(c)(1) of this chapter (relating to CPE Purpose and Definitions), that the course contains the underlying intent established in the following criteria:

(1) the course shall be designed to teach CPAs to achieve and maintain the highest standards of ethical conduct through ethical reasoning and the core values of the profession: integrity, objectivity, and independence, as ethical principles in addition to rules of conduct;

(2) the course shall address ethical considerations and the application of the board's Rules of Professional Conduct to all aspects of the professional accounting work whether performed by CPAs in client practice or CPAs who are not in client practice; and

(3) the course shall convey the spirit and intent of the board's Rules of Professional Conduct in the licensee's performance of accounting services, and not mere technical compliance.

(d) Ethics courses must be taught in one single four-hour session, including one 10-minute break each hour or its equivalent.

(e) Ethics courses may be reevaluated every three years or as required by the CPE committee. Updated versions of the course and any other course materials, such as course evaluations, shall be provided when requested by the committee for the course to be continued as an approved course.

(f) At the conclusion of each course, the sponsor shall administer a test to determine whether the program participants have obtained a basic understanding of the course content, including the need for a high level of ethical standards in the accounting profession.

(g) A sponsor of an ethics course approved by the board pursuant to this section shall comply with the board's rules concerning sponsors of CPE and shall provide its advertising materials to the board's CPE committee for approval. Such advertisements shall:

- (1) avoid commercial exploitation;
- (2) identify the primary focus of the course; and
- (3) be professionally presented and consistent with the intent of §501.82 of this title (relating to Advertising).

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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J. Randel (Jerry) Hill

General Counsel

Texas State Board of Public Accountancy

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