HB 2455-3
(LC 699)
3/3/23 (LHF/ps)

Requested by Representative NOSSE

PROPOSED AMENDMENTS TO
HOUSE BILL 2455

On page 2 of the printed bill, delete lines 39 through 45 and delete page 3.

On page 4, delete lines 1 through 17 and insert:

"SECTION 3. Sections 4 and 5 of this 2023 Act are added to and made a part of ORS chapter 414.

"SECTION 4. (1) As used in this section:

"(a) 'Audit' has the meaning given that term in section 5 of this 2023 Act.

"(b) 'Provider' means an individual who is licensed, certified or otherwise authorized to provide physical or mental health services and supplies and who contracts with a coordinated care organization or is enrolled as a Medicaid provider in this state.

(2) The Oregon Health Authority shall establish an education unit within the division of the authority that is charged with overseeing the integrity of provider billing. The education unit, in concert with the compliance officers of coordinated care organizations and with input from communities and culturally competent providers, shall develop a curriculum based on federal and state statutes and rules to inform providers regarding audits or reviews conducted by or on behalf of coordinated care organizations or the authority. The curriculum shall include, but is not limited to brochures and presentations explaining

the documentation that is necessary for audits or reviews and best practices for preparing and managing records to best prepare providers for audits or reviews.

"(3) Curriculum materials and presentations must be:

"(a) Easily understood and may not solely rely on references to statutes; and

"(b) Be posted to the authority's website and available to all providers.

"(4) The authority and coordinated care organizations must ensure that providers are aware of the curriculum and how to access the curriculum.

"(5) The education unit must be sufficiently staffed to allow for travel to in-state conferences and make presentations regionally regarding the curriculum.

"SECTION 5. (1) As used in this section:

"(a) 'Audit' means an on-site or remote review of records of or claims made by a provider by or on behalf of a coordinated care organization or the Oregon Health Authority.

"(b) 'Behavioral health treatment' includes:

"(A) Mental health treatment and services as defined in ORS 743B.427; and

"(B) Substance use disorder treatment and services as defined in ORS 743B.427.

"(c) 'Claim' means a request made by a provider to a coordinated care organization or the authority to reimburse the cost of behavioral health treatment provided to a member of the coordinated care organization or to a medical assistance recipient who is not enrolled in a coordinated care organization.

"(d) 'Clerical error' means a minor error in the keeping, recording or transcribing of records or documents or in the handling of elec-

tronic or hard copies of correspondence that does not result in financial harm to a coordinated care organization or to a patient.

"(e) 'Provider' means an individual who is licensed certified or otherwise authorized to provide behavioral health treatment in this state.

"(2) A coordinated care organization and the Oregon Health Authority must notify providers no later than 30 days before the effective date of any changes by the coordinated care organization or the authority to provider audit requirements.

"(3) An audit of a claim:

"(a) May not be conducted on any paid claim submitted by a provider on a date more than three years earlier without evidence of fraud or a duplicate payment;

"(b) Must be completed no later than 180 days from the date an audit is initiated on a claim;

"(c) Must be conducted by a behavioral health professional; and

"(d) May not result in reversing or overturning a medical necessity determination made by a coordinated care organization or the authority when the claim was submitted or prior authorization of the service approved.

"(4) In the course of an audit, a coordinated care organization or the authority must respond to a provider with findings no later than 30 days after the date the provider responds to a request from a coordinated care organization or the authority for additional information regarding the claim.

"(5) If a coordinated care organization or the authority identifies an error during an audit of a claim that results in a demand for recoupment of the payment on the claim, the coordinated care organization or the authority must work with a provider on a repayment plan.

"(6) A coordinated care organization or the authority conducting an audit may not compensate an individual for conducting the audit that is based on a percentage of the overpayments recouped or in any other way that creates a financial incentive to identify errors that result in recoupment.

"(7) The provisions of this section apply to audits conducted by a coordinated care organization and the authority and to audits conducted by a third party on behalf of a coordinated care organization or the authority.".

In line 18, delete "5" and insert "6".

In line 27, delete "4" and insert "5".

In line 30, delete "6" and insert "7".
