

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to the [Oklahoma Health Care Authority \(OHCA\) Proposed Changes Blog](#).

OHCA COMMENT DUE DATE: February 17, 2017

The proposed policy is a Permanent Rule. The proposed policy was presented at the January 3, 2017 Tribal Consultation and is scheduled to be presented to the Medical Advisory Committee on March 9, 2017 and the OHCA Board of Directors on March 23, 2017.

Reference: APA WF 16-36

SUMMARY:

Program Integrity Audits and Records' Signatures – The proposed Program Integrity Audits revisions clarify the OHCA audit process. The proposed electronic records and signatures revisions set a consistent timeframe for medical records to be authenticated. Revisions also include other minor clean-up to improve consistency.

LEGAL AUTHORITY

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 447.202; 42 CFR 431.220; 56 O.S. 1011.9; 75 O.S. 250.2; 42 U.S.C. 1396(a)(42)(B)(ii)(III); 42 CFR 431.151; 42 CFR 431.153

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

FROM: Harvey Reynolds
Federal and State Authorities

SUBJECT: Rule Impact Statement
APA WF # 16-36

A. Brief description of the purpose of the rule:

The proposed revisions to the Program Integrity Audits/Reviews policy clarify the OHCA audit process by: explaining that the scope of audits may include examination for fraud, waste, and/or abuse of the SoonerCare program; establishing a clearly defined response due date for providers who want to request an informal reconsideration and/or formal appeal of audit findings; and by informing providers that overpayments identified through the audit process may be withheld from future payments if the provider fails to timely contest the underlying audit findings. Also, proposed revisions in Uniform Electronic Transaction Act policy set a consistent timeframe in which medical records must be authenticated, including those instances in which transcription occurs. In addition, the rules have been revised to improve reader comprehension and make the language consistent with other OHCA administrative rules.

- B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

All providers will be affected by the proposed rule changes as all providers are required to authenticate their medical records by signature. Also, individuals and entities who are involved in a Program Integrity audit or audit appeal with the Oklahoma Health Care Authority will be affected by the proposed rule changes.

- C. A description of the classes of persons who will benefit from the proposed rule:

Clinical provider audits staff will benefit from the proposed rule changes through clearer policy regarding authentication of records.

- D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact and there are no fee changes associated with the rule changes for any classes of persons or any political subdivision.

- E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The proposed rule changes will not have an impact on the budget.

- F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule.

- G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The agency does not anticipate that the proposed rule will have an adverse effect on small businesses.

- H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there are no other legal or less costly methods to achieve the purpose of the proposed rule. Measures included a formal public comment period and tribal consultation.

- I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should not have any effect on the public health, safety or environment. The proposed rule is not designed to reduce significant risks to the public health, safety or environment.

- J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effect on the public health, safety or environment if the proposed rule is not implemented.

- K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared date: December 7, 2016

RULE TEXT:

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-2.1. Program Integrity Audits/Reviews

- ~~(a) This section applies to all contractors/providers:~~

~~(1) "Contractor/provider" means any person or organization that has signed a provider agreement with the Oklahoma Health Care Authority (OHCA).~~

~~(2) "Extrapolation" means the methodology of estimating an unknown value by projecting, with a calculated precision (i.e., margin of error), the results of a probability sample to the universe from which the sample was drawn.~~

~~(3) "Probability sample" means the standard statistical methodology in which a sample is selected based on the theory of probability (a mathematical theory used to study the occurrence of random events).~~

~~(4) "Universe" means all paid claims or types of paid claims audited/reviewed during a specified timeframe.~~

~~(5) "Sample" means a statistically valid number of claims obtained from the universe of claims audited/reviewed.~~

~~(6) "Error Rate" means the percentage of dollars of audited claims found to be billed in error.~~

- ~~(b) An OHCA audit/review includes the following:~~

- ~~(1) An examination of provider records, by either an on-site or desk audit. Claims may be examined for compliance with provider contracts, relevant federal and state laws and regulations, including but not limited to the Oklahoma Administrative Code.~~
- ~~(2) An initial audit/review report contains preliminary findings. Upon receipt of the findings, a provider may elect to:~~
- ~~(A) Remit the identified overpayment to OHCA;~~
 - ~~(B) Request informal reconsideration of the initial report per OAC 317:30-3-2.1(b)(3); or~~
 - ~~(C) Request a formal appeal of the initial report per OAC 317:30-3-2.1(b)(4).~~
- ~~(3) An informal reconsideration period. If a provider requests an informal reconsideration, the provider shall provide any and all documentation or relevant information to clear any misunderstandings and/or findings identified in the initial report. Only claims identified by the provider for reconsideration will be reviewed by the OHCA. Any claims or findings not identified by the provider for reconsideration will be deemed waived by the provider if the provider chooses to later appeal the reconsideration finding. The reconsideration findings will replace the initial findings and be identified as the final report.~~
- ~~(4) The right to a formal appeal, if requested by the provider. A request for reconsideration does not limit a provider's right to a formal appeal. However, all claims not specifically identified by the provider for further audit/review at reconsideration will be deemed waived by the provider for purposes of a formal audit appeal. Additionally, the provider must specifically identify each claim to be contested on appeal and any claim not identified in the appeal will be deemed waived on appeal.~~
- ~~(5) If the provider does not request either a reconsideration or a formal appeal within the specified timeframe, the initial report will become the final report and the provider will be obligated to reimburse OHCA for any identified overpayment, which amount shall be immediately due and payable to OHCA.~~
- ~~(c) When OHCA conducts a probability sample audit, the sample claims are selected on the basis of recognized and generally accepted sampling methods. If an audit reveals an error rate exceeding 10%, OHCA shall extrapolate the error rate to the universe of the dollar amount of the audited paid claims.~~
- ~~(1) When using statistical sampling, OHCA uses a sample that is sufficient to ensure a minimum confidence level of 95%.~~

~~(2) When calculating the amount to be recovered, OHCA ensures that all overpayments and underpayments reflected in the probability sample are totaled and extrapolated to the universe from which the sample was drawn.~~

~~(3) OHCA does not consider non-billed services or supplies when calculating underpayments and overpayments.~~

~~(d) If a probability sample audit reveals an error rate of 10% or less, the provider will be required to reimburse OHCA for any overpayments noted during the audit/review.~~

(a) This section applies to all contracted providers. The following words and terms, when used in this Section, shall have the following meaning:

(1) "Contractor/provider" means any person or organization that has signed a provider agreement with the Oklahoma Health Care Authority (OHCA).

(2) "Extrapolation" means the methodology of estimating an unknown value by projecting, with a calculated precision (i.e., margin of error), the results of a probability sample to the universe from which the sample was drawn.

(3) "Probability sample" means the standard statistical methodology in which a sample is selected based on the theory of probability (a mathematical theory used to study the occurrence of random events).

(4) "Universe" means all paid claims or types of paid claims audited/reviewed during a specified timeframe.

(5) "Sample" means a statistically valid number of claims obtained from the universe of claims audited/reviewed.

(6) "Error Rate" means the percentage of dollars of audited claims found to be billed in error.

(b) An OHCA audit/review includes an examination of provider records, by either an on-site or desk audit. Claims may be examined for compliance with provider contracts and/or relevant Federal and State laws and regulations, as well as for practices indicative of fraud, waste, and/or abuse of the SoonerCare program, including, but not limited to, inappropriate coding and consistent patterns of overcharging.

(c) An initial audit/review report contains preliminary findings. Within twenty (20) days of the date of the audit/review report, a provider may elect to:

(1) Remit the identified overpayment to OHCA;

(2) Request informal reconsideration of the initial audit report per OAC 317:30-3-2.1(d); or

(3) Request a formal appeal of the initial audit report per OAC 317:30-3-2.1(e).

(d) If a provider requests an informal reconsideration, the provider, within twenty (20) days of the date of the audit/review report, shall:

(1) Produce any and all written existing documentation that is relevant to, and could reasonably be used to clarify or rebut findings as identified in the initial report. Documents submitted for reconsideration shall not be altered or created for purposes of the audit; and

(2) Specifically identify those claims and findings to be reviewed for reconsideration. Any claims or findings not specifically identified by the provider for reconsideration will be deemed to have been waived by the provider for purposes of both the informal reconsideration and the formal appeal, if requested. The reconsideration findings will replace the initial findings and be identified as the final audit report.

(e) A request for an informal reconsideration does not limit a provider's right to a formal appeal as long as any formal appeal of the final audit report is received by the OHCA Legal Docket Clerk within twenty (20) days of the date of the final audit report. However, all claims and findings not specifically identified by the provider upon an informal reconsideration request will be deemed to have been waived by the provider for purposes of a subsequent formal audit appeal. Additionally, the provider must specifically identify each claim to be contested on appeal, and any remaining appealable claim that has not already been waived during the informal reconsideration and is not specifically identified in the initial appeal filing, will be deemed waived on appeal.

(f) If the provider does not request either an informal reconsideration or a formal appeal within the specified timeframe, the initial report will become the final audit report and the provider will be obligated to reimburse OHCA for any identified overpayment, which amount shall be immediately due and payable to OHCA. OHCA may, at its discretion, withhold the overpayment amount from the provider's future payments.

(g) When OHCA conducts a probability sample audit, the sample claims are selected on the basis of recognized and generally accepted sampling methods. If an audit reveals an error rate exceeding 10%, OHCA shall extrapolate the error rate to the universe of the dollar amount of the audited paid claims.

(1) When using statistical sampling, OHCA uses a sample that is sufficient to ensure a minimum confidence level of 95%.

(2) When calculating the amount to be recovered, OHCA ensures that all overpayments and underpayments reflected in the probability sample are totaled and extrapolated to the universe from which the sample was drawn.

(3) OHCA does not consider non-billed services or supplies when calculating underpayments and overpayments.

(h) If a probability sample audit reveals an error rate of 10% or less, the provider will be required to reimburse OHCA for any overpayments noted during the audit/review.

317:30-3-4.1. Uniform Electronic Transaction Act

~~The Oklahoma Health Care Authority enacts the provisions of the Uniform Electronic Transaction Act as provided in this Section with the exception to the act as provided in this Section.~~ These rules regulate the format, use, and retention of electronic records and signatures generated, sent, communicated, received, or stored by the Oklahoma Health Care Authority (OHCA), in conformity with the Uniform Electronic Transaction Act, found at Section 15-101 et seq. of Title 12A of the Oklahoma Statutes.

~~(1) **Scope of Act.** The Electronic Transaction Act applies to an electronic record and an electronic signature created with a record that is generated, sent, communicated, received or stored by the Oklahoma Health Care Authority.~~

~~(2)~~ **(1) Use of electronic records and electronic signatures.** The rules regarding electronic records and electronic signatures apply when both parties agree to conduct business electronically. Nothing in these regulations requires parties to conduct business electronically. However, should a party have the capability and desire to conduct business electronically with the Oklahoma Health Care Authority OHCA, then the following guidelines must be adhered to:

(A) Only employees designated by the provider's agency may make entries in the member's medical record. All entries in the member's medical record must be dated and authenticated with a method established to identify the author. The identification method may include computer keys, Private/Public Key Infrastructure (PKIs), voice authentication systems that utilize a personal identification number (PIN) and voice authentication, or other codes. Providers must have a process in place to deactivate an employee's access to records upon termination of employment of the designated employee.

(B) When PKIs, computer key/code(s), voice authentication systems or other codes are used, a signed statement must be completed by the agency's employee documenting that the chosen method is under the sole control of the person using it and further demonstrate that:

(i) A list of PKIs, computer key/code(s), voice authentication systems or other codes can be verified;

(ii) All adequate safeguards are maintained to protect against improper or unauthorized use of PKIs, computer keys, or other codes for electronic signatures; and

(iii) Sanctions are in place for improper or unauthorized use of computer key/code(s), PKIs, voice authentication systems or other code types of electronic signatures.

(C) There must be a specific action by the author to indicate that the entry is verified and accurate. Systems requiring an authentication process include, but are not limited to:

(i) Computerized systems that require the provider's employee to review the document on-line and indicate that it has been approved by entering a unique computer key/code capable of verification;

(ii) A system in which the provider's employee signs off against a list of entries that must be verified in the member's records;

(iii) A mail system that sends transcripts to the provider's employee for review;

(iv) A postcard identifying and verifying the accuracy of the record(s) signed and returned by the provider's employee; or

(v) A voice authentication system that clearly identifies the author by a designated personal identification number or security code.

(D) Auto-authentication systems that authenticate a report prior to the transcription process do not meet the stated requirements and will not be an acceptable method for the authentication process.

(E) The authentication of an electronic medical record (signature and date entry) ~~is expected on the day the record is completed. If~~ must occur within three (3) days of the provision of the underlying service, including those instances in which the electronic medical record is transcribed by someone other than the provider, ~~the signature of the rendering provider and date entry is expected within three business days from the day the record is completed. Before any claim is submitted to OHCA for payment of a provided service, the provider must authenticate the electronic medical records relating to that service.~~

(F) Records may be edited by designated administrators within the provider's facility. Edits must be in the form of a correcting entry which preserves entries from the original record. Edits must be completed prior to claims submission or no later than ~~45~~forty-five (45) days after the date of service, whichever ~~is later~~occurs first.

(G) Use of the electronic signature, for clinical documentation, shall be deemed to constitute a signature

and will have the same effect as a written signature on the clinical documentation. The section of the electronic record documenting the service provided must be authenticated by the employee or individual who provided the described service.

(H) Any authentication method for electronic signatures must:

- (i) be unique to the person using it;
- (ii) identify the individual signing the document by name and title;
- (iii) be capable of verification, assuring that the documentation cannot be altered after the signature has been affixed;
- (iv) be under the sole control of the person using it;
- (v) be linked to the data in such a manner that if the data is changed, the signature is invalidated; and
- (vi) provide strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

(I) Failure to properly maintain or authenticate medical records (i.e., signature and date entry) may result in the denial or recoupment of SoonerCare payments.

(3)(2) Record retention for provider medical records. Providers must retain electronic medical records and have access to the records in accordance with guidelines found at OAC 317:30-3-15.

(4)(3) Record retention for documents submitted to OHCA electronically.

(A) The ~~Oklahoma Health Care Authority's~~OHCA's system provides that receivers of electronic information may both print and store the electronic information they receive. The ~~Oklahoma Health Care Authority~~OHCA is the custodian of the original electronic record and will retain that record in accordance with a disposition schedule as referenced by the Records Destruction Act. The ~~Oklahoma Health Care Authority~~OHCA will retain an authoritative copy of the transferable record as described in the Electronic Transaction Act that is unique, identifiable and unalterable.

(i) **Manner and format of electronic signature.** The manner and format required by the ~~Oklahoma Health Care Authority~~OHCA will vary dependent upon whether the sender of the document is a member or a provider. In the limited case where a provider is a client, the manner and format is dependent upon the function served by the receipt of the record. In the case the function served is a request for services, then the format

required is that required by a recipient. In the case the function served is related to payment for services, then the format required is that required by a provider.

(ii) **~~Recipient~~Member format requirements.** The ~~Oklahoma Health Care Authority~~OHCA will allow members to request SoonerCare services electronically. An electronic signature will be authenticated after a validation of the data on the form by another database or databases.

(iii) **Provider format requirements.** The ~~Oklahoma Health Care Authority~~OHCA will permit providers to contract with the ~~Oklahoma Health Care Authority~~OHCA, check and amend claims filed with the ~~Oklahoma Health Care Authority~~OHCA, and file prior authorization requests with the ~~Oklahoma Health Care Authority~~OHCA. Providers with a social security number or federal employer's identification number will be given a personal identification number (PIN). After using the PIN to access the database, a PIN will be required to transact business electronically.

(B) Providers with the assistance of the ~~Oklahoma Health Care Authority~~OHCA will be required to produce and enforce a security policy that outlines who has access to their data and what transaction employees are permitted to complete as outlined in the policy rules for electronic records and electronic signatures contained in paragraph two (2) of this section.

(C) Third Party billers for providers will be permitted to perform electronic transaction as stated in paragraph two (2) only after the provider authorizes access to the provider's PIN and a power of attorney by the provider is executed.

~~(5)~~(4) **Time and place of sending and receipt.** The provisions of the Electronic Transaction Act apply to the time and place of sending and receipt with the exception of a power. Should a power failure, Internet interruption or Internet virus. Should any of the exceptions in this paragraph occur, confirmation is required by the receiving party. occur, confirmation by the receiving party will be required to establish receipt.

~~(6)~~(5) **Illegal representations of electronic transaction.** Any person who fraudulently represents facts in an electronic transaction, acts without authority, or exceeds ~~their~~his or her authority to perform an electronic transaction may be prosecuted under all applicable criminal and civil laws.

317:30-3-30. Signature requirements

(a) For medical review purposes, the Oklahoma Health Care Authority (OHCA) requires that all services provided and/or ordered be authenticated by the author. The method used shall be a ~~hand-written~~handwritten signature, electronic signature, or signature attestation statement. Stamped signatures are not acceptable. Pursuant to ~~federal~~Federal and/or ~~state~~State law, there are some circumstances for which an order does not need to be signed.

(1) Facsimile of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

(2) Orders for clinical diagnostic tests are not required to be signed. If the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a ~~hand-written~~handwritten or electronic signature.

(3) Orders for outpatient prescription drugs are not required to be signed. If the order for a prescription drug is unsigned, there must be medical documentation by the treating physician that he/she intended that the prescription drug be ordered. This documentation showing the intent that the prescription drug be ordered must be authenticated by the author via a ~~hand-written~~handwritten or electronic signature.

(b) A ~~hand-written~~handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance, or obligation. The authentication of a medical record (signature and date entry) ~~is expected on the day the record is completed. If the medical record is transcribed by someone other than the provider, the signature of the rendering provider and date entry is expected within three business days from the day the record is completed.~~must occur within three (3) days of provision of the underlying service, including those instances in which the electronic medical record is transcribed by someone other than the provider. Before any claim is submitted to the OHCA for payment of a provided service, the provider must authenticate the electronic medical records relating to that service.

(1) If a signature is illegible, the OHCA will consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

(2) If the signature is missing from an order, the OHCA will disregard the order during the review of the claim.

- (3) If the signature is missing from any other medical documentation, the OHCA will accept a signature attestation from the author of the medical record entry.
- (c) Providers may include in the documentation they submit a signature log that lists the typed or printed name of the author associated with initials or an illegible signature.
- (1) The signature log may be included on the actual page where the initials or illegible signature are used or may be a separate document.
- (2) The OHCA will not deny a claim for a signature log that is missing credentials.
- (3) The OHCA will consider all submitted signature logs regardless of the date they were created.
- (d) Providers may include in the documentation they submit a signature attestation statement. In order to be considered valid for medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the member.
- (1) The OHCA will not consider signature attestation statements where there is no associated medical record entry.
- (2) The OHCA will not consider signature attestation statements from someone other than the author of the medical record entry in question.
- (3) The OHCA will consider all signature attestation statements that meet the above requirements regardless of the date the attestation was created, except in those cases where the regulations or rules indicate that a signature must be in place prior to a given event or a given date.
- (e) Providers may use electronic signatures as an alternate signature method.
- (1) Providers must use a system and software products which are protected against modification and must apply administrative procedures which are adequate and correspond to recognized standards and laws.
- (2) Providers utilizing electronic signatures bear the responsibility for the authenticity of the information being attested to.
- (3) Providers utilizing electronic signatures must comply with OAC 317:30-3-4.1.
- (f) Nothing in this section is intended to absolve the provider of their obligations in accordance with the conditions set forth in their SoonerCare contract and the rules delineated in OAC 317:30.