Stricken language would be deleted from and underlined language would be added to the law as it existed prior to this session of the General Assembly.

Act 1758 of the Regular Session

State of Arkansas *As Engrossed: S3/10/05 S3/14/05 S3/15/05 S3/22/05*

85th General Assembly

A Bill

Regular Session, 2005 SENATE BILL 982

By: Senators Wooldridge, J. Bookout, Critcher, *Horn*

By: Representative Bradford

For An Act To Be Entitled

THE MEDICAID FAIRNESS ACT; TO ENSURE FAIR TREATMENT OF HEALTH CARE PROVIDERS THAT SERVE MEDICAID RECIPIENTS; AND FOR OTHER PURPOSES.

Subtitle

THE MEDICAID FAIRNESS ACT.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 77 is amended to add an additional subchapter to read as follows:

20-77-1601. Legislative findings and intent.

(a) The General Assembly finds that:

(1) Health care providers who serve Medicaid recipients are an indispensable and vital link in serving this state's needy citizens;

(2) The Department of Human Services already has in place various provisions to:

(A) Ensure the protection and respect for the rights of Medicaid recipients; and

(B) Sanction errant Medicaid providers when necessary.

(b) The General Assembly intends this subchapter to ensure that the department and its outside contractors treat providers with fairness and due process.

20-77-1602. Definitions.

As used in this subchapter:

(1) "Adverse decision" means any decision by the Department of Human Services or its reviewers or contractors that adversely affects a Medicaid provider or recipient in regard to receipt of and payment for Medicaid claims and services, including, but not limited to decisions as to:

(A) Appropriate level of care or coding;

(B) Medical necessity;

(C) Prior authorization;

(D) Concurrent reviews;

(E) Retrospective reviews;

(F) Least restrictive setting;

(G) Desk audits;

(H) Field audits and onsite audits; and

(I) Inspections;

(2) "Appeal" means an appeal under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.;

(3) "Claim" means a request for payment of services or for prior, concurrent, or retrospective authorization to provide services;

(4) "Concurrent review" or "concurrent authorization" means a review to determine whether a specified recipient currently receiving specific services may continue to receive services;

(5) "Denial" means denial or partial denial of a claim;

(6) "Department" means:

(A) The Department of Human Services;

(B) All the divisions and programs of the Department of Human Services, including the state Medicaid program; and

(C) All the Department of Human Services' contractors, fiscal agents, and other designees and agents;

(7) "Medicaid" means the medical assistance program under Title XIX of the Social Security Act that is operated by the Arkansas Department of Human Services, including contractors, fiscal agents, and all other designees and agents.

(8) "Person" means any individual, company, firm, organization, association, corporation, or other legal entity;

(9) "Primary care physician" means a physician whom the department has designated as responsible for the referral or management, or

both, of a Medicaid recipient's health care;

(10) "Prior authorization" means the approval by the state Medicaid program for specified services for a specified Medicaid recipient before the requested services may be performed and before payment will be made by the state Medicaid program;

(11) "Provider" means a person enrolled to provide health or medical care services or goods authorized under the state Medicaid program;

(12) "Recoupment" means any action or attempt by the department to recover or collect Medicaid payments already made to a provider with respect to a claim by:

(A) Reducing other payments currently owed to the provider;

(B) Withholding or setting off the amount against current or future payments to the provider;

(C) Demanding payment back from a provider for a claim already paid; or

(D) Reducing or affecting in any other manner the future claim payments to the provider;

(13) "Retrospective review" means the review of services or practice patterns after payment, including, but not limited to:

(A) Utilization reviews;

(B) Medical necessity reviews;

(C) Professional reviews;

(D) Field audits and onsite audits; and

(E) Desk audits;

(14) "Reviewer" means any person, including, but not limited to, reviewers, auditors, inspectors, and surveyors that in reviewing a provider or a provider's provision of services and goods performs review actions, including, but not limited to:

(A) Reviews for quality;

(B) Quantity;

(C) Utilization;

(D) Practice patterns;

(E) Medical necessity;

(F) Peer review; and

(G) Compliance with Medicaid standards; and

(15)(A) "Technical deficiency" means an error or omission in documentation by a provider that does not affect direct patient care of the recipient.

(B) "Technical deficiency" does not include:

(i) Lack of medical necessity or failure to document medical necessity in a manner that meets professionally recognized applicable standards of care;

(ii) Failure to provide care of a quality that meets professionally recognized local standards of care;

(iii) Failure to obtain prior or concurrent authorization if required by regulation;

(iv) Fraud;

(v) A pattern of abusive billing;

(vi) A pattern of noncompliance; or

(vii) A gross and flagrant violation.

20-77-1603. Technical deficiencies.

(a) The Department of Human Services may not recoup from providers for technical deficiencies if the provider can substantiate through other documentation that the services or goods were provided and that the technical deficiency did not adversely affect the direct patient care of the recipient.

(b) A technical deficiency in complying with a requirement in federal statutes or regulations shall not result in a recoupment unless:

(1) The recoupment is specifically mandated by federal statute or regulation; or

(2) The state can show that failure to recoup will result in a loss of federal matching funds or other penalty against the state.

(c) This section does not preclude a corrective action plan or other nonmonetary measure in response to technical deficiencies.

(d)(1) If a provider fails to comply with a corrective action plan for a pattern of non-compliance with technical requirements, then appropriate monetary penalties may be imposed if permitted by law.

(2) However, the department first must be clear as to what the technical requirements are by providing clear communication in writing, or a promulgated rule where required.

20-77-1604. Provider administrative appeals allowed.

(a) The General Assembly finds it necessary to:

(1) Clarify its intent that providers have the right to administrative appeals; and

(2) Emphasize that this right of appeal is to be liberally construed and not limited through technical or procedural arguments by the Department of Human Services.

(b)(1) In response to an adverse decision, a provider may appeal on behalf of the recipient or on its own behalf, or both, under the Arkansas Administrative Procedure Act, § 25-15-201 et seq., regardless of whether the provider is an individual or a corporation.

(2) The provider may appear:

(A) In person or through a corporate representative; or

(B) With prior notice to the department, through legal counsel.

(3)(A) A Medicaid recipient may attend any hearing related to his or her care, but the department may not make his or her participation a requirement for provider appeals.

(B) The department may compel the recipient's presence via subpoena, but failure of the recipient to appear shall not preclude the provider appeal.

(c) A provider does not have standing to appeal a nonpayment decision if the provider has not furnished any service for which payment has been denied.

(d) Providers, like Medicaid recipients, have standing to appeal to circuit court unfavorable administrative decisions under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(e) If an administrative appeal is filed by both provider and recipient concerning the same subject matter, then the department may consolidate the appeals.

(f) This subchapter shall apply to all pending and subsequent appeals that have not been finally resolved at the administrative or judicial level as of the effective date of this subchapter.

20-77-1605. Explanations for adverse decisions required.

Each denial or other deficiency that the Department of Human Services

makes against a Medicaid provider shall be prepared in writing and shall specify:

(1) The exact nature of the adverse decision;

(2) The statutory provision or specific rule alleged to have been violated; and

(3) The specific facts and grounds constituting the elements of the violation.

20-77-1606. Rebilling at an alternate level instead of complete denial.

(a)(1) Absent fraud or a pattern of abuse, and provided the care being billed was furnished by a provider legally qualified and authorized to deliver the care, if a provider's claim is denied then the provider shall be entitled to rebill at the level that would have been appropriate according to the Department of Human Services's basis for denial.

(2) A referral from a primary care physician or other condition met prior to the claim denial shall not be reimposed.

(b) The denial notice from the department shall explain the reason for the denial under § 20-77-1605 and specify the level of care that it deems appropriate based on the documentation submitted.

(c) A provider's decision to rebill at the alternate level does not waive the provider's or recipient's right to appeal the denial of the original claim.

(d) Nothing prevents the department from reviewing the claim for reasons unrelated to level of care and taking action that may be warranted by the review, subject to other provisions of law.

20-77-1607. Prior authorizations -- Retrospective reviews.

The Department of Human Services may not retrospectively recoup or deny a claim from a provider if the department previously authorized the Medicaid care, unless:

(1) The retrospective review establishes that:

(A) The previous authorization was based upon misrepresentation by act or omission; and

(B) If the true facts had been known the specific level of care would not have been authorized; or

(2)(A) The previous authorization was based upon conditions that later changed, thereby rendering the Medicaid care medically unnecessary.

(B) Recoupments based upon lack of medical necessity shall not include payments for any Medicaid care that was delivered before the change of circumstances that rendered the care medically unnecessary.

20-77-1608. Medical necessity.

There is a presumption in favor of the medical judgment of the attending physician in determining medical necessity of treatment.

20-77-1609. Promulgation before enforcement.

(a) The Department of Human Services may not use state policies, guidelines, manuals, or other such criteria in enforcement actions against providers unless the criteria have been promulgated.

(b) Nothing in this section requires or authorizes the department to attempt to promulgate standards of care that physicians use in determining medical necessity or rendering medical decisions, diagnoses, or treatment.

(c) Medicaid contractors may not use a different provider manual than the Medicaid Provider Manual promulgated for each service category.

20-77-1610. Records.

(a) If the Department of Human Services makes an adverse decision in a Medicaid case and a provider then lodges an administrative appeal, the department shall deliver to the provider well in advance of the appeal its file on the matter so that the provider will have time to prepare for the appeal.

(b) The file shall include the records of any utilization review contractor or other agent, subject to any other federal or state law regarding confidentiality restrictions.

20-77-1611. Copies.

Providers shall be required to supply records at their own cost to the Department of Human Services no more than once.

20-77-1612. Notices.

When the Department of Human Services sends letters or other forms of

notices with deadlines to providers or recipients, the deadline shall not begin to run before the next business day following the date of the postmark on the envelope, the facsimile transmission confirmation sheet, or the electronic record confirmation, unless otherwise required by federal statute or regulation.

20-77-1613. Deadlines.

(a) The Department of Human Services may not issue a claim denial or demand for recoupment to providers for missing a deadline if the department or its contractor contributed to the delay or the delay was reasonable under the circumstances, including, but not limited to:

(1) Intervening weekends or holidays;

(2) Lack of cooperation by third parties;

(3) Natural disasters; or

(4) Other extenuating circumstances.

(b) This section is subject to good faith on the part of the provider.

20-77-1614. Hospital claims.

(a) When more than one (1) hospital provides services to a recipient and the amount of claims exceeds the recipient's benefit limit, then the hospitals are entitled to reimbursement based on the earliest date of service.

(b) If the claims have been paid by Medicaid contrary to this provision, and voluntary coordination among the hospitals involved does not resolve the matter, then the hospitals shall resort to mediation or arbitration at the hospitals' expense.

(c) The Department of Human Services may promulgate rules to implement this section.

20-77-1615. Federal law.

If any provision of this subchapter shall be found to conflict with current federal law, including promulgated federal regulations, the federal law shall override that provision.

SECTION 2. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that Medicaid providers are frustrated in their attempts to access the appeals process and to interact with the Medicaid program, and that it is imperative that changes be made in state law to remedy these problems. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

/s/ Wooldridge

APPROVED: 4/05/2005

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