INTERIM STUDY PROPOSAL 2015-092

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A Bill

SENATE BILL 829

By: Senator D. Sanders

Filed with: Senate Committee on Public Health, Welfare, and Labor
pursuant to A.C.A. §10-3-217.

For An Act To Be Entitled

AN ACT TO ENHANCE THE PUBLIC INTEGRITY OF THE MEDICAID FAIRNESS ACT; TO AMEND CERTAIN PROVISIONS OF THE MEDICAID FAIRNESS ACT; AND FOR OTHER PURPOSES.

Subtitle

TO ENHANCE THE PUBLIC INTEGRITY OF THE MEDICAID FAIRNESS ACT; AND TO AMEND CERTAIN PROVISIONS OF THE MEDICAID FAIRNESS ACT.

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

SECTION 1. Arkansas Code §§ 20-77-1702 – 20-77-1704 are amended to read as follows:

20-77-1702. Definitions.

As used in this subchapter:

(1) "Abuse" means ~~a pattern of~~ provider ~~conduct~~ practices that ~~is~~ are inconsistent with sound fiscal, business, or medical practices and that ~~results~~ result in:

(A) ~~An unnecessary~~ Unnecessary cost to the Medicaid program; or

(B) Reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care;

(2)(A) “Adverse decision” means any decision by the Department of Human Services ~~or its reviewers or contractors~~ that materially and adversely affects a Medicaid provider or recipient in regard to:

(i) 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 or surveys; and

(ii) Payment amounts due to or from a particular provider resulting from gain sharing, risk sharing, incentive payments, or another reimbursement mechanism or methodology, including calculations that affect or have the potential to affect payment.

(B) To constitute an adverse decision, an agency decision need not have a monetary penalty attached but must have a material and direct monetary consequence to the provider.

(C) “Adverse decision” does not include:

(i) ~~the~~ The design of or changes to an element of a reimbursement methodology or payment system that is of general applicability and implemented through the rule-making process;

(ii) A decision regarding the Medicaid eligibility of a specified Medicaid recipient or applicant for Medicaid benefits; or

(iii) A determination of disability for a specified Medicaid recipient or applicant for Medicaid benefits;

(3) “Appeal” means an appeal of an adverse decision to an independent administrative law judge as provided under this subchapter;

(4) “Claim” means a request for payment of services or for prior, concurrent, or retrospective authorization to provide services;

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

(6) “Denial” means denial or partial denial of a claim;

(7) “Department” or "Department of Human Services" ~~means~~ includes:

(A) The Department of Human Services;

(B) All the divisions and programs of the department, including the state Medicaid program; ~~and~~

(C) ~~All the department’s contractors, fiscal agents, and other designees and agents~~ A fiscal agent employed by the department to operate the Medicaid Management Information System;

(D) A quality improvement organization, quality improvement organization-like entity, or other utilization review contractor employed by the department to perform medical and utilization review functions as required by law; and

(E) The Office of Medicaid Inspector General;

(8) “Final determination” means, for purposes of recoupment, a Medicaid overpayment determination:

(A) For which ~~all provider appeals have been exhausted~~ an administrative law judge has rendered a decision; or

(B) That cannot be appealed ~~or appealed further~~ by the provider to an administrative law judge because the time to file an appeal has passed;

(9)(A) “Fraud” means ~~an intentional representation that is untrue or made in disregard of its truthfulness for the purpose of inducing reliance in order to obtain or retain anything of value under the Medicaid program~~ a purposeful deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or another person.

(B) "Fraud" includes any act that constitutes fraud under applicable federal or state law;

(10) “Level of care” means:

(A) The level of licensure or certification of the caregiver that is required to provide medically necessary services, for example, a physician or a registered nurse; and

(B) As applicable to the adverse decision:

1 (i) With respect to medical assistance reimbursed by
2 procedure code or unit of service, the quantity of each medically necessary
3 procedure or unit;
4 (ii) With respect to durable medical equipment, the
5 type of equipment required and the duration of equipment use; and
6 (iii) With respect to all other medical assistance,
7 the:
8 (a) Intensity of service, for example, whether
9 intensive care unit hospital services were required;
10 (b) Duration of service, for example, the
11 number of days of a hospital stay; or
12 (c) Setting in which the service is delivered,
13 for example, inpatient or outpatient;
14 (11) "Medicaid" means the medical assistance program under Title
15 XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., and Title XXI of
16 the Social Security Act, 42 U.S.C. § 1397aa et seq., that is operated by the
17 department, including contractors, fiscal agents, and all other designees and
18 agents;
19 (12) "Person" means any individual, company, firm, organization,
20 association, corporation, or other legal entity;
21 (13) "Primary care physician" means a physician whom the
22 department has designated as responsible for the referral or management, or
23 both, of a Medicaid recipient's health care;
24 (14) "Prior authorization" means the approval by the state
25 Medicaid program for specified services for a specified Medicaid recipient
26 before the requested services may be performed and before payment will be
27 made by the state Medicaid program;
28 (15) "Provider" means a person enrolled to provide health or
29 medical care services or goods authorized under the state Medicaid program;
30 (16) "Recoupment" means any action or attempt by the department
31 to recover or collect Medicaid payments already made to a provider with
32 respect to a claim by:
33 (A) Reducing other payments currently owed to the
34 provider;
35 (B) Withholding or setting off the amount against current
36 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;

(17) "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;

(F) Automated reviews, including review of claims data to identify fraud, waste, or abuse without the need for human review of medical records or other records; and

(G) Self-directed reviews conducted by a provider upon the request or direction of the department;

(18) "Reviewer" means any person, including, but not limited to, reviewers, auditors, inspectors, and surveyors, who in reviewing a provider or a provider's provision of medical assistance, reviews without limitation:

(A) Quality;

(B) Quantity;

(C) Utilization;

(D) Practice patterns;

(E) Medical necessity; and

(F) Compliance with Medicaid laws, regulations, and rules; ~~and~~

(19)(A) "Technical deficiency" means ~~an~~ a minor or inadvertent error or omission in documentation by a provider that does not:

(i) Adversely affect ~~direct patient care of the recipient~~ the health or safety of a patient; or

(ii) Result in an unnecessary cost to the Arkansas Medicaid Program.

(B) "Technical deficiency" does not include:

(i) Lack of medical necessity according to professionally recognized local standards of care;

1 (ii) Failure to provide care of a quality that meets
2 professionally recognized local standards of care;
3 (iii) Failure to document a mandatory quality
4 measure required for gain sharing or medical home or health home incentive
5 payments as specified in a reimbursement mechanism or methodology;
6 (iv) Failure to obtain prior or concurrent
7 authorization if required by regulation;
8 (v) Fraud;
9 (vi) Abuse;
10 (vii) Waste;
11 (viii) A pattern of noncompliance; ~~or~~
12 ~~(viii)~~(ix) A gross and flagrant violation;
13 (x) An error or omission resulting in the provision
14 of services in a scope or quantity greater than what is medically necessary;
15 or
16 (xi) An error or omission resulting in the provision
17 of services in a scope or quantity exceeding professionally recognized
18 standards for health care; and
19 (20) "Waste" means when taxpayers are not receiving reasonable
20 value for money in connection with a government-funded activity due to an
21 inappropriate act or omission involving mismanagement, inappropriate actions,
22 or inadequate oversight by the person with control over or access to
23 government resources.
24
25 20-77-1703. Recoupment.
26 (a)(1) The Department of Human Services shall not use a technical
27 deficiency as grounds for recoupment unless identifying the technical
28 deficiency as an overpayment is mandated by a specific federal statute or
29 regulation or the state is required to repay the funds to the Centers for
30 Medicare and Medicaid Services, or both.
31 (2) When recoupment is permitted, the department shall not
32 recoup until there is a final determination identifying the funds to be
33 recouped as overpayments.
34 (3) The recoupment amount shall accrue interest at the rate
35 established by law for judgments entered by a court, beginning on the day the
36 department first makes written demand for payment.

(b)(1) The department shall recognize that an error or omission is a technical deficiency if:

(A) The error or omission meets the definition of "technical deficiency" in § 20-77-1702;

(B) The error or omission involved a covered service; and

(C) The provider can substantiate through other contemporaneous documentation that the medical assistance was provided in an appropriate scope and quantity.

(2) Other documentation under subdivision (b)(1)(C) of this section shall be:

(A) In accord with generally accepted healthcare practices; and

(B) Contemporaneously created at or before the time of service.

(3) Other documentation under subdivision (b)(1)(C) of this section is not required to be equivalent in form to, nor required to duplicate, the documentation containing the error or omission, if all the documentation taken together establishes that the claim is payable.

(c) This section does not preclude a corrective action plan or other nonmonetary measure, if approved by the department, in response to technical deficiencies.

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

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

(e)(1) The department shall not issue a recoupment on a minor omission such as a missing date or signature if the requirements of this section are met and the omission meets the definition of "technical deficiency" in § 20-77-1702.

(2) This subsection (e) of this section shall not apply to the omission of a treating physician's signature on a prescription order for services.

(f)(1) The department shall not rely on the denial of one (1) claim as the sole basis for the denial of a subsequent claim and shall establish that the subsequent claim is deficient.

(2) The department may rely on an error or omission in one (1) claim as the sole basis for the denial of a subsequent claim if the subsequent service is provided as a result of the error or omission.

20-77-1704. Provider administrative appeals allowed.

(a) The General Assembly finds it necessary to:

(1) Clarify its intent that providers have the right to fair and impartial 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)(A) In response to an adverse decision, a provider may appeal ~~on behalf of the recipient or~~ only on its own behalf~~, or both, regardless of whether the provider is an individual or a corporation~~.

(B)(i) A provider appeal shall be governed by the Arkansas Administrative Procedure Act, § 25-15-201 et seq., except as otherwise provided in this subchapter.

(ii) Multiple appeals by the same provider may be consolidated, unless medical necessity is at issue.

(C) An administrative law judge employed by the Department of Health shall conduct all Medicaid provider administrative appeals of adverse decisions under this subchapter.

(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~~ Department of Health may not make his or her participation a requirement for provider appeals.

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

(c)(1) An administrative law judge shall be guided by the need to reach a just determination and may depart from strict adherence to the formal rules of evidence.

(2) An administrative law judge shall exclude irrelevant, immaterial, and unduly repetitious evidence.

(3) An administrative law judge shall receive oral or documentary evidence not privileged if the oral or documentary evidence is of a type commonly relied upon by a reasonably prudent person in the conduct of his or her affairs.

(4) An administrative law judge shall rule on each evidentiary objection, and the objection and ruling shall be noted of record.

~~(d)(1)(A) If a provider submits evidence that the Department of Human Services has not had an opportunity to consider before the hearing, an administrative law judge shall continue the hearing for thirty (30) days to allow the Department of Human Services to review the evidence.~~

~~(B) An administrative law judge may extend the thirty-day continuance under subdivision (d)(1)(A) of this section for good cause.~~

~~(2) Before the end of a continuation under subdivision (d)(1) of this section, the Department of Human Services shall send the provider and the administrative law judge notice stating whether the Department of Human Services will modify its decision with an explanation of the modification.~~

(d)(1) After an appeal is filed, the provider may submit evidence that the Department of Human Services has not had an opportunity to consider, only if the administrative law judge finds that:

(A) The new evidence is material and goes to the merits of the appeal;

(B) The new evidence is not cumulative; and

(C) The new evidence could not have been obtained by the provider and presented to the Department of Human Services with reasonable diligence prior to the appeal.

(2)(A) If the administrative law judge allows a provider to introduce new evidence, the judge shall continue the hearing for at least thirty (30) days to allow the Department of Human Services to review the evidence.

(B) The Department of Human Services may modify its findings and decision by reason of the additional evidence and shall file any

modifications, new findings, or decisions with the administrative law judge with notice to the provider.

(3)(A) Unless the provider notifies the administrative law judge and the Department of Human Services that the provider wishes to withdraw its appeal, the administrative law judge shall notify the parties of the date and time at which the hearing will continue.

(B) The date under subdivision (d)(3)(A) of this section shall be no later than thirty (30) days after the Department of Human Services' notification under subdivision (d)(2) of this section.

(e) A provider does not have standing to appeal a decision denying payment or ordering recoupment of payments already made if the provider has not furnished any service for which payment has been denied.

(f)(1) 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.

(2) The Department of Human Services may seek judicial review of a final, appealable order issued by an administrative law judge.

(g)(1) ~~Burdens of proof shall be determined under~~ In accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq., the proponent of an order shall have the burden of proof.

(2) For the purposes of this section, the "proponent of an order" includes without limitation:

(A) A provider seeking payment or authorization for services;

(B) A provider contesting recoupment; and

(C) The Department of Human Services in seeking to permanently exclude or bar a provider from participation in Medicaid.

(h)(1)~~(A)~~ A final decision by an administrative law judge in favor of a provider is a final appealable order.

~~(B) A final decision under this section shall not be overturned by the Director of the Division of Medical Services of the Department of Human Services or another official within the Department of Human Services.~~

(2)~~(A) Within thirty (30) days after August 16, 2013, the Department of Human Services shall request a waiver from the Centers for Medicare and Medicaid Services of the single state agency requirement~~

1 ~~contained in 42 C.F.R. § 431.10 to allow final decisions in Medicaid provider~~
2 ~~administrative appeals to be issued by an administrative law judge in a~~
3 ~~separate agency.~~
4 ~~(B)~~ An administrative law judge shall follow the rules
5 adopted by the Department of Human Services in making final decisions.
6 ~~(3) The Department of Human Services shall make available to the~~
7 ~~public all communications with regard to the waiver application under~~
8 ~~subdivision (h)(2)(A) of this section and shall work jointly with provider~~
9 ~~representatives to obtain and maintain approval for the waiver.~~
10 (i)(1) ~~Until the waiver under subdivision (h)(2) of this section is~~
11 ~~approved, an~~ An administrative law judge's decision shall constitute a
12 recommended decision to the Director of the Division of Medical Services of
13 the Department of Human Services.
14 (2)(A) The ~~Director of the Division of Medical Services~~
15 director, upon a review of the record submitted by an administrative law
16 judge, shall adopt, reject, or modify the recommended decision.
17 (B) A modification or rejection of an administrative law
18 judge's decision shall state with particularity the reasons for the
19 modification or rejection, shall include references to the record, and shall
20 constitute the final decision.
21 (C) As an alternative to the process under subdivision
22 (i)(2)(B) of this section, the Director of the Division of Medical Services
23 may remand the decision to the administrative law judge with additional
24 guidance on Medicaid policy.
25 (3)(A) The ~~Director of the Division of Medical Services~~ director
26 shall issue a final decision under this subsection within thirty (30) days
27 after receipt of the administrative law judge's decision.
28 (B) Unless the ~~Director of the Division of Medical~~
29 ~~Services~~ director modifies or rejects the recommended decision of the
30 administrative law judge within thirty (30) days after receipt of the
31 administrative law judge's decision, the recommended decision is the final
32 decision.
33 (j) If an administrative appeal is filed by both provider and
34 recipient concerning the same subject matter, then the Department of Human
35 Services may consolidate the appeals.

(k)(1) This subchapter shall apply to all pending and subsequent appeals that have not been finally resolved at the administrative or judicial level as of April 5, 2005.

(2) The amendatory provisions of this act apply to a pending and subsequent appeal that has not been finally resolved at the administrative or judicial level on August 16, ~~2013~~ 2015.

SECTION 2. Arkansas Code § 20-77-1706(a)(2) and (3) are amended to read as follows:

(2)~~(A)~~ If the department does not have sufficient documentation to determine the level of care that was medically necessary, the department ~~shall not recoup at that time, but shall~~ may request from the provider additional documentation the department needs to determine the level of care that was medically necessary.

~~(B) After receiving documentation requested under subdivision (b)(2)(A) of this section, the department shall review the documentation and determine whether to proceed with a recoupment and notice, subject to § 20-77-1707.~~

(3)~~(A) No physician referral shall be required as a condition of payment for care that is determined to be medically necessary upon a review conducted under this section.~~

~~(B)~~ A requirement for a referral from a primary care physician shall not be imposed retroactively.

SECTION 3. Arkansas Code § 20-77-1706(b)(2) and (3) are amended to read as follows:

(2)~~(A)~~ If the department does not have sufficient documentation to determine the level of care that is medically necessary, the department ~~shall not deny the claim at that time but shall~~ may request from the provider the additional documentation the department needs to determine the level of care that is medically necessary.

~~(B) The department shall then:~~

~~(i) Review the request; and~~

~~(ii) If the department denies the request, explain the reason for the denial in accordance with subdivision (b)(4) of this section.~~

(3)~~(A) No physician referral shall be required as a condition of payment for care that is determined to be medically necessary upon a review conducted under this section.~~

~~(B)~~ A requirement for a referral from a primary care physician shall not be imposed retroactively.

SECTION 4. Arkansas Code §§ 20-77-1707 — 20-77-1709 are amended to read as follows:

20-77-1707. Prior authorizations — Retrospective reviews.

If the Department of Human Services requires a provider to justify the medical necessity of a service through prior authorization, the department shall not later take the position that the services were not medically necessary, unless the retrospective review establishes that:

(1) The previous authorization was based upon or affected by misrepresentation by act or omission;

(2) The services billed were not provided or were provided in a quantity or at a level of care other than what was authorized or outside the time period authorized; or

(3) An unexpected change occurred that rendered the prior-authorized care not medically necessary.

20-77-1708. Medical necessity.

(a) There is a rebuttable presumption in favor of the medical judgment of the performing or prescribing physician in determining medical necessity of treatment.

(b) If an administrative law judge finds that the Department of Human Services has overcome the presumption under subsection (a) of this section, he or she shall state the manner by which the presumption was overcome.

(c) The department may overcome the presumption under subsection (a) of this section by:

(1) Introducing evidence of a type commonly relied upon by a reasonably prudent person in the conduct of his or her affairs, including without limitation medical or opinion evidence generated by a reviewer or other medical professional; or

(2) Demonstrating that the medical judgment of the performing or prescribing physician is inconsistent with:

(A) Standards of evidence-based medicine; or

(B) Professionally recognized standards for health care.

20-77-1709. 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 practitioners use in determining medical necessity or rendering medical decisions, diagnoses, or treatment.

(c) Medicaid contractors may not use a different provider manual than the ~~Centers for Medicare and Medicaid Services~~ Provider Reimbursement Manual promulgated for each service category.

SECTION 5. Arkansas Code § 20-77-1713, concerning deadlines, is amended to add an additional subsection to read as follows:

(c) This section does not permit the extension or excusal of any deadline for filing an appeal.

SECTION 6. Arkansas Code § 20-77-1717 and 20-77-1718 are amended to read as follows:

20-77-1717. Timelines for audits.

(a) If a Medicaid provider audit by the federal Medicaid Integrity Program or Audit Medicaid Integrity Contractors is conducted, the Department of Human Services or the contractor shall provide the audit report to the provider within the later of one hundred fifty (150) days after the completion of the audit field work or the date on which the provider submitted all documentation necessary for the audit to be completed.

(b) If a provider requests an administrative reconsideration of an audit finding or report, the department shall provide the results of the reconsideration within sixty (60) days after the department's receipt of the request for reconsideration.

(c) Additional provider records furnished by a provider in conjunction with a provider's request for administrative reconsideration shall have been contemporaneously created.

(d) If there is a failure to meet the timelines specified in this section, no adverse decision based on the noncompliant audit shall be enforced against the provider unless:

(1) ~~the~~ The department shows good cause for the failure to meet the timelines;

(2) The provider fails to supply all documentation necessary for the audit to be completed; or

(3) The federal government is recovering or has recovered payments from the department on the basis of the audit findings.

20-77-1718. Termination — Appeals.

(a) A Medicaid provider that is aggrieved by an adverse decision of the Department of Human Services with respect to termination of the provider's certification or Medicaid provider agreement or an action by the department that has the same effect as terminating the provider's certification or Medicaid provider agreement for more than fifteen (15) days may appeal the decision to Pulaski County Circuit Court or in a circuit court in a county in which the provider resides or does business, regardless of whether all administrative remedies have been exhausted.

(b) Pending a determination by the circuit court of the matter on appeal, the provider is entitled to an injunction preserving the provider's Medicaid participation upon showing that immediate and irreparable injury, loss, or damage to the provider will result, unless the circuit court determines that preserving the provider's participation is likely to pose a danger to the health or safety of beneficiaries or to the integrity of the Arkansas Medicaid Program.

(c) This section does not apply to an adverse decision resulting from:

(1) ~~the~~ The department's determination that there is a credible allegation of fraud for which an investigation is pending;

(2) Federal government action; or

(3) The requirements of federal law.

Referred by the Arkansas Senate

Prepared by: JLC