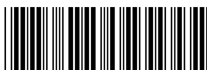
Stricken language would be deleted from and underlined language would be added to the law as it existed prior to this session of the General Assembly.

1 State of Arkansas
2 85th General Assembly
A Bill
3 Regular Session, 2005 SENATE BILL 982
4
5 By: Senators Wooldridge, J. Bookout, Critcher
6 By: Representative Bradford
7
8
9 ## For An Act To Be Entitled
10 THE MEDICAID FAIRNESS ACT; TO ENSURE FAIR
11 TREATMENT OF HEALTH CARE PROVIDERS THAT SERVE
12 MEDICAID RECIPIENTS; AND FOR OTHER PURPOSES.
13
14 ## Subtitle
15 THE MEDICAID FAIRNESS ACT.
16
17
18 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:
19
20 SECTION 1. Arkansas Code Title 20, Chapter 77 is amended to add an
21 additional subchapter to read as follows:
22 20-77-1601. Legislative findings and intent.
23 (a) The General Assembly finds that:
24 (1) Health care providers who serve Medicaid recipients are an
25 indispensable and vital link in serving this state's needy citizens;
26 (2) The Department of Human Services already has in place
27 various provisions to:
28 (A) Ensure the protection and respect for the rights of
29 Medicaid recipients; and
30 (B) Sanction errant Medicaid providers when necessary.
31 (b) The General Assembly intends this subchapter to ensure that the
32 department and its outside contractors treat providers with fairness and due
33 process.
34
35 20-77-1602. Definitions.
36 As used in this subchapter:



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

(A) Decisions as to 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 or request for authorization;

(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)(A) "Medicaid" means the medical assistance program under Title XIX of the Social Security Act, as it existed on January 1, 2005, that is operated by the Arkansas Department of Human Services, including contractors, fiscal agents, and all other designees and agents.

(B) As used in this subchapter, "Medicaid" includes the department and vice versa;

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

1 (9) "Primary care physician" means a physician whom the
2 department has designated as responsible for the referral or management, or
3 both, of a Medicaid recipient's health care;
4 (10) "Prior authorization" means the approval by the state
5 Medicaid program for specified services for a specified Medicaid recipient
6 before the requested services may be performed and before payment will be
7 made by the state Medicaid program;
8 (11) "Provider" means a person enrolled to provide health or
9 medical care services or goods authorized under the state Medicaid program;
10 (12) "Recoupment" means any action or attempt by the department
11 to recover or collect Medicaid payments already made to a provider with
12 respect to a claim by:
13 (A) Reducing other payments currently owed to the
14 provider;
15 (B) Withholding or setting off the amount against current
16 or future payments to the provider;
17 (C) Demanding payment back from a provider for a claim
18 already paid; or
19 (D) Reducing or affecting in any other manner the future
20 claim payments to the provider;
21 (13) "Retrospective review" means the review of services or
22 practice patterns after payment, including, but not limited to:
23 (A) Utilization reviews;
24 (B) Medical necessity reviews;
25 (C) Professional reviews;
26 (D) Onsite audits; and
27 (E) Desk audits;
28 (14) "Reviewer" means any person, including, but not limited to,
29 reviewers, auditors, inspectors, and surveyors that in reviewing a provider
30 or a provider's provision of services and goods performs any of the following
31 actions, including, but not limited to:
32 (A) Reviews for quality;
33 (B) Quantity;
34 (C) Utilization;
35 (D) Practice patterns;
36 (E) Medical necessity;

1 (F) Peer review; and
2 (G) Compliance with Medicaid standards; and
3 (15)(A) “Technical deficiency” means an error or ommission in
4 documentation by a provider.
5 (B) "Technical deficiency" does not include:
6 (i) Lack of medical necessity;
7 (ii) Failure to obtain prior authorization if
8 required by regulation;
9 (iii) Fraud; or
10 (iv) A pattern of abusive billing.
11
12 20-77-1603. Technical deficiencies.
13 (a) The Department of Human Services may not recoup from providers for
14 technical deficiencies if:
15 (1) The provider can substantiate through other means that the
16 services or goods were provided; or
17 (2) It is reasonable to conclude from surrounding circumstances
18 that the services or goods were provided.
19 (b) A technical requirement in federal statutes or regulations shall
20 not result in a recoupment unless:
21 (1) The recoupment is specifically mandated by federal statute
22 or regulation; or
23 (2) The state can show that failure to recoup will result in a
24 loss of federal matching funds or other penalty against the state.
25 (c) This section does not preclude a corrective action plan or other
26 nonmonetary measure in response to technical deficiencies.
27
28 20-77-1604. Provider appeals allowed
29 (a) The General Assembly finds it necessary to:
30 (1) Clarify its intent with regard to the right of providers to
31 appeal under § 20-77-107(f)(5); and
32 (2) Emphasize that this provision is to be liberally construed
33 and not limited through technical or procedural arguments by the Department
34 of Human Services.
35 (b)(1) In response to an adverse decision, a provider may appeal on
36 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 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.

(c) The department may not prevent providers from submitting for reconsideration or appeal records in addition to those reviewed by Medicaid reviewers if the additional records were in existence and available at the time of the initial review or are otherwise relevant to the episode of care at issue.

(d) Appeals shall be permitted for providers and Medicaid recipients even if the decision being appealed involves a so-called "administrative policy".

(e 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.

(f) This section 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 actions 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 violation;

(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.

1 (a)(1) Absent fraud or a pattern of abuse, if a provider's claim is
2 denied, the provider shall be entitled to rebill at the level that would have
3 been appropriate according to Medicaid's basis for denial.
4 (2) A referral from a primary care physician or other condition
5 met prior to the claim denial shall not be reimposed.
6 (b) The denial notice from Medicaid shall specify the level of care
7 that Medicaid deems appropriate and the reason for the denial.
8 Alternatively, Medicaid shall automatically rebill the claim with the reason
9 for the rebilling.
10 (c) Rebilling at an alternate level does not waive the provider's or
11 Medicaid's or patient's right to appeal the denial of the original claim.
12
13 20-77-1607. No procedural obstacles to care or reimbursement.
14 (a) If the Department of Human Services imposes primary care physician
15 referrals, gatekeepers, prior authorization, continuing care authorizations,
16 processing periods, or other utilization controls and procedural rules, the
17 department shall ensure that Medicaid recipients can still obtain the
18 appropriate level of care without a delay that might put the recipient's
19 health at risk and without putting a provider at risk of nonreimbursement if
20 the recipient or provider substantially complies with the rules.
21 (b) If the department imposes both prior or continuing care
22 authorizations and primary care physician referrals the purposes of the prior
23 or continuing care authorizations and the primary care physician referrals
24 shall not overlap.
25 (c)(1) If the department requires prior or continuing care
26 authorizations, a specialty physician need not obtain the primary care
27 physician's approval to provide or make a change in diagnosis, prescriptions,
28 treatment, or other needed care.
29 (2) A primary care physician shall not be allowed to override
30 the medical determination of a specialty physician.
31 (3) The specialty physician shall keep the primary care
32 physician appropriately informed.
33
34 20-77-1608. Prior authorizations -- Retrospective reviews.
35 The Department of Human Services may not retrospectively recoup or deny
36 a claim from a provider if the department previously authorized the Medicaid

care, unless the retrospective review establishes that the previous authorization was based upon misrepresentation and that if the true facts had been known, the specific level of care would not have been authorized.

20-77-1609. Medical necessity.

(a) The medical necessity determination of the Medicaid recipient's attending physician, whether a primary care physician or a specialist, shall carry a rebuttable presumption of appropriateness if:

(1) The care has been delivered at the time of the determination; and

(2) The physician has engaged in direct treatment or observation of the patient.

(b) If the Department of Human Services denies a claim based on medical necessity, the department shall carry the burden of proof in any administrative appeal or court proceeding of disproving the medical necessity determination of the attending physician.

20-77-1610. Promulgation required.

(a)(1) The Department of Human Services shall promulgate through the Arkansas Administrative Procedure Act, § 25-15-201 et seq., all state criteria, guidelines, policies, standards, manuals, and materials of similar nature before it may enforce them against providers.

(2) The department may not use any criteria to review providers claims that have not been publicly promulgated.

(b)(1) If the department formally or informally uses in any portion of its Medicaid program a definition of medical necessity that differs from that which has been promulgated and is currently published in the Medicaid Provider Manual Glossary, the definition shall be publicly promulgated.

(2) However, nothing in this section requires or authorizes Medicaid to attempt to promulgate standards of care that physicians use in determining medical necessity.

(c)(1) Medicaid contractors may not use a different provider manual than the Medicaid Provider Manual promulgated for each service category.

(2) Any other rules that contractors use shall be promulgated by the department and included in the standard Medicaid Provider Manual.

1 20-77-1611. Records.
2 If the Department of Human Services takes adverse action against a
3 provider, the department shall deliver to the provider well in advance of any
4 appeal its file on the matter including the records of any utilization review
5 contractor or other agent so that the provider will have time to prepare for
6 the appeal.
7
8 20-77-1612. Copies.
9 If the Department of Human Services requests copies of records that the
10 provider has provided previously, then the department shall pay to the
11 provider twenty-five cents (25¢) per page.
12
13 20-77-1613. Notices.
14 The Department of Human Services shall send letters and notices with
15 deadlines by certified mail or a similar method that has proof of delivery
16 date, and the deadline shall begin to run beginning with the next business
17 day following receipt, unless otherwise required by federal statute or
18 regulation.
19
20 20-77-1614. Deadlines.
21 The Department of Human Services may not issue a claim denial or claim
22 for recoupment to providers for missing a deadline if the department or its
23 contractor contributed to the delay or the delay was reasonable under the
24 circumstances, including, but not limited to:
25 (1) Intervening weekends or holidays;
26 (2) Lack of cooperation by third parties;
27 (3) Natural disasters; or
28 (4) Other extenuating circumstances.
29
30 20-77-1615. Program for indigent medical care - Rules.
31 (a) The Director of the Department of Human Services may enter into
32 agreements with private or public entities to assist in the enforcement of
33 rules and regulations of an indigent patient medical program, including:
34 (1) Utilization review; and
35 (2) Professional review of providers participating in the
36 program.

1 (b)(1) The director shall ensure that any entity with which the
2 department contracts to assist in the enforcement of rules and regulations of
3 an indigent patient medical program will fulfill its duties in accordance
4 with state and federal law and regulations.
5 (2) The director may terminate any contractor that excessively
6 burdens the State of Arkansas with the defense of appeals of sanctions or
7 citations of deficiencies that are resolved in favor of the program provider.
8 (c)(1) This subchapter does not permit the department or any entity
9 with which it contracts to enforce any rules or regulations that are not
10 lawfully promulgated pursuant to federal or state law.
11 (2) The department and any entity with which it contracts may
12 rely on official publications of the United States Department of Health and
13 Human Services for the administration of the Medicaid program and other
14 rules, regulations, standards, guidance, or information that apply to the
15 Medicaid program by reference in statute, promulgated regulation, rule, or
16 official federal publication, as they existed on January 1, 2005.
17 (d) Except for long-term care facilities and their reviewers, the
18 director shall ensure that the professional review of providers participating
19 in the program complies with the following:
20 (1) The party conducting any professional reviews of providers
21 participating in the program shall be knowledgeable in the specific areas of
22 law and regulations being enforced;
23 (2)(A) Every citation or deficiency cited to a provider shall
24 refer by source and number to the authority upon which the citation or
25 deficiency is based.
26 (B) However, the requirement of subdivision (d)(2)(A) of
27 this section does not limit the department and any entity with which it
28 contracts in the exercise and application of professional medical judgment in
29 determining when and under what circumstances care is medically necessary;
30 (3) The professional review process shall include an informal
31 dispute resolution process to allow the provider to challenge the citation or
32 deficiency cited or sanction to a person other than the person making the
33 citation as defined by the director;
34 (4) The director shall establish a system to ensure standard and
35 consistent application of sanctions and citations or deficiencies among
36 surveyors in different areas of the state;

1 (5) The director may establish the following rules consistent
2 with this subchapter, including penalties that may be imposed on a program
3 provider upon a finding that the provider has violated statutes or
4 regulations in the administration of or billing for health care in an
5 indigent medical care program:
6 (A) Rules only requiring the program provider to reimburse
7 to the indigent medical care program funds paid to the program provider for
8 services that were:
9 (i) Not actually provided;
10 (ii) Not medically necessary; or
11 (iii) Provided without prior authorization, if
12 preapproval is required by statute or regulation;
13 (B)(i) Rules permitting the department to levy upon final
14 determination of a violation of a statute regulation that was observed during
15 onsite or offsite surveys or to review a fine that shall not exceed five
16 hundred dollars ($500)per category of violation up to a maximum of two
17 thousand five hundred dollars ($2,500) per survey or review.
18 (ii) A fine may only be levied if a provider is not
19 in substantial compliance with a rule or statute. and
20 (iii) Rules permitting the department to terminate a
21 program provider's participation in an indigent patient medical care program
22 upon final determination that the program provider is found:
23 (a)(i) To have placed a resident in immediate
24 jeopardy as that term is defined by 42 CFR § 488.301, as it existed on
25 January 1, 2005; and
26 (b) To have failed to take immediate steps to
27 remedy the immediate jeopardy; or
28 (c) Not to be operating in substantial
29 compliance with statutes or regulations governing an indigent medical care
30 program over a period of at least two (2) years; and
31 (6) The director shall establish a process for program providers
32 to appeal a decision of a reviewer pursuant to the Arkansas Administrative
33 Procedure Act, § 25-15-201 et seq.
34
35 SECTION 2. EMERGENCY CLAUSE. It is found and determined by the
36 General Assembly of the State of Arkansas that providers who are essential to

the state's Medicaid program are being denied rightful claims, appeals, and other processes and that procedural technicalities are frustrating attempts by providers to serve Medicaid recipients. 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.