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.

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

(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;

(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) 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 any of the following 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 ommission in documentation by a provider.

(B) "Technical deficiency" does not include:

(i) Lack of medical necessity;

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

(iii) Fraud; or

(iv) A pattern of abusive billing.

20-77-1603. Technical deficiencies.

(a) The Department of Human Services may not recoup from providers for technical deficiencies if:

(1) The provider can substantiate through other means that the services or goods were provided; or

(2) It is reasonable to conclude from surrounding circumstances that the services or goods were provided.

(b) A technical 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.

20-77-1604. Provider appeals allowed

(a) The General Assembly finds it necessary to:

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

(2) Emphasize that this provision 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 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.

(a)(1) Absent fraud or a pattern of abuse, if a provider’s claim is

denied, the provider shall be entitled to rebill at the level that would have been appropriate according to Medicaid'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 Medicaid shall specify the level of care that Medicaid deems appropriate and the reason for the denial. Alternatively, Medicaid shall automatically rebill the claim with the reason for the rebilling.

(c) Rebilling at an alternate level does not waive the provider's or Medicaid's or patient's right to appeal the denial of the original claim.

20-77-1607. No procedural obstacles to care or reimbursement.

(a) If the Department of Human Services imposes primary care physician referrals, gatekeepers, prior authorization, concurrent authorizations, processing periods, or other utilization controls and procedural rules, the department shall ensure that Medicaid recipients can still obtain the appropriate level of care without a delay that can reasonably be expected to put the recipient's health at risk and without putting a provider at risk of nonreimbursement."

(b) If the department imposes both prior or concurrent authorizations and primary care physician referrals, the purposes of the prior or concurrent authorizations and the primary care physician referrals shall not overlap.

(c)(1) A specialty physician need not obtain the primary care physician's approval to provide or make a change in diagnosis or medications, unless requested by the primary care physician.

(2) The specialty physician shall keep the primary care physician appropriately informed.

20-77-1608. 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 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 shall carry a rebuttable presumption of appropriateness if 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 review providers' claims using any criteria 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.

20-77-1611. Records.

If the Department of Human Services takes adverse action against a provider, the department shall deliver to the provider well in advance of any appeal its file on the matter including the records of any utilization review contractor or other agent, subject to any federal confidentiality restrictions, so that the provider will have time to prepare for the appeal.

20-77-1612. Copies.

If the Department of Human Services requests copies of records that the provider has provided previously, then the department shall pay to the provider twenty-five cents (25¢) per page.

20-77-1613. Notices.

The Department of Human Services shall send letters and notices with deadlines by certified mail or a similar method that has proof of delivery date, and the deadline shall begin to run beginning with the next business day following receipt, unless otherwise required by federal statute or regulation.

20-77-1614. Deadlines.

The Department of Human Services may not issue a claim denial or claim 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.

SECTION 2. EMERGENCY CLAUSE. It is found and determined by the 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.

/s/ Wooldridge