

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 *As Engrossed: S3/10/05 S3/14/05 S3/15/05*

2 85th General Assembly

A Bill

3 Regular Session, 2005

SENATE BILL 982

4

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

6 By: Representative Bradford

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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;

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(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.

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35

20-77-1602. Definitions.

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As used in this subchapter:



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

5 (A) Decisions as to appropriate level of care or coding;

6 (B) Medical necessity;

7 (C) Prior authorization;

8 (D) Concurrent reviews;

9 (E) Retrospective reviews;

10 (F) Least restrictive setting;

11 (G) Desk audits;

12 (H) Field audits and onsite audits; and

13 (I) Inspections;

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

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

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

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

22 (6) “Department” means:

23 (A) The Department of Human Services;

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

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

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

32 (B) As used in this subchapter, “Medicaid” includes the
33 department and vice versa;

34 (8) “Person” means any individual, company, firm, organization,
35 association, corporation, or other legal entity;

36 (9) “Primary care physician” means a physician whom the

1 department has designated as responsible for the referral or management, or
2 both, of a Medicaid recipient's health care;

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

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

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

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

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

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

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

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

22 (A) Utilization reviews;

23 (B) Medical necessity reviews;

24 (C) Professional reviews;

25 (D) Onsite audits; and

26 (E) Desk audits;

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

31 (A) Reviews for quality;

32 (B) Quantity;

33 (C) Utilization;

34 (D) Practice patterns;

35 (E) Medical necessity;

36 (F) Peer review; and

1 (G) Compliance with Medicaid standards; and
2 (15)(A) "Technical deficiency" means an error or omission in
3 documentation by a provider.

4 (B) "Technical deficiency" does not include:
5 (i) Lack of medical necessity;
6 (ii) Failure to obtain prior or concurrent
7 authorization if required by regulation;
8 (iii) Fraud; or
9 (iv) A pattern of abusive billing.

10
11 20-77-1603. Technical deficiencies.

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

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

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

18 (b) A technical requirement in federal statutes or regulations shall
19 not result in a recoupment unless:

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

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

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

26
27 20-77-1604. Provider appeals allowed

28 (a) The General Assembly finds it necessary to:

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

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

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

1 provider is an individual or a corporation.

2 (2) The provider may appear:

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

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

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

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

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

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

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

23
24 20-77-1605. Explanations for adverse actions required.

25 Each denial or other deficiency that the Department of Human Services
26 makes against a Medicaid provider shall be prepared in writing and shall
27 specify:

28 (1) The exact nature of the violation;

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

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

33
34 20-77-1606. Rebilling at an alternate level instead of complete
35 denial.

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

1 denied, the provider shall be entitled to rebill at the level that would have
2 been appropriate according to Medicaid's basis for denial.

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

5 (b) The denial notice from Medicaid shall specify the level of care
6 that Medicaid deems appropriate and the reason for the denial.
7 Alternatively, Medicaid shall automatically rebill the claim with the reason
8 for the rebilling.

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

11
12 20-77-1607. No procedural obstacles to care or reimbursement.

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

20
21 20-77-1608. Prior authorizations -- Retrospective reviews.

22 The Department of Human Services may not retrospectively recoup or deny
23 a claim from a provider if the department previously authorized the Medicaid
24 care, unless the retrospective review establishes that the previous
25 authorization was based upon misrepresentation and that if the true facts had
26 been known, the specific level of care would not have been authorized.

27
28 20-77-1609. Medical necessity.

29 (a) The medical necessity determination of the Medicaid recipient's
30 attending physician shall carry a rebuttable presumption of appropriateness
31 if the physician has engaged in direct treatment or observation of the
32 patient.

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

1
2 20-77-1610. Promulgation required.

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

7 (2) The department may not review providers' claims using any
8 criteria that have not been publicly promulgated.

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

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

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

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

20
21 20-77-1611. Records.

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

27
28 20-77-1612. Copies.

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

32
33 20-77-1613. Notices.

34 The Department of Human Services shall send letters and notices with
35 deadlines by certified mail or a similar method that has proof of delivery
36 date, and the deadline shall begin to run beginning with the next business

1 day following receipt, unless otherwise required by federal statute or
2 regulation.

3
4 20-77-1614. Deadlines.

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

- 9 (1) Intervening weekends or holidays;
10 (2) Lack of cooperation by third parties;
11 (3) Natural disasters; or
12 (4) Other extenuating circumstances.

13
14 SECTION 2. EMERGENCY CLAUSE. It is found and determined by the
15 General Assembly of the State of Arkansas that providers who are essential to
16 the state's Medicaid program are being denied rightful claims, appeals, and
17 other processes and that procedural technicalities are frustrating attempts
18 by providers to serve Medicaid recipients. Therefore, an emergency is
19 declared to exist and this act being immediately necessary for the
20 preservation of the public peace, health, and safety shall become effective
21 on:

- 22 (1) The date of its approval by the Governor;
23 (2) If the bill is neither approved nor vetoed by the Governor,
24 the expiration of the period of time during which the Governor may veto the
25 bill; or
26 (3) If the bill is vetoed by the Governor and the veto is
27 overridden, the date the last house overrides the veto.

28
29 */s/ Wooldridge*