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: S3/15/07*
86th General Assembly **A Bill**
Regular Session, 2007 SENATE BILL 819

By: Senator Critcher
By: Representative Cooper

For An Act To Be Entitled

AN ACT TO AMEND THE MEDICAID FAIRNESS ACT TO CLARIFY CERTAIN PROVISIONS; AND FOR OTHER PURPOSES.

Subtitle

AN ACT TO AMEND THE MEDICAID FAIRNESS ACT TO CLARIFY CERTAIN PROVISIONS.

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

SECTION 1. Arkansas Code §§ 20-77-1702 and 20-77-1703 are amended to read as follows:

20-77-1702. Definitions.

As used in this subchapter:

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

(A) An 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;

~~(1)~~(2) "Adverse decision" means any decision by the Department of Health and 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)~~(3) "Appeal" means an appeal under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.;

~~(3)~~(4) "Claim" means a request for payment of services or for prior, concurrent, or retrospective authorization to provide services;

~~(4)~~(5) "Concurrent review" or "concurrent authorization" means a review to determine whether a specified recipient currently receiving specific services may continue to receive services;

~~(5)~~(6) "Denial" means denial or partial denial of a claim;

~~(6)~~(7) "Department" means:

(A) The Department of Health and 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;

(8) "Final determination" means a Medicaid overpayment determination:

(A) For which all provider appeals have been exhausted; or

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

(9) "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;

(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, physician or registered nurse; and

(B) As applicable to the adverse decision:

(i) With respect to medical assistance reimbursed by procedure code or unit of service, the quantity of each medically necessary procedure or unit;

(ii) With respect to durable medical equipment, the type of equipment required and the duration of equipment use;

(iii) With respect to all other medical assistance, the:

(a) Intensity of service, for example, whether intensive care unit hospital services were required;

(b) Duration of service, for example, the number of days of a hospital stay; or

(c) Setting in which the service is delivered, for example, inpatient or outpatient;

~~(7)~~(11) "Medicaid" means the medical assistance program under Title XIX of the Social Security Act that is operated by the department, including contractors, fiscal agents, and all other designees and agents;

~~(8)~~(12) "Person" means any individual, company, firm, organization, association, corporation, or other legal entity;

~~(9)~~(13) "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)~~(14) "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)~~(15) "Provider" means a person enrolled to provide health or medical care services or goods authorized under the state Medicaid program;

~~(12)~~(16) "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)~~(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;

~~(14)~~(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 ~~services and goods performs review actions, including, but not limited to~~ medical assistance reviews, without limitation:

(A) Quality;

(B) Quantity;

(C) Utilization;

(D) Practice patterns;

(E) Medical necessity; and

~~(F) Peer review; and~~

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

~~(15)(A)~~(19)(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~~ according to professionally recognized local 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~~ Abuse;

(vi) A pattern of noncompliance; or

(vii) A gross and flagrant violation.

20-77-1703. Technical deficiencies.

(a)(1) The Department of Health and Human Services shall not use a technical deficiency as grounds for recoupment unless identifying the technical deficiency as an overpayment is mandated by a specific federal statute or regulation or the state is required to repay the funds to the *Centers for Medicare and Medicaid Services, or both.*

(2) When recoupment is permitted, the department shall not recoup until there is a final determination identifying the funds to be recouped as overpayments.

~~(a)~~(b)(1) The ~~Department of Health and Human Services may not recoup from a provider for technical deficiencies if~~ 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) Involved a covered service; and

(C) ~~the~~ The provider can substantiate through other documentation that the ~~services or goods were~~ medical assistance was provided ~~and that the technical deficiency did not adversely affect the direct patient care of the recipient~~.

(2) Documentation shall be:

(A) In accord with generally accepted health care practices; and

(B) Contemporaneously created.

~~(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 ~~noncompliance with technical requirements~~ 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 ~~requirements~~ deficiencies are by providing clear communication in writing or a promulgated rule when required.

SECTION 2. Arkansas Code §§ 20-77-1705 and 20-77-1706 are amended to read as follows:

20-77-1705. Explanations for adverse decisions required.

Each denial or other deficiency that the Department of Health and 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~~ that form the basis for the adverse decision.

20-77-1706. ~~Rebilling~~ Reimbursement at an alternate level instead of complete denial.

(a)(1)(A) ~~If a provider's claim is denied, then absent fraud or a pattern of abuse, and provided that the care being billed was furnished by a provider legally qualified and authorized to deliver the care,~~ Subject to § 20-77-1707 for retrospective reviews, if the Department of Health and Human Services has sufficient documentation to determine that some level of care other than the level that was claimed is medically necessary, then the department may recoup.

(B) However, the provider shall be entitled to ~~rebill~~ file a second claim at the level that ~~would have been appropriate~~ was medically necessary according to the Department of Health and Human Services' ~~basis for denial~~ explanation for recoupment.

(C) Alternatively, the department may recoup the *difference between the amount previously paid and the amount that would be payable for the care deemed to be medically necessary*.

(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 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.

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

~~(b)~~(4)(A) The ~~denial~~ recoupment notice from the department under subdivisions (a)(1) and (2) of this section shall explain the reason for the ~~denial~~ recoupment under ~~§ 20-77-1605~~ § 20-77-1705 and ~~specify the level of care that it deems appropriate based on the documentation submitted~~ shall include one (1) of the following statements:

(i) "In the reviewer's professional judgment, the documentation submitted establishes that the following care, treatment, or evaluation was medically necessary: _____"; or

(ii) "In the reviewer's professional judgment, the documentation submitted does not establish that any care, service, or evaluation was medically necessary".

(B) For purposes of this subdivision, "care" may include referrals to health care professionals.

~~(c)~~(5) A provider's decision to ~~rebill~~ file a second claim at the ~~alternate~~ level of care approved by the reviewer or the department's decision to recoup rather than requiring a second claim does not waive the provider's or recipient's right to appeal the denial of the original claim if the provider disagrees with the department's determination.

(b)(1) For concurrent or prior authorization, if the department has sufficient documentation to establish that some level of care other than the requested level is medically necessary, the department shall approve the request at the other level of care with proper notice.

(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 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.

(4)(A) The denial notice from the department under subdivisions (b)(1) and (2) of this section shall explain the reason for the denial as required by § 20-77-1705 and shall include one (1) of the following statements:

(i) "In the reviewer's professional judgment the documentation submitted establishes that the following care, treatment, or evaluation was medically necessary: _____"; or

(ii) "In the reviewer's professional judgment the documentation submitted does not establish that any care, service, or evaluation was medically necessary".

(B) For purposes of this subsection, "care" may include referrals to health care professionals.

(5) The department's decision to approve a request at another level of care under this subsection does not remove the provider's or recipient's right to appeal the denial of the original claim if the provider disagrees with the department's determination.

~~(d)~~(c)(1) Subsections (a) and (b) of this section apply only:

(A) In the absence of fraud or abuse; and

(B) If the care is furnished by a provider legally qualified and authorized to deliver the care.

(2) 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.

SECTION 3. Arkansas Code § 20-77-1708 is amended to read as follows:

20-77-1708. Medical necessity.

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

SECTION 4. Arkansas Code § 20-77-1709(b), concerning promulgation of rules before enforcement, is amended to read as follows:

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

SECTION 5. Arkansas Code § 20-77-1711 is amended to read as follows:

20-77-1711. Copies

(a) ~~Providers shall be required to supply records at their own cost to the Department of Health and Human Services no more than one (1) time.~~ Except as provided in subsection (b), providers must supply records to the Department of Health and Human Services at their own cost.

(b) If the provider has supplied records to the Department of Health and Human Services and the provider identifies to whom the records were supplied, the provider is not required to provide a second copy of the records at its own cost.

SECTION 6. Arkansas Code § 20-77-1714 is amended to read as follows:

20-77-1714. 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 Health and Human Services may promulgate rules to implement this section.~~

SECTION 7. Arkansas Code Title 20, Chapter 77, Subchapter 17 is *amended to add an additional section to read as follows:*

20-77-1716. Regulations.

The Department of Health and Human Services may promulgate rules to implement this subchapter.

SECTION 8. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that clarifications are needed in order for Medicaid providers to gain access to the appeals process and to interact with the Medicaid program as envisioned under the Medicaid Fairness Act; 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/ Critcher