

# Medicaid Fairness Act

This Act is designed to ensure the fair treatment of health care providers who treat Medicaid patients. Under the Act, the state department of human services may not recoup from providers for technical deficiencies if the providers can substantiate through other documentation that the services were provided and that the technical deficiency did not adversely affect the patient. A technical deficiency in complying with federal statutes shall not result in recoupment unless it is specifically mandated by federal statute or regulation, the state can illustrate that the recoup will result in the loss of federal matching funds or other penalty.

Provider administrative appeals are allowed and it is emphasized that the right of appeal is to be liberally construed and not limited through technical and procedural arguments by the department of human services. In response to an adverse decision a provider may appeal on behalf of the recipient, or on their own behalf, or both. A Medicaid recipient may attend a hearing related to his or her care, but his or participation is not mandatory for provider appeals. If an administrative appeal is filed by both provider and recipient concerning the same subject matter the appeals may be consolidated. If the department of human services makes an adverse decision in a Medicaid case and the provider files an appeal they must deliver to the provider a copy of the file on the matter so that the provider will have time to prepare for the appeal.

Explanations for adverse decisions are required. Each denial or deficiency that the department of human services makes against a Medicaid provider shall be prepared in writing and shall specify the exact nature of the adverse decision, the specific statutory provision violated and the facts and grounds constituting the elements of the violation.

A provider may rebill at an alternative level that would have been appropriate according to the department of human services' basis for denial instead of complete denial if the provider is absent fraud or a pattern of abuse and provided the care being billed was furnished by a legally qualified and authorized provider in the area. The right of the provider to re-bill at an alternative level does not waive the provider's or recipient's right to appeal the denial of the original claim. The department of human services may not retroactively recoup or deny a claim from a provider if the department previously authorized the Medicaid care unless the retroactive review establishes that the previous authorization was based on a misconception or omission that would have altered the level of care that was authorized; likewise if previous care was authorized based on conditions that later changed, rendering the Medicaid care medically unnecessary. Recoupments based upon lack of medical necessity shall not include payments for any medical care what was delivered before the change of circumstances that rendered the care medically unnecessary.

Submitted as:

Arkansas

[Act 1758](#)

Status: Enacted into law in 2005.

## Suggested State Legislation

(Title, enacting clause, etc.)

- 1           Section 1. [*Short Title.*] This Act may be cited as the “Medicaid Fairness Act.”
- 2
- 3           Section 2. [*Legislative Findings And Intent.*]
- 4           (a) The [General Assembly] finds that:

5 (1) Health care providers who serve Medicaid recipients are an indispensable and  
6 vital link in serving this state's needy citizens;

7 (2) The [Department of Human Services] already has in place various provisions  
8 to:

9 (A) Ensure the protection and respect for the rights of Medicaid  
10 recipients; and

11 (B) Sanction errant Medicaid providers when necessary.

12 (b) The [General Assembly] intends this Act to ensure that the [Department] and its  
13 outside contractors treat providers with fairness and due process.

14  
15 Section 3. *Definitions.*

16 (a) As used in this Act:

17 (1) "Adverse decision" means any decision by the [Department of Human  
18 Services] or its reviewers or contractors that adversely affects a Medicaid provider or recipient in  
19 regard to receipt of and payment for Medicaid claims and services, including, but not limited to  
20 decisions as to:

21 (A) Appropriate level of care or coding;

22 (B) Medical necessity;

23 (C) Prior authorization;

24 (D) Concurrent reviews;

25 (E) Retrospective reviews;

26 (F) Least restrictive setting;

27 (G) Desk audits;

28 (H) Field audits and onsite audits; and

29 (I) Inspections;

30 (2) "Appeal" means an appeal under the state Administrative Procedure Act;

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

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

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

37 (6) "Department" means:

38 (A) The [Department of Human Services];

39 (B) All the divisions and programs of the [Department of Human  
40 Services], including the state Medicaid program; and

41 (C) All the [Department of Human Service's] contractors, fiscal agents,  
42 and other designees and agents;

43 (7) "Medicaid" means the medical assistance program under Title XIX of the  
44 Social Security Act that is operated by the [state Department of Human Services], including  
45 contractors, fiscal agents, and all other designees and agents.

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

48 (9) "Primary care physician" means a physician whom the [Department] has  
49 designated as responsible for the referral or management, or both, of a Medicaid recipient's  
50 health care;

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

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

56 (12) "Recoupment" means any action or attempt by the [Department] to recover  
57 or collect Medicaid payments already made to a provider with respect to a claim by:

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

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

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

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

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

66 (A) Utilization reviews;

67 (B) Medical necessity reviews;

68 (C) Professional reviews;

69 (D) Field audits and onsite audits; and

70 (E) Desk audits;

71 (14) "Reviewer" means any person, including, but not limited to, reviewers,  
72 auditors, inspectors, and surveyors that in reviewing a provider or a provider's provision of  
73 services and goods performs review actions, including, but not limited to:

74 (A) Reviews for quality;

75 (B) Quantity;

76 (C) Utilization;

77 (D) Practice patterns;

78 (E) Medical necessity;

79 (F) Peer review; and

80 (G) Compliance with Medicaid standards; and

81 (15) (A) "Technical deficiency" means an error or omission in documentation by  
82 a provider that does not affect direct patient care of the recipient.

83 (B) "Technical deficiency" does not include:

84 (i) Lack of medical necessity or failure to document medical  
85 necessity in a manner that meets professionally recognized applicable standards of care;

86 (ii) Failure to provide care of a quality that meets professionally  
87 recognized local standards of care;

88 (iii) Failure to obtain prior or concurrent authorization if required  
89 by regulation;

90 (iv) Fraud;

91 (v) A pattern of abusive billing;

92 (vi) A pattern of noncompliance; or

93 (vii) A gross and flagrant violation.

94  
95 Section 4. [*Technical Deficiencies.*]

96 (a) The [Department of Human Services] may not recoup from providers for technical  
97 deficiencies if the provider can substantiate through other documentation that the services or  
98 goods were provided and that the technical deficiency did not adversely affect the direct patient  
99 care of the recipient.

100 (b) A technical deficiency in complying with a requirement in federal statutes or  
101 regulations shall not result in a recoupment unless:

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

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

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

107 (d) (1) If a provider fails to comply with a corrective action plan for a pattern of non-  
108 compliance with technical requirements, then appropriate monetary penalties may be imposed if  
109 permitted by law.

110 (2) However, the [Department] first must be clear as to what the technical  
111 requirements are by providing clear communication in writing, or a promulgated rule where  
112 required.

113

114 Section 5. [*Provider Administrative Appeals Allowed.*]

115 (a) The [General Assembly] finds it necessary to:

116 (1) Clarify its intent that providers have the right to administrative appeals; and

117 (2) Emphasize that this right of appeal is to be liberally construed and not limited  
118 through technical or procedural arguments by the [Department of Human Services].

119 (b) (1) In response to an adverse decision, a provider may appeal on behalf of the  
120 recipient or on its own behalf, or both, under the [state Administrative Procedure Act], regardless  
121 of whether the provider is an individual or a corporation.

122 (2) The provider may appear:

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

124 (B) With prior notice to the Department, through legal counsel.

125 (3) (A) A Medicaid recipient may attend any hearing related to his or her care,  
126 but the [Department] may not make his or her participation a requirement for provider appeals.

127 (B) The [Department] may compel the recipient's presence via subpoena,  
128 but failure of the recipient to appear shall not preclude the provider appeal.

129 (c) A provider does not have standing to appeal a nonpayment decision if the provider  
130 has not furnished any service for which payment has been denied.

131 (d) Providers, like Medicaid recipients, have standing to appeal to circuit court  
132 unfavorable administrative decisions under the [state Administrative Procedure Act].

133 (e) If an administrative appeal is filed by both provider and recipient concerning the  
134 same subject matter, then the [Department] may consolidate the appeals.

135 (f) This Act shall apply to all pending and subsequent appeals that have not been finally  
136 resolved at the administrative or judicial level as of the effective date of this Act.

137

138 Section 6. [*Explanations for Adverse Decisions Required.*] Each denial or other  
139 deficiency that the [Department of Human Services] makes against a Medicaid provider shall be  
140 prepared in writing and shall specify:

141 (1) The exact nature of the adverse decision;

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

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

144

145 Section 7. [*Rebilling at an Alternate Level Instead of Complete Denial.*]

146 (a) (1) Absent fraud or a pattern of abuse, and provided the care being billed was  
147 furnished by a provider legally qualified and authorized to deliver the care, if a provider's claim  
148 is denied then the provider shall be entitled to rebill at the level that would have been appropriate  
149 according to the [Department of Human Service's] basis for denial.

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

152 (b) The denial notice from the [Department] shall explain the reason for the denial under  
153 and specify the level of care that it deems appropriate based on the documentation submitted.

154 (c) A provider's decision to rebill at the alternate level does not waive the provider's or  
155 recipient's right to appeal the denial of the original claim.

156 (d) Nothing prevents the [Department] from reviewing the claim for reasons unrelated to  
157 level of care and taking action that may be warranted by the review, subject to other provisions  
158 of law.

159  
160 Section 8. [*Prior Authorizations -- Retrospective Reviews.*] The [Department of Human  
161 Services] may not retrospectively recoup or deny a claim from a provider if the [Department]  
162 previously authorized the Medicaid care, unless:

163 (1) The retrospective review establishes that:

164 (A) The previous authorization was based upon misrepresentation by act  
165 or omission; and

166 (B) If the true facts had been known the specific level of care would not  
167 have been authorized; or

168 (2) (A) The previous authorization was based upon conditions that later  
169 changed, thereby rendering the Medicaid care medically unnecessary.

170 (B) Recoupments based upon lack of medical necessity shall not include  
171 payments for any Medicaid care that was delivered before the change of circumstances that  
172 rendered the care medically unnecessary.

173  
174 Section 9. [*Medical Necessity.*] There is a presumption in favor of the medical judgment  
175 of the attending physician in determining medical necessity of treatment.

176  
177 Section 10. [*Promulgation before Enforcement.*]

178 (a) The [Department of Human Services] may not use state policies, guidelines,  
179 manuals, or other such criteria in enforcement actions against providers unless the criteria have  
180 been promulgated.

181 (b) Nothing in this section requires or authorizes the [Department] to attempt to  
182 promulgate standards of care that physicians use in determining medical necessity or rendering  
183 medical decisions, diagnoses, or treatment.

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

186  
187 Section 11. [*Records.*]

188 (a) If the [Department of Human Services] makes an adverse decision in a Medicaid case  
189 and a provider then lodges an administrative appeal, the [Department] shall deliver to the  
190 provider well in advance of the appeal its file on the matter so that the provider will have time to  
191 prepare for the appeal.

192 (b) The file shall include the records of any utilization review contractor or other agent,  
193 subject to any other federal or state law regarding confidentiality restrictions.

194  
195 Section 12. [*Copies.*] Providers shall be required to supply records at their own cost to the  
196 [Department of Human Services] no more than [once].

197  
198 Section 13. [*Notices.*] When the [Department of Human Services] sends letters or other  
199 forms of notices with deadlines to providers or recipients, the deadline shall not begin to run  
200 before the [next business day following the date of the postmark on the envelope], the facsimile

201 transmission confirmation sheet, or the electronic record confirmation, unless otherwise required  
202 by federal statute or regulation.

203

204 Section 14. [*Deadlines.*]

205 (a) The [Department of Human Services] may not issue a claim denial or demand for  
206 recoupment to providers for missing a deadline if the [Department] or its contractor contributed  
207 to the delay or the delay was reasonable under the circumstances, including, but not limited to:

208 (1) Intervening weekends or holidays;

209 (2) Lack of cooperation by third parties;

210 (3) Natural disasters; or

211 (4) Other extenuating circumstances.

212 (b) This section is subject to good faith on the part of the provider.

213

214 Section 15. [*Hospital Claims.*]

215 (a) When more than [1 hospital] provides services to a recipient and the amount of  
216 claims exceeds the recipient's benefit limit, then the hospitals are entitled to reimbursement  
217 based on the earliest date of service.

218 (b) If the claims have been paid by Medicaid contrary to this provision, and voluntary  
219 coordination among the hospitals involved does not resolve the matter, then the hospitals shall  
220 resort to mediation or arbitration at the hospitals' expense.

221 (c) The [Department of Human Services] may promulgate rules to implement this  
222 section.

223

224 Section 16. [*Severability.*] [Insert severability clause.]

225

226 Section 17. [*Repealer.*] [Insert repealer clause.]

227

228 Section 18. [*Effective Date.*] [Insert effective date.]