WESTLAW

## Subchapter 17—Medicaid Fairness Act

☑ Select all items 19 items selected clear selected

☑ **T. 20, Subt. 5, Ch. 77, Subch. 17, Refs & Annos**

**Chapter 77. Medical Assistance (Refs & Annos)**

☑ **§ 20-77-1701. 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, and

(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.

☑ **§ 20-77-1702. 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;

(2)(A) "Adverse decision" means any decision by the Department of Human Services or its reviewers or contractors that adversely affects a Medicaid provider or recipient in regard to:

(i) 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 or surveys; and

(ii) Payment amounts due to or from a particular provider resulting from gain sharing, risk sharing, incentive payments, or another reimbursement mechanism or methodology, including calculations that affect or have the potential to affect payment.

(B) To constitute an adverse decision, an agency decision need not have a monetary penalty attached but must have a direct monetary consequence to the provider.

(C) "Adverse decision" does not include the design of or changes to an element of a reimbursement methodology or payment system that is of general applicability and implemented through the rule-making process.

(3) "Appeal" means an appeal of an adverse decision to an independent administrative law judge as provided under this subchapter;

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

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

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

(7) "Department" means:

(A) The Department of 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, a physician or a 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; and

(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;

(11) "Medicaid" means the medical assistance program under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., and Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq., that is operated by the department, including contractors, fiscal agents, and all other designees and agents;

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

(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;

(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,

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

(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;

(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;

(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 medical assistance, reviews without limitation:

(A) Quality;

(B) Quantity;

(C) Utilization;

(D) Practice patterns,

(E) Medical necessity; and

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

(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 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 document a mandatory quality measure required for gain sharing or medical home or health home incentive payments as specified in a reimbursement mechanism or methodology;

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

(v) Fraud;

(vi) Abuse;

(vii) A pattern of noncompliance, or

(viii) A gross and flagrant violation.

☑ **§ 20-77-1703. Recoupment**

(a)(1) The Department of 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.

(b)(1) 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) The error or omission involved a covered service; and

(C) The provider can substantiate through other documentation that the medical assistance was provided.

(2) Other documentation under subdivision (b)(1)(C) of this section shall be:

(A) In accord with generally accepted healthcare practices; and

(B) Contemporaneously created.

(3) Other documentation under subdivision (b)(1)(C) of this section is not required to be equivalent in form to, nor required to duplicate, the documentation containing the error or omission, if all the documentation taken together establishes that the claim is payable.

(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 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 deficiencies are by providing clear communication in writing or a promulgated rule when required.

(e) The department shall not issue a recoupment on a minor omission such as a missing date or signature if the requirements of this section are met.

(f) The department shall not rely on the denial of one claim as the sole basis for the denial of a subsequent claim and shall establish that the subsequent claim is deficient.

☑ **§ 20-77-1704. Provider administrative appeals allowed**

(a) The General Assembly finds it necessary to:

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

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

(b)(1)(A) In response to an adverse decision, a provider may appeal on behalf of the recipient or on its own behalf, or both, regardless of whether the provider is an individual or a corporation.

(B)(i) A provider appeal shall be governed by the Arkansas Administrative Procedure Act, § 25-15-201 et seq., except as otherwise provided in this subchapter.

(ii) Multiple appeals by the same provider may be consolidated.

(C) An administrative law judge employed by the Department of Health shall conduct all Medicaid provider administrative appeals of adverse decisions under this subchapter.

(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) 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.

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

(c)(1) An administrative law judge shall be guided by the need to reach a just determination and may depart from strict adherence to the formal rules of evidence.

(2) An administrative law judge shall exclude irrelevant, immaterial, and unduly repetitious evidence.

(3) An administrative law judge shall receive oral or documentary evidence not privileged if the oral or documentary evidence is of a type commonly relied upon by a reasonably prudent person in the conduct of his or her affairs.

(4) An administrative law judge shall rule on each evidentiary objection, and the objection and ruling shall be noted of record.

(d)(1)(A) If a provider submits evidence that the Department of Human Services has not had an opportunity to consider before the hearing, an administrative law judge shall continue the hearing for thirty (30) days to allow the Department of Human Services to review the evidence.

(B) An administrative law judge may extend the thirty-day continuance under subdivision (d)(1)(A) of this section for good cause.

(2) Before the end of a continuation under subdivision (d)(1) of this section, the Department of Human Services shall send the provider and the administrative law judge notice stating whether the Department of Human Services will modify its decision with an explanation of the modification.

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(3)(A) Unless the provider notifies the administrative law judge and the Department of Human Services that the provider wishes to withdraw its appeal, the administrative law judge shall notify the parties of the date and time at which the hearing will continue.

(B) The date under subdivision (d)(3)(A) of this section shall be no later than thirty (30) days after the Department of Human Services' notification under subdivision (d)(2) of this section.

(e) A provider does not have standing to appeal a decision denying payment or ordering recoupment of payments already made if the provider has not furnished any service for which payment has been denied.

(f)(1) 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.

(2) The Department of Human Services may seek judicial review of a final, appealable order issued by an administrative law judge.

(g) Burdens of proof shall be determined under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(h)(1)(A) A final decision by an administrative law judge in favor of a provider is a final appealable order.

(B) A final decision under this section shall not be overturned by the Director of the Division of Medical Services of the Department of Human Services or another official within the Department of Human Services.

(2)(A) Within thirty (30) days after August 16, 2013, the Department of Human Services shall request a waiver from the Centers for Medicare and Medicaid Services of the single state agency requirement contained in 42 C.F.R. § 431.10 to allow final decisions in Medicaid provider administrative appeals to be issued by an administrative law judge in a separate agency.

(B) An administrative law judge shall follow the rules adopted by the Department of Human Services in making final decisions.

(3) The Department of Human Services shall make available to the public all communications with regard to the waiver application under subdivision (h)(2)(A) of this section and shall work jointly with provider representatives to obtain and maintain approval for the waiver.

(i)(1) Until the waiver under subdivision (h)(2) of this section is approved, an administrative law judge's decision shall constitute a recommended decision to the Director of the Division of Medical Services.

(2)(A) The Director of the Division of Medical Services, upon a review of the record submitted by an administrative law judge, shall adopt, reject, or modify the recommended decision.

(B) A modification or rejection of an administrative law judge's decision shall state with particularity the reasons for the modification or rejection, shall include references to the record, and shall constitute the final decision.

(C) As an alternative to the process under subdivision (i)(2)(B) of this section, the Director of the Division of Medical Services may remand the decision to the administrative law judge with additional guidance on Medicaid policy.

(3)(A) The Director of the Division of Medical Services shall issue a final decision under this subsection within thirty (30) days after receipt of the administrative law judge's decision.

(B) Unless the Director of the Division of Medical Services modifies or rejects the recommended decision of the administrative law judge within thirty (30) days after receipt of the administrative law judge's decision, the recommended decision is the final decision.

(j) If an administrative appeal is filed by both provider and recipient concerning the same subject matter, then the department may consolidate the appeals.

(k)(1) This subchapter shall apply to all pending and subsequent appeals that have not been finally resolved at the administrative or judicial level as of April 5, 2005.

(2) The amendatory provisions of this act apply to a pending and subsequent appeal that has not been finally resolved at the administrative or judicial level on August 16, 2013.

## ☑ § 20-77-1705. Explanations for adverse decisions 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 nature of the adverse decision;

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

(3) The facts and grounds that form the basis for the adverse decision.

## ☑ § 20-77-1706. Reimbursement at an alternate level instead of complete denial

(a)(1)(A) Subject to § 20-77-1707 for retrospective reviews, if the Department of 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 file a second claim at the level that was medically necessary according to the department's 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.

(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 recoupment notice from the department under subdivisions (a)(1) and (2) of this section shall explain the reason for the recoupment under § 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 subdivision (a)(4), "care" may include referrals to health care professionals.

(5) A provider's decision to file a second claim at the 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 subdivision (b)(4), "care" may include referrals to healthcare 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.

(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.

### ☑ § 20-77-1707. Prior authorizations--Retrospective reviews

If the Department of Human Services requires a provider to justify the medical necessity of a service through prior authorization, the department shall not later take the position that the services were not medically necessary, unless the retrospective review establishes that:

(1) The previous authorization was based upon misrepresentation by act or omission;

(2) The services billed were not provided, or

(3) An unexpected change occurred that rendered the prior-authorized care not medically necessary.

### ☑ § 20-77-1708. Medical necessity

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

(b) If an administrative law judge finds that the Department of Human Services has overcome the presumption under subsection (a) of this section, he or she shall state the manner by which the presumption was overcome.

### ☑ § 20-77-1709. Promulgation before enforcement

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

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

(c) Medicaid contractors may not use a different provider manual than the Centers for Medicare and Medicaid Services Provider Reimbursement Manual promulgated for each service category.

### ☑ § 20-77-1710. Records

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

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

### ☑ § 20-77-1711. Copies

(a) Except as provided in subsection (b) of this section, providers must supply records to the Department of Human Services at their own cost.

(b) If the provider has supplied records to the department 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.

### ☑ § 20-77-1712. Notices

When the Department of Human Services sends letters or other forms of notice with deadlines to providers or recipients, the deadline shall not begin to run before the next business day following the date of the postmark on the envelope, the facsimile transmission confirmation sheet, or the electronic record confirmation, unless otherwise required by federal statute or regulation.

### ☑ § 20-77-1713. Deadlines

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

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

### ☑ § 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.

### ☑ § 20-77-1715. Federal law

(a) If any provision of this subchapter is found to conflict with current federal law, including promulgated federal regulations, the federal law shall override that provision.

(b) If under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq., the federal government recovers an erroneous or improper medical assistance payment from the Department of Human Services, the department may recover the erroneous or improper medical assistance payment from the provider that received the payment or from a successor in interest who is legally responsible for the erroneous or improper medical assistance payment.

### ☑ § 20-77-1716. Regulations

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

### ☑ § 20-77-1717. Timelines for audits

(a) If a Medicaid provider audit by the federal Medicaid Integrity Program or Audit Medicaid Integrity Contractors is conducted, the Department of Human Services or the contractor shall provide the audit report to the provider within one hundred fifty (150) days after the completion of the audit field work.

(b) If a provider requests an administrative reconsideration of an audit finding or report, the department shall provide the results of the reconsideration within sixty (60) days after the department's receipt of the request for reconsideration.

(c) Additional provider records furnished by a provider in conjunction with a provider's request for administrative reconsideration shall have been contemporaneously created.

(d) If there is a failure to meet the timelines specified in this section, no adverse decision based on the noncompliant audit shall be enforced against the provider unless the department shows good cause for the failure to meet the timelines.

### ☑ § 20-77-1718. Termination--Appeals

(a) A Medicaid provider that is aggrieved by an adverse decision of the Department of Human Services with respect to termination of the provider's certification or Medicaid provider agreement or an action by the department that has the same effect as terminating the provider's certification or Medicaid provider agreement for more than fifteen (15) days may appeal the decision to Pulaski County Circuit Court or in a circuit court in a county in which the provider resides or does business, regardless of whether all administrative remedies have been exhausted.

(b) Pending a determination by the circuit court of the matter on appeal, the provider is entitled to an injunction preserving the provider's Medicaid participation upon showing that immediate and irreparable injury, loss, or damage to the provider will result, unless the circuit court determines that preserving the provider's participation is likely to pose a danger to the health or safety of beneficiaries.

(c) This section does not apply to an adverse decision resulting from the department's determination that there is a credible allegation of fraud for which an investigation is pending.