Arkansas Department of Health and Human Services

Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers**

DATE: **December 1, 2005**

SUBJECT: **Section I Provider Manual Update Transmittal**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
		190.000 – 191.006	12-1-05

Explanation of Updates

In compliance with Acts 1758 and 2227 of 2005, the following changes are made to Section I of all provider policy manuals:

Sections 190.000 through 190.014 contain information about and the process for provider due process.

Sections 191.000 through 191.006 contain information about and the process for beneficiary due process.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

SECTION I - GENERAL POLICY

CONTENTS

190.000 PROVIDER DUE PROCESS 12-1-05

190.001 The Medicaid Fairness Act 12-1-05

The Medicaid Fairness Act, Ark. Code Ann. §§ 20-77-1601 – 20-77-1615, requires that the Department of Health and Human Services and its outside contractors treat providers with fairness and due process.

190.002 Definitions 12-1-05

A. *Adverse decision/adverse action* means any decision or action by the Department of Health and Human Services or its reviewers or contractors that adversely affects a Medicaid provider or beneficiary in regard to receipt of and payment for Medicaid claims and services including but not limited to decisions as to:

1. Appropriate level of care or coding,
2. Medical necessity,
3. Prior authorization,
4. Concurrent reviews,
5. Retrospective reviews,
6. Least restrictive setting,
7. Desk audits,
8. Field audits and onsite audits, and
9. Inspections.

B. *Appeal* means an appeal under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218.

C. *Claim* means a request for payment of services.

D. *Concurrent review* or *concurrent authorization* means a review to determine whether a specified beneficiary currently receiving specific services may continue to receive services.

E. *Denial* means denial or partial denial of a claim or authorization of services.

F. *Department* means:

1. The Arkansas Department of Health and Human Services,
2. All of the divisions and programs of the Arkansas Department of Health and Human Services, including the state Medicaid Program, and
3. All of the Arkansas Department of Health and Human Services' contractors, fiscal agents, and other designees and agents.

G. *Medicaid* means the medical assistance program under Title XIX of the Social Security Act that is operated by the Arkansas Department of Health and Human Services and its contractors, fiscal agents, and all other designees and agents.

H. *Person* means any individual, company, firm, organization, association, corporation, or other legal entity.

I. *Primary care physician* means a physician whom the department has designated as responsible for the referral or management, or both, of a Medicaid beneficiary's health care.

J. *Prior authorization* means the approval by the state Medicaid Program for specified services for a specified Medicaid beneficiary before the requested services may be performed and before payment will be made by the state Medicaid Program.

K. *Provider* means a person enrolled to provide health or medical care services or goods authorized under the state Medicaid Program.

L. *Recoupment* means any action or attempt by the Department of Health and Human Services to recover or collect Medicaid payments already made to a provider with respect to a claim by:

1. Reducing, withholding or affecting in any other manner current or future payments to a provider or
2. Demanding payment back from a provider for a claim already paid.

M. *Retrospective review* means the review of services or practice patterns after payment, including, but not limited to:

1. Utilization reviews,
2. Medical necessity reviews,
3. Professional reviews,
4. Field audits and onsite audits, and
5. Desk audits.

N. *Reviewer* means any person, including reviewers, auditors, inspectors, surveyors and others who, in reviewing a provider or a provider's provision of services and goods, performs review actions, including, but not limited to:

1. Reviews for quality,
2. Reviews for quantity,
3. Utilization,
4. Practice patterns,
5. Medical necessity,
6. Peer review, and
7. Compliance with Medicaid standards.

O. *Technical deficiency* means an error or omission in documentation by a provider that does not affect direct patient care of the beneficiary. Technical deficiency does not include:

1. Lack of medical necessity or failure to document medical necessity in a manner that meets professionally recognized applicable standards of care,
2. Failure to provide care of a quality that meets professionally recognized local standards of care,
3. Failure to obtain prior, concurrent or mandatory authorization if required by regulation,
4. Fraud,
5. A pattern of abusive billing,
6. A pattern of noncompliance, or
7. A gross and flagrant violation.

190.003 Administrative Appeals 12-1-05

A. The following appeals are available in response to an adverse decision:

1. A beneficiary may appeal on his or her own behalf

2. A provider of medical assistance that is the subject of the adverse action may appeal on the beneficiary's behalf

3. If the adverse action denies a claim for covered medical assistance that was previously provided to a Medicaid-eligible beneficiary, the provider of such medical assistance may appeal on the provider's behalf. The provider does not have standing to appeal a nonpayment decision if the provider has not furnished any service for which payment has been denied.

B. All appeals shall conform to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218.

C. Providers may appear in person, through a corporate representative or, with prior notice to the department, through legal counsel.

D. Beneficiaries may represent themselves or they may be represented by a friend, by any other spokesperson except a corporation, or by legal counsel.

E. A Medicaid beneficiary 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. The department may compel the beneficiary's presence via subpoena, but failure of the beneficiary to appear shall not preclude the provider's appeal.

F. If an administrative appeal is filed by both a provider and beneficiary concerning the same subject matter, the department may consolidate the appeals.

G. Any person who considers himself or herself injured in his or her person, business, or property by the decision rendered in the administrative appeal is entitled to judicial review of the decision under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218.

H. This rule 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.

190.004 Records 12-1-05

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

190.005 Technical Deficiencies 12-1-05

The Department of Health and Human Services may not recoup from providers for technical deficiencies if the provider can substantiate through other documentation that the services or goods were provided and that the technical deficiency did not adversely affect the direct patient care of the beneficiary.

A technical deficiency in complying with a requirement in federal statutes or regulations shall not result in a recoupment unless:

A. The recoupment is specifically mandated by federal statute or regulation, or

B. The state can show that failure to recoup will result in a loss of federal matching funds or in another penalty against the state.

The Department of Health and Human Services may initiate a corrective action plan or other nonmonetary measure in response to technical deficiencies. If a provider fails to comply with a corrective action plan for a pattern of non-compliance with technical requirements, then appropriate monetary penalties may be imposed if permitted by law. However, the department first must be clear as to what the technical requirements are by providing clear communication in writing or a promulgated rule where required.

190.006 Explanations of Adverse Decisions Required 12-1-05

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:

A. The exact nature of the adverse decision,

B. The statutory provision or specific rule alleged to have been violated, and

C. The specific facts and grounds constituting the elements of the violation.

190.007 Rebilling at an Alternate Level Instead of Complete Denial 12-1-05

The denial notice from the department shall explain the reason for the denial in accordance with rule 190.006 above and shall specify the level of care that the Department deems appropriate based on the documentation submitted by the provider.

If a legally qualified and authorized provider's claim is denied, the provider shall be entitled to rebill at the level that would have been appropriate according to the Department's basis for denial, absent fraud or a pattern of abuse by the provider. A referral from a primary care physician or other condition met prior to the denial shall not be reimposed.

A provider's decision to rebill at the alternate level does not waive the provider's or beneficiary's right to appeal the denial of the original claim.

Nothing prevents the department from reviewing the claim for reasons unrelated to the level of care and taking action that may be warranted by the review, subject to other provisions of law.

190.008 Prior Authorizations – Retrospective Reviews 12-1-05

The Department of Health and Human Services may not retrospectively recoup or deny a claim from a provider if the department previously authorized the care unless the retrospective review establishes that:

A. The previous authorization was based upon misrepresentation by act or omission, and

B. If the true facts had been known the specific level of care would not have been authorized, or

C. The previous authorization was based upon conditions that later changed, thereby rendering the care medically unnecessary.

Recoupments based upon lack of medical necessity shall not include payments for any care that was delivered before the change of circumstances that rendered the care medically unnecessary.

190.009 Medical Necessity 12-1-05

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

190.010 Promulgation Before Enforcement 12-1-05

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

Nothing in this rule requires or authorizes the department to attempt to promulgate standards of care that physicians use in determining medical necessity or rendering medical decisions, diagnoses, or treatment.

Medicaid contractors shall use Medicaid provider manuals promulgated pursuant to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218.

190.011 Copies 12-1-05

If the Department or its contractor requires a provider to supply duplicates of documents already furnished to the department or its contractors, the Department division or contractor making the request shall pay the actual cost of photocopies, not to exceed 15 cents per page, for duplicates produced and supplied by providers in response to such requests.

190.012 Notices 12-1-05

When the Department of Health and Human Services sends letters or other forms of notices with deadlines to providers or beneficiaries, 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.

190.013 Deadlines 12-1-05

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

A. Intervening weekends or holidays,

B. Lack of cooperation by third parties,

C. Natural disasters, or

D. Other extenuating circumstances.

This rule is subject to good faith on the part of the provider.

190.014 Federal Law 12-1-05

If any provision of these policies and procedures are found to conflict with current federal law, including promulgated federal regulations, the federal law shall override that provision.

191.000 BENEFICIARY DUE PROCESS 12-1-05

191.001 Definitions 12-1-05

A. *Adverse decision/adverse action* means any decision or action by the Department of Health and Human Services or its reviewers or contractors that adversely affects a Medicaid provider or beneficiary in regard to receipt of and payment for Medicaid claims and services by limiting, terminating, suspending, or reducing Medicaid eligibility or covered services in connection with, but not limited to:

1. Appropriate level or care or coding,
2. Medical necessity,
3. Prior authorization,
4. Concurrent reviews,
5. Retrospective reviews,
6. Least restrictive setting,
7. Desk audits,
8. Field audits and onsite audits, and
9. Inspections.

B. *Beneficiary* means:

1. A person who has applied for medical assistance under the Arkansas Medicaid Program or
2. A person who is a recipient of medical assistance under the Arkansas Medicaid Program.

C. *Department* means the Department of Health and Human Services.

191.002 Notice **12-1-05**

A. If an application or claim for medical assistance is denied in whole or in part or is not acted upon with reasonable promptness, the department shall provide written notice:

1. Of the beneficiary's right and opportunity for a fair hearing under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218,
2. Of the method by which the beneficiary may obtain a fair hearing, and
3. Of the beneficiary's right to:
   a. Represent himself or herself, or
   b. Be represented by legal counsel, a friend, or any other spokesperson except a corporation.

B. A notice required under this rule shall include but not be limited to:

1. A statement detailing the type and amount of medical assistance that the beneficiary has requested,
2. A statement of the adverse action that the department has taken or proposes to take,
3. The reasons for the adverse action which shall include but not be limited to:
   a. The specific facts regarding the individual beneficiary that support the action and
   b. The sources from which the facts were derived,
4. An explanation of the beneficiary's right to request a fair hearing, if available; or in cases of an adverse action based on a change in law:
   a. The circumstances under which a fair hearing will be granted and
   b. An explanation of the circumstances under which medical assistance is provided or continued if a fair hearing is requested.

191.003 Determination of Medical Necessity – Content of Notice 12-1-05

If the adverse action that the department has taken or proposes to take is based on a determination of medical necessity or other clinical decision, the notice required under Rule 191.002 shall include all of the following:

A. Specification of the medical records upon which the physician or clinician relied in making the determination,

B. Specification of any portion of the criteria for medical necessity or coverage that is not met by the beneficiary,

C. The specific regulation(s) that support the adverse action, or the change in federal or state law that has occurred since the application was filed that requires adverse action, and

D. A brief statement of the reasons for the adverse action based upon the individual beneficiary's circumstances.

The department and others acting on behalf of the department may not cite or rely on policies that are inconsistent with federal or state laws and regulations or that were not properly promulgated. Generic rationales or explanations shall not suffice to meet the requirements of this rule.

191.004 Administrative Appeals 12-1-05

When notice of an adverse decision is received from the Division of Medical Services, the beneficiary may appeal. The appeal request must be in writing and submitted to the Department of Health and Human Services, Appeals and Hearings Section. **View or print the Department of Health and Human Services, Appeals and Hearings Section contact information.** The appeal request must be received by the Appeals and Hearings Section no later than thirty (30) days from the next business day following the date of the postmark on the envelope containing the written notice of an adverse decision.

All appeals shall conform to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218. Beneficiaries may represent themselves or they may be represented by a friend, by any other spokesperson except a corporation, or by legal counsel.

If an administrative appeal is filed by both a provider and beneficiary concerning the same subject matter, the department may consolidate the appeals.

Any person who considers himself or herself injured in his or her person, business, or property by the decision rendered in the administrative appeal is entitled to judicial review of the decision under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 -- 25-15-218.

191.005 Conducting the Hearing 12-1-05

If a beneficiary appeals an adverse action under the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218, the reviewing authority shall consider only those adverse actions that were included in the written notice to the beneficiary as required under Rules 191.002 and 191.003.

All determinations of the medical necessity of any request for medical assistance shall be based on the individual needs of the beneficiary and on his or her medical history.

191.006 Records 12-1-05

When the department receives an appeal from a beneficiary regarding an adverse action, the department shall provide the beneficiary all records or documents pertaining to the department's or its contractor's decision to take the adverse action.

If the adverse action is based upon a determination that the requested medical assistance is, or was, not medically necessary, the records and documents required to be provided under this rule shall include all material that contains relevant information concerning the medical necessity determination produced by the department or its contractor.