HOUSE BILL No. 4908

May 25, 1995, Introduced by Reps. Hill, Llewellyn, Johnson, Ryan and Jamian and referred to the Committee on Insurance.

A bill to amend section 111a of Act No. 280 of the Public Acts of 1939, entitled as amended

"The social welfare act,"

as amended by Act No. 227 of the Public Acts of 1986, being section 400.111a of the Michigan Compiled Laws.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Section 111a of Act No. 280 of the Public Acts of 1939, as amended by Act No. 227 of the Public Acts of 1986, being section 400.111a of the Michigan Compiled Laws, is amended to read as follows:

Sec. 111a. (1) The director, after appropriate consultation with affected providers and the medical care advisory council established pursuant to federal regulations, may establish policies and procedures that he or she considers appropriate, relating to the conditions of participation and requirements for

providers established by section 111b and to applicable federal law and regulations, to assure that the implementation and enforcement of state and federal laws are all of the following:

(a) Reasonable, fair, effective, and efficient.

(b) In conformance with law.

(c) In conformance with the state plan for medical assistance adopted pursuant to section 10 and approved by the United States department of health and human services.

(2) The consultation required by this section shall be conducted in accordance with guidelines adopted by the state department pursuant to section 24 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being section 24.224 of the Michigan Compiled Laws.

(3) The director shall develop, after appropriate consultation with affected providers in accordance with guidelines, forms and instructions to be used in administering the program. Forms developed by the director shall be, to the extent administratively feasible, compatible with forms providers are required to file with 1 or more other third party payers or with 1 or more regulatory agencies and, to the extent administratively feasible, shall be designed to facilitate use of a single form to satisfy requirements imposed on providers by more than 1 payer, agency, or other entity. The forms and instructions shall relate, at a minimum, to standards of performance by providers, conditions of participation, methods of review of claims, and administrative requirements and procedures that the director considers reasonable and proper to assure all of the following:

(a) That claims against the program are timely, substantiated, and not false, misleading, or deceptive.

(b) That reimbursement is made for only medically appropriate services.

(c) That reimbursement is made for only covered services.

(d) That reimbursement is not made to those providers whose services, supplies, or equipment cost the program in excess of the reasonable value received.

(e) That the state is a prudent buyer.

(f) That access and availability of services to the medically indigent are reasonable.

(4) As used in subsection (3), "prudent buyer" means a purchaser who does 1 or more of the following:

(a) Buys from only those providers of services, supplies, or equipment to medically indigent individuals whose performance, in terms of quality, quantity, cost, setting, and location is appropriate to the specific needs of those individuals, and who, in the case of providers who receive payment on the basis of costs, comply with the prudent buyer concept of titles XVIII and XIX.

(b) Pays for only those services, supplies, or equipment that are needed or appropriate.

(c) Seeks to economize by minimizing cost.

(5) The director shall select providers to participate in arrangements such as case management, in supervision of services for recipients who misutilize or abuse the medical services program, and in special projects for the delivery of medical services to eligible recipients. Providers shall be selected

based upon criteria that may include a comparison of services and related costs with those of the provider's peers and a review of previous participation warnings or sanctions undertaken against the provider or the provider's employer, employees, related business entities, or others who have a relationship to the provider, by the medicaid, medicare, or other health-related programs. The director may consult with the appropriate peer review advisory committees as appointed by the department.

(6) The director shall give notice to each provider of a change in a policy, procedure, form, or instruction established or developed pursuant to this section which affects the provider. In the case of a change which affects 1 or more types of providers, a departmental bulletin or updating insert to a departmental manual mailed 30 days before the effective date of the change shall constitute sufficient notice.

(7) The director may do all of the following:

(a) Enroll in the program for medical assistance only a provider who has entered into an agreement of enrollment required by section 111b(4), and enter into an agreement only with a provider who satisfies the conditions of participation and requirements for a provider established by section 111b and the administrative requirements established or developed pursuant to subsections (1) ~~, (2),~~ and (3) with the appropriate consultation required by this section.

(b) Enforce the requirements established pursuant to this act by applying the procedures of sections 111c to 111f. ~~When, in these procedures~~ IF the director is required to consult with

professionals or experts, ~~prior to first utilizing these individuals in the program,~~ the director shall ~~have given the opportunity to review their professional credentials to~~ GIVE the appropriate medicaid peer review advisory committee THE OPPORTUNITY TO REVIEW THE CREDENTIALS OF THE PROFESSIONALS OR EXPERTS BEFORE FIRST USING THOSE INDIVIDUALS IN THE PROGRAM.

(c) Develop, with the appropriate consultation required by this section, and require the form or format for claims, applications, certifications, or certifications and recertifications of medical necessity required by section 108, and develop specifications for and require supporting documentation that is compatible with the approved state medical assistance plan under title XIX. THE DEPARTMENT SHALL REQUIRE ALL PROVIDERS TO SUBMIT CLAIMS ON THE STANDARD MEDICAL CLAIM FORM OR STANDARD MEDICAL CLAIM ELECTRONIC DATA FORMAT ESTABLISHED BY THE INSURANCE COMMISSIONER PURSUANT TO SECTION 2240 OF THE INSURANCE CODE OF 1956, ACT NO. 218 OF THE PUBLIC ACTS OF 1956, BEING SECTION 500.2240 OF THE MICHIGAN COMPILED LAWS.

(d) Recover payments to a provider in excess of the reimbursement to which the provider is entitled. The department shall have a priority lien on any assets of a provider for any overpayment, as a consequence of fraud or abuse, which is not reimbursed to the department.

(e) Notwithstanding any other provisions of this act, before payment of claims, identify for examination for compliance with the program of medical assistance, including but not limited to medical necessity, the claims submitted by a particular provider

based upon a determination that the provider's claims for disputed services exceed the average program dollar amount or volume of the same type of services, submitted by the same type of provider, performed in the same setting, and submitted during the same period. In order to carry out the authority conferred by this subdivision, the director shall notify the provider in the form of registered mail, receipted by the addressee, or by proof of service to the provider, or representative of the provider, of the state department's intent to impose specific conditions and controls prior to authorizing payment for specific claims for services. The notice shall contain all of the following:

(*i*) A list of the particular practice or practices disputed by the state department and a factual description of the nature of the dispute.

(*ii*) A request for specific medical records and any other relevant supporting information that fully discloses the basis and extent to which the disputed practice or practices were rendered.

(*iii*) A date certain for an informal conference between the provider or representative of the provider and the state department to resolve the differences surrounding the disputed practice or practices.

(*iv*) A statement that unless the provider or representative of the provider demonstrates at the informal conference that the disputed practice or practices are medically necessary, or are in compliance with other program coverages, specific conditions and

controls may be imposed on future payments for the disputed practice or practices, and claims may be rejected, beginning on the sixteenth day after delivery of this notice.

(8) For any provider who is subject to a notice of intent to impose specific conditions and controls prior to authorizing payment for specific claims for services, as specified in subsection (7)(e), the state department shall afford that provider an opportunity for an informal conference before the sixteenth day after delivery of the notice under subsection (7)(e). If the provider fails to appear at the conference, or fails to demonstrate that the disputed practice or practices are medically necessary or are in compliance with program coverages, the state department beginning on the sixteenth day following receipt of notice by the provider ~~,~~ is authorized to impose specific conditions and controls prior to payment for the disputed practice or practices and may reject claims for payments for such practice or practices. The state department, within 5 days following the informal conference, shall notify the provider of its decision regarding the imposition of special conditions and controls prior to payment for the disputed practice or practices. Upon the imposition of specific conditions and controls prior to payment, the provider upon request shall be entitled to an immediate hearing held in conformity with chapter 4 and chapter 6 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.271 to 24.287 and 24.301 to 24.306 of the Michigan Compiled Laws, if any of the following occurs:

(a) The claim for services rendered is not paid within 30 days of the provider's compliance with the conditions imposed.

(b) The claim is rejected.

(c) The provider notifies the state department by registered mail that the provider does not intend to comply with the specific conditions and controls imposed, and the claim for services rendered is not paid within 30 days after delivery of this notice.

(9) The hearing provided for under subsection (8) shall be conducted in a prompt and expeditious manner. At the hearing, the provider may contest the state department's decision to impose specific conditions and controls prior to payment. Subsequent hearings may be conducted at the provider's request only if the claims have not been considered at a prior hearing and reflect issues that also have not been considered at a prior hearing, or if a claim for services rendered is not paid within 60 days after the provider's compliance with the conditions imposed.

(10) The authority conferred in subsection (8) with respect to the claims submitted by a particular provider does not prohibit the state department from examining claims or portions of claims before payment of the claims to determine their compliance with the program of medical assistance, in compliance with law. The director may take additional action pursuant to subsection (8) during the pendency of an appeal taken pursuant to subsection (8).

(11) If in the department's opinion, the provider shifts his or her claims from the disputed services addressed under subsection (7)(e) to other claims which fall under the purview of subsection (7)(e), the director may impose the claims review process of this section immediately upon delivery of the notice of that imposition to the provider as provided in subsection (7)(e).

(12) If in the department's opinion, claims similar to the disputed services addressed under subsection (7)(e) are shifted to another provider in the same corporation, partnership, clinic, provider group, or to another provider in the employ of the same employer or contractor, the director may impose the claims review process of this section immediately upon delivery of notice of that imposition to the new provider as provided in subsection (7)(e). The department shall afford the new provider an opportunity for an immediate informal conference within 7 days pursuant to subsection (8) after the initiation of the claims process.

(13) The director may request a provider to open books and records in accordance with section 111b(7) and may photocopy, at the state department's expense, the records of a medically indigent individual. The records shall be confidential, and the state department shall use the records only for purposes directly and specifically related to the administration of the program. The immunity from liability of a provider subject to the director's authority under this subsection shall be governed by section 111b(7).

(14) The director shall not pay for services, supplies, or equipment furnished by a provider, or shall recover for payment made, during a period in which the provider does not have on file with the state department disclosure forms as required by section 111b(19).

(15) The director shall make payments to, and collect overpayments from, the provider, unless the provider and the provider's employer satisfy the conditions prescribed in section 111b(25), (26), and (27), in which case the director may make payments directly to, and collect overpayments from, the provider's employer.

(16) The director, with the appropriate consultation required by this section, may develop specifications for and require estimated cost and charge information to be submitted by a provider under section 111b(13) and the form or format for submission of the information.

(17) If the director decides that a payment under the program has been made to which a provider is not or may not be entitled, or that the amount of a payment is or may be greater or less than the amount to which the provider is entitled, the director, except as otherwise provided in this subsection or under other applicable law or regulation, shall promptly notify the provider of this decision. The director shall withhold notification to the provider of the decision upon advice from the department of attorney general or other state or federal enforcement agency in a case where action by the department of attorney general or other state or federal enforcement agency may be

compromised by the notification. If the director notifies a provider of a decision that the provider has received an underpayment, the state department shall reimburse the provider, either directly or through an adjustment of payments, in the amount found to be due.

Section 2. This amendatory act shall not take effect unless Senate Bill No. _____ or House Bill No. 4906 (request no. 02094'95 *) of the 88th Legislature is enacted into law.