# MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

1206

2005 HOUSE HUMAN SERVICES

HB 1206

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB1206

House Human Services Committee

❑ Conference Committee

Hearing Date 1/12/05

| Tape Number | Side A | Side B | Meter # |
|---|---|---|---|
| #1 | x | x | #2984 - (b)1958 |

Committee Clerk Signature

**Minutes:**

**Chairman Price** opened hearing on 1206.

**Rep. Porter**: Operates the ambulance service in Bismarck - Mandan. We provide a service for billing for other ambulance services across the state. We provide the services because the rules and guidelines as well as the billing process is so complicated, the volunteer services can't take care of those billings, they want to rely on companies that do a lot of business with them. Golden Heart in Rugby, performs the same services. Last year in dealing with claims from the dept. of Human Services, I was disappointed with their rejection in their payment for claim for payment for ambulance service. In talking with the utilization review staff, there is a procedure that you can go through if your a patient, but none if you are a provider. The patient, in most cases, have no financial back course if the claim is denied. The Medicaid recipient is transported, even though the dept. says you can bill the patient, in order to qualify for Medicaid in the first place, you have to be at 133% of poverty.

Chances are you will not be paid, for me to get the authorizing to appeal the decision is somewhat difficult at best. Medicare has a system in place, that allows the provider to appeal the claim. You do a written appeal, it is reviewed - the next step is a hearing,

The CMS carrier, under guidelines, hire a staff of fair hearing officers. They are separate from the claims reviewers and they provide for a fair hearing. If you disagree with their decision, you can take it to an administrative law judge. He hears testimony and its in the court of law. In the process of trying to appeal, I was informed by letter with a copy of the procedure that indicated that only an applicant or recipient can file an appeal a claim. Once the Dept. Human Services make a decision, there is no other process for a provider to take if they think they have wrongly been denied payment on a claim. Discussion was held regarding various situations concerning claims under reviewing/settlement. The scope of this bill needs to be scaled down so it only covers providers/medical services and claims for medical services. When I met with agency, they agreed something need to be done for the provider's such as individual review with in department, possibly the provider would have option to go to District Court for review. The providers would have the ability as need cases, if they didn't agree with the independent review process, they could go to District Court.

**Rep. Kaldor:** Sect: 75-01-0303 - Is that where these definitions come from? Do you have any experience with a patient going through the fair hearing process?

**Rep. Porter**: I have never been contacted from a patient requesting my presence at the hearing.

**Rep. Kreidt:** As you go through this process, will the Dept. have the final say, or do you go up the ladder to the Supreme Court.

**Rep. Porter:** Under the way the bill is written, it would just be an opinion, don't know about the District Court. That would be a question for the Dept.

MR# 4811

**Rep. Kreidt:** If that is the situation, you will wind up right back where you are, because they will overrule you anyway.

**Rep. Porter**: In my opinion, when we put the amendment together, we should put it in they will have to follow the district court rules.

**Rep. Kriedt**: That is the only way your ever going to win.

**Rep. Sandvig**: Is there another bill similar coming up this session.

**Rep. Porter:** There might be, it was one that was clarifying the use of the definitions within this particular part of the code. It didn't have to do with the appeals process.

**Rep. Sandvig**: Are the district courts complain that they have to much to do already and we are adding to their workload?

**Rep. Porter**: I hope they wouldn't - I hope that in the initial step of this process, would clean up 99.9% of these type claims and there would be no opportunity to take it to district court, that it would be basically putting them on notice, that you better follow your own rules, or you will be going to district court. I would hope it would never leave the dept.

**Rep. Nelson**: In your testimony, you set examples that warranted your review. What would you anticipate the increased load, what would you deem reasonable to present before a review committee.

**Rep. Porter:** It seems to go in cycles, when you present a batch, you may get no rejections and then when you present some, you can get several rejections. When there is abuse in the process, I have no way of stopping that, but I still have to absorb those costs of doing that call.

As far, as a number, I don't know that I could guess a number, but I would know that this particular grouping came around the 2004 mark, when I was disappointed with the decision that the dept. made, then I started tracking claims, so I could come up with the basic evidence of the testimony.

**Rep. Nelson**: When you respond to a call, when you arrive if you suspect abuse of the service, can you walk away from the call?

**Rep. Porter:** We passed a law a couple sessions ago, that allowed ambulance services, upon discussion, with medical control to refuse service to a patient.

MR#5875

**Melissa Hauer, Director Legal Advisory Unit**

**See Attached Testimony**

**Fiscal Note:** The note involves the cost that anticipates the cost that could happen, during the processing appeal, not to pay claims that were wrongfully denied. We are hoping to work out a process like a Medicare appeal to assist us with the process.

**Side B MR# 1**

**Chairman Price:** Do you abide by that now?

**Rep Kaldor**: I have a question concerning denial, how does that work? Can they file a formal appeal?

**M. Hauer:** With the District Ct. decision? Yes, we do. The agency can't change that, the court has a final decision.

**Rep. Devlin**: Will the Dept. sign off on the District Ct. having the final level, even if the Dept. looses? Can it go any further?

**M. Hauer:** That is what we discussed with Rep. Porter, we talked about having the paper review, then the court appeal, then beyond that the Supreme Court.

**Rep. Devlin:** If the administrative judge rules against the dept. and the district court rules against the dept., will you appeal it or will you allow the provider to have decision.

**M. Hauer:** Either party can appeal, the process proposing a paper review.

**Rep. Devlin:** The dept. has very deep pockets, the provider does not have money to appeal it.

**Rep. Kaldor:** I share that concern, I would hope you would find a process that the third party making a determination and minimize the appeal to end up in district or supreme court.

**M. Hauer:** We could do a paper review, to try to cut time/complexity and costs. Provider needs to provide all the paper documents, to do the review. This would be more streamlined and more efficient. We also have a budget to deal with.

**Arnold Thomas, president of ND Health Care Assn.**

In favor of concept of HB 1206. The task force that what was formed by the Gov. and would like to take a look at Medicaid programs costs and particular with mention care providers and how to better manage the challenges in the short/long term. One of the recommendations is that there should be an additional appeal mechanism brought into the dept. Because the judgment to be made about medical necessity don't allow for absolute clarity. When codes are put into place

with multiple diagnoses, how do you prioritize ? Need a vehicle to allow open discussion. Also, need to find out what is valid payment. We would look for a forum that the medical decisions and providers would also have an opportunity to be reviewed with the dept. as they exercise the evaluation making a determination whether they should pay. I do not know the amount of claims, they don't believe any claim review, would be in excess of $50.00, per claim. So we would hope that we would be included with the bill sponsor and discussion with the dept. in seeking an option for providers to have a forum. The courts are not a medical evaluator. There are issues in multi diagnoses, where depending on which code is used. In some instances, it may be in the payers best interest to pay the lowest code presented.

**Jean Mullion, Attorney General Dept.** (Neutral)

The AG's office will work on Fiscal Note also, $150,000.00 some of that will offset because the Dept. of HS, is a bill able agency, with working on appeal process. I do appeals for the dept/HS. most concerning Medicaid.

**Chairman Price:** Number of cases that are denied?

**J. Mullian:** About 1000 cases denied a year, assume 5% would be appealed. Time consists of at least 3-31/2 days per hearing. When you see the amount of time involved, you can understand the cost vs paper review.

**Rep. Devlin:** I would like clarification, concerning administrative rules process. I understand the prudent lay person's argument. We may work with the agency, what ever dept. you work with, you need an appeals process. The administrative rules committee has to find a solution to this process. I am hoping that the dept. can work with others as this is needed in ND.

**Shelly Peterson, Long Term Care Assn.**

MR#1526

I would like to lend support, we do have extreme frustration with the current process. Anytime you disagree with the dept. You have 30 days to register your appeal. In concept you think it is a good idea, but it is not always that way. When it goes through this process, almost always the dept. will disagree with the administrative ruling and has changed the order and we are forced to go to district court. Going to district court, is extremely costly. We would like to have paper review, and skip other process and go directly to district court. We believe in the concept and hope there will be a resolution.

**Rep. Nelson:** I serve on a hospital board and understand what you are saying. I am going to use rural hospitals, as I understand them, with the discounts that we live with, most of these facilities are at a breaking point. We budget $500,000.00 a year in discounts. The dept. is one of the players in that, but not the only player. What about 3rd party providers?

**Shelly Peterson:** Eventually might want to do that. Not at this time, but maybe in next session.

**Rep. Kaldor:** Is there a federal prohibition against making a final determination at the administrative law judge level.

**M. Hauer:** Yes, for Medicaid, a regulation that requires the Medicaid agency to be the final determinant. Other programs could be handled differently, but not this one.

**Chairman Price** closed hearing.

2005 HOUSE STANDING COMMITTEE MINUTES

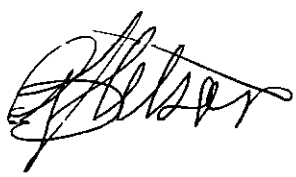
BILL/RESOLUTION NO. HB 1206

House Human Services Committee

☐ Conference Committee

Hearing Date January 25, 2005

| Tape Number | Side A | Side B | Meter # |
|---|---|---|---|
| #1 | x | | |

Committee Clerk Signature 

Minutes:

**Chairman Price** opened the hearing.

**Rep. Porter:** We have met with the dept. with the changes.

The Fiscal Note will be going down to zero.

**Rep. Porter** moved to accept the amendment,

**Rep. Uglem** seconded.

**Chairman Price**: Does the Attorney General's office need to be contacted.

**Rep. Porter:** The dept. will be doing that.

Voice vote to accept the amendment. 9 yes, 0 no 3 absent.

**Rep. Porter** moved a **Do Pass as Amended**.

**Rep. Pietsch** seconded.

**Vote: 9 yes, 0 no, 3 Absent. Carrier: Rep Devlin.**

# FISCAL NOTE

**Requested by Legislative Council**
03/04/2005

Amendment to: Engrossed HB 1206

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

| | 2003-2005 Biennium | | 2005-2007 Biennium | | 2007-2009 Biennium | |
|---|---|---|---|---|---|---|
| | General Fund | Other Funds | General Fund | Other Funds | General Fund | Other Funds |
| **Revenues** | $0 | $0 | $0 | $0 | $0 | $0 |
| **Expenditures** | $0 | $0 | $0 | $0 | $0 | $0 |
| **Appropriations** | $0 | $0 | $0 | $0 | $0 | $0 |

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

| 2003-2005 Biennium | | | 2005-2007 Biennium | | | 2007-2009 Biennium | | |
|---|---|---|---|---|---|---|---|---|
| Counties | Cities | School Districts | Counties | Cities | School Districts | Counties | Cities | School Districts |
| $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill would create and enact a new section to chapter 50-24.1 of the NDCC relating to provider appeals of medical assistance reimbursement denials; and it would amend and reenact section 50-24.1-15 relating to prehospital emergency medical services. The amendment provides for the appeal to be handled by the Department internally resulting in no fiscal impact.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*


| | | | |
|---|---|---|---|
| **Name:** | Brenda Weisz | **Agency:** | Human Services |
| **Phone Number:** | 325-2397 | **Date Prepared:** | 03/07/2005 |

# FISCAL NOTE

**Requested by Legislative Council**
01/28/2005

Amendment to: HB 1206

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

| | 2003-2005 Biennium | | 2005-2007 Biennium | | 2007-2009 Biennium | |
|---|---|---|---|---|---|---|
| | General Fund | Other Funds | General Fund | Other Funds | General Fund | Other Funds |
| **Revenues** | $0 | $0 | $0 | $0 | $0 | $0 |
| **Expenditures** | $0 | $0 | $0 | $0 | $0 | $0 |
| **Appropriations** | $0 | $0 | $0 | $0 | $0 | $0 |

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

| 2003-2005 Biennium | | | 2005-2007 Biennium | | | 2007-2009 Biennium | | |
|---|---|---|---|---|---|---|---|---|
| Counties | Cities | School Districts | Counties | Cities | School Districts | Counties | Cities | School Districts |
| $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill would create and enact a new section to chapter 50-24.1 of the NDCC relating to provider appeals of medical assistance reimbursement denials. The amendment provides for the appeal to be handled by the Department internally resulting in no fiscal impact.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

| | | | |
|---|---|---|---|
| **Name:** | Brenda Weisz | **Agency:** | Human Services |
| **Phone Number:** | 325-2397 | **Date Prepared:** | 01/31/2005 |

# FISCAL NOTE

**Requested by Legislative Council**
01/07/2005

Bill/Resolution No.: HB 1206

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

| | 2003-2005 Biennium | | 2005-2007 Biennium | | 2007-2009 Biennium | |
|---|---|---|---|---|---|---|
| | General Fund | Other Funds | General Fund | Other Funds | General Fund | Other Funds |
| **Revenues** | $0 | $0 | $0 | $205,728 | $0 | $211,941 |
| **Expenditures** | $0 | $0 | $205,728 | $205,728 | $211,941 | $211,941 |
| **Appropriations** | $0 | $0 | $205,728 | $205,728 | $211,941 | $211,941 |

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

| 2003-2005 Biennium | | | 2005-2007 Biennium | | | 2007-2009 Biennium | | |
|---|---|---|---|---|---|---|---|---|
| Counties | Cities | School Districts | Counties | Cities | School Districts | Counties | Cities | School Districts |
| $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill would create and enact a new section to chapter 50-24.1 of the NDCC relating to provider appeals of medical assistance reimbursement denials.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The deparment would receive federal funds at a 50% match rate in the amount of $205,728.

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Expenditures would be incurred totalling $411,456; general funds would be required to match 50% of the total cost or $205,728 and the remaining $205,728 would be federal funds.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

An appropriation for the total expenditure amount of $411,456 would be needed in the operating line item - 50% or $205,728 would be general funds and the remaining 50% or $205,728 would be federal funds.

| | | | |
|---|---|---|---|
| **Name:** | Brenda Weisz | **Agency:** | Human Services |
| **Phone Number:** | 328-2397 | **Date Prepared:** | 01/11/2005 |

**Date:** 1/12/05 **Roll Call Vote #: 1**

## 2005 HOUSE STANDING COMMITTEE ROLL CAll
## BILL/RESOLUTION NO. 1206

**House** **Human Services** **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass as amended

Motion Made By Rep. Uglem Seconded By Rep. Weisz

| Representatives | | Yes | No | Representatives | | Yes | No |
|---|---|---|---|---|---|---|---|
| Chairman C.S.**Price** | | x | | Rep.L. **Kaldor** | AB | | |
| V Chrm.G. **Kreidt** | | x | | Rep.L. **Potter** | | x | |
| Rep. V. **Pietsch** | | x | | Rep.S. **Sandvig** | | x | |
| Rep.J.O. **Nelson** | AB | | | | | | |
| Rep.W.R. **Devlin** | | x | | | | | |
| Rep.T. **Porter** | | x | | | | | |
| Rep.G. **Uglem** | | x | | | | | |
| Rep C. **Damschen** | | x | | | | | |
| Rep.R. **Weisz** | AB | | | | | | |

**Total Yes:** 9 **No** 0
**Absent** 3

**Floor Assignment** **Rep. Devlin**

If the vote is on an amendment, briefly indicate intent:

Adopted by the Human Services Committee
January 25, 2005

VR 1/25/05 1052

HOUSE AMENDMENTS TO HOUSE BILL NO. 1206 H.S. 1-26-05

Page 1, line 6, after "**appeals**" insert " **- Definitions**" and replace "The department shall adopt rules for an appeal procedure by which" with:

"1. For purposes of this section:

a. "Denial of payment" means that the department has denied payment for a medical assistance claim or reduced the level of service payment for a service provided to an individual who was an eligible medical assistance recipient at the time the service was provided.

b. "Department" means the department of human services.

c. "Provider" means an individual, entity, or facility that furnishes medical or remedial services or supplies pursuant to a provider agreement with the department.

2. A provider may request a review of denial of payment under this section by filing within thirty days of the date of the department's denial of the claim a written notice with the department which includes a statement of each disputed item and the reason or basis for the dispute. A provider may not request review under this section of the rate paid for a particular service.

3. Within thirty days after requesting a review, a provider shall provide to the department all documents, written statements, exhibits and other written information that support the provider's request for review, together with a computation and the dollar amount that reflects the provider's claim as to the correct computation and dollar amount for each disputed item.

4. The department shall assign to a provider's request for review someone other than any individual who was involved in the initial denial of the claim. A provider who has requested review may contact the department for an informal conference regarding the review anytime before the department has issued its final decision.

5. The department shall make and issue its final decision within seventy-five days of receipt of the notice of request for review. A provider may appeal the final decision of the department to the district court in the manner provided in section 28-32-42. The judgment of the district court in an appeal from a request for review may be reviewed in the supreme court on appeal by any party in the same manner as provided in section 28-32-49.

6. Upon receipt of notice that the provider has appealed its final decision to the district court, the department shall make a record of all documents, written statements, exhibits and other written information submitted by the provider or the department in connection with the request for review and the department's final decision on review, which constitutes the entire record. Within thirty days after an appeal has been taken to district court as provided in this section, the department shall prepare and file in the office of the clerk of the district court in which the appeal is pending the original and a certified copy of the entire record, and that record must be treated as the record on appeal for purposes of section 28-32-44."

Page 1, remove lines 7 through 16

Renumber accordingly

**Date:** 1/25/05 **Roll Call Vote #:** 2

**2005 HOUSE STANDING COMMITTEE ROLL CALL**
**BILL/RESOLUTION NO.** HB 1206

**House** **Human Services** **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass as Amd

Motion Made By **Rep.** Porter Seconded By **Rep** Pietsch

| Representatives | Yes | No | Representatives | Yes | No |
|---|---|---|---|---|---|
| Chairman C.S. **Price** | ✓ | | Rep.L. **Kaldor** | AB | |
| V Chrm.G. **Kreidt** | ✓ | | Rep.L. **Potter** | ✓ | |
| Rep. V. **Pietsch** | ✓ | | Rep.S. **Sandvig** | ✓ | |
| Rep.J.O. **Nelson** | AB | | | | |
| Rep.W.R. **Devlin** | ✓ | | | | |
| Rep.T. **Porter** | ✓ | | | | |
| Rep.G. **Uglem** | ✓ | | | | |
| Rep C. **Damschen** | ✓ | | | | |
| Rep.R. **Weisz** | AB | | | | |

**Total** **Yes** 9 **No** 0

**Absent** 3

**Floor Assignment** **Rep.** Devlin.

If the vote is on an amendment, briefly indicate intent:
Amd - moved Rep Porter / 2nd Rep Uglem

## REPORT OF STANDING COMMITTEE

**HB 1206: Human Services Committee (Rep. Price, Chairman)** recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (9 YEAS, 0 NAYS, 3 ABSENT AND NOT VOTING). HB 1206 was placed on the Sixth order on the calendar.

Page 1, line 6, after "**appeals**" insert " **- Definitions**" and replace "The department shall adopt rules for an appeal procedure by which" with:

"1. For purposes of this section:

a. "Denial of payment" means that the department has denied payment for a medical assistance claim or reduced the level of service payment for a service provided to an individual who was an eligible medical assistance recipient at the time the service was provided.

b. "Department" means the department of human services.

c. "Provider" means an individual, entity, or facility that furnishes medical or remedial services or supplies pursuant to a provider agreement with the department.

2. A provider may request a review of denial of payment under this section by filing within thirty days of the date of the department's denial of the claim a written notice with the department which includes a statement of each disputed item and the reason or basis for the dispute. A provider may not request review under this section of the rate paid for a particular service.

3. Within thirty days after requesting a review, a provider shall provide to the department all documents, written statements, exhibits and other written information that support the provider's request for review, together with a computation and the dollar amount that reflects the provider's claim as to the correct computation and dollar amount for each disputed item.

4. The department shall assign to a provider's request for review someone other than any individual who was involved in the initial denial of the claim. A provider who has requested review may contact the department for an informal conference regarding the review anytime before the department has issued its final decision.

5. The department shall make and issue its final decision within seventy-five days of receipt of the notice of request for review. A provider may appeal the final decision of the department to the district court in the manner provided in section 28-32-42. The judgment of the district court in an appeal from a request for review may be reviewed in the supreme court on appeal by any party in the same manner as provided in section 28-32-49.

6. Upon receipt of notice that the provider has appealed its final decision to the district court, the department shall make a record of all documents, written statements, exhibits and other written information submitted by the provider or the department in connection with the request for review and the department's final decision on review, which constitutes the entire record. Within thirty days after an appeal has been taken to district court as provided in this section, the department shall prepare and file in the office of the clerk of the district court in which the appeal is pending the original and a certified copy of the entire record, and that record must be treated as the record on appeal for purposes of section 28-32-44."

Page 1, remove lines 7 through 16

Renumber accordingly

# 2005 SENATE HUMAN SERVICES

HB 1206

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1206

Senate Human Services Committee

☐ Conference Committee

Hearing Date February 16, 2005

| Tape Number | Side A | Side B | Meter # |
|---|---|---|---|
| 1 | X | | 1-1307 |

Committee Clerk Signature

Minutes:**Chairman Lee opened the hearing on HB 1206. The bill relates to provider appeals of medical assistance reimbursement denials. All Senators were present.**

**Representative Todd Porter** introduced the bill. In the House, we hoghoused the bill to allow the process for providers to appeal their claims if they were wrongfully denied. Most other insurance providers and third party payers have a procedure in place that the provider can appeal the claim. This bill will give providers a voice in this area. He distributed and explained an amendment to the committee for their consideration. (See attachment). Basically, if the claim meets the prudent layperson definition, even after a retrospective review, they cannot use the medical necessity to trump the prudent layperson provision.

**Chairman Lee-** So, the rules would not trump the statute on this?

**Porter-** Correct.

**Senator Brown-** Is there a fiscal note?

**Representative Porter-** No. The fiscal note went away with the amendment on the bill.

**Dean Lampe, Executive Director of the ND EMS Association,** appeared in support of the bill..

See written testimony.

**Senator Dever-** This bill applies to Medicaid. Do you have a similar situation with denials of claims for private insurance.

**Dean-** Yes. There is a bill from Chip Thomas with NDHA that has dealt with that issue.

**Chairman Lee** distributed written testimony from Representative Devlin to the committee members. See attached.

**Melissa Hauer, representing the Department of Human Services** appeared in support of the bill. See written testimony.

**Jim Ganje, Office of the State Supreme Court Administrator** appeared with neutral testimony on the bill. See attached.

**Chariman Lee-** Do you have any amendments to recommend?

**Jim-** No. I'm not sure of the extent the Department wants to go with this in that area.

**Senator Dever-** I know there is another Senate Bill that involves the review of insurance claims, is this the same situation to apply to that?

**Jim-** I'm not sure, it depends on how it is structured with the appeal process.

**Chairman Lee** asked Melissa Hauer to visit with Jim Ganje on a possible amendment to the bill. They agreed to work on it.

**Chairman Lee closed the hearing on HB 1206. No action was taken.**

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1206

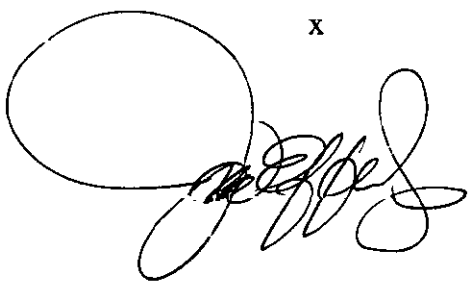
Senate Human Services Committee

☐ Conference Committee

Hearing Date March 2, 2005

| Tape Number | Side A | Side B | Meter # |
|---|---|---|---|
| 2 | | x | 4980 - 5840 |

Committee Clerk Signature



Minutes:

**Chairman Judy Lee** opened the discussion on HB 1206. This is the provider appeal for medical assistance denials. We had an amendment from Representative Porter. This would allow providers to have an appeals process. We were waiting for Jim Ganze. Have we heard anything from him?

**Carlee** said not that she knows of, we had an email with an additional amendment from Howard. He is the one who addressed Jim Ganze's concerns, the guy from the Supreme Court.

**Senator Dever** asked why he has notes that say the rule doesn't trump statute?

**Senator J. Lee** said that is what Representative Porter's amendment states.

**Senator Warner** said medically necessary is in rule, prudent layperson standard is in law.

**Senator J. Lee** read from 28-32-39. 42 and 46.

**Senator Warner** said if it is already in statute it must have been tested and refined.

**Senator Warner** moved amendments 50422.0201 and the amendments to page 2 lines 8 and 9.

**Senator Brown** seconded the motion.

**The motion passed** on a roll call vote 4-0-1. Senator Lyson was absent.

**Senator Brown** moved a do pass as amended.

**Senator Dever** seconded the motion.

The motion passed on a roll call vote 5-0-0.

**Senator Dever** will carry the bill.

Attachment 1

50422.0201
Title.

Prepared by the Legislative Council staff for
Representative Porter
February 14, 2005

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1206

Page 1, line 2, after "denials" insert "; and to amend and reenact section 50-24.1-15 of the North Dakota Century Code, relating to prehospital emergency medical services"

Page 1, after line 3, insert:

"**SECTION 1. AMENDMENT.** Section 50-24.1-15 of the North Dakota Century Code is amended and reenacted as follows:

**50-24.1-15. Prehospital emergency medical services.** Medical assistance coverage must include prehospital emergency medical services benefits in the case of a medical condition that manifests itself by symptoms of sufficient severity which may include severe pain and which a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of medical attention to result in placing the person's health in jeopardy, serious impairment of a bodily function, or serious dysfunction of any body part. A medical assistance claim that meets the prudent layperson standard of this section may not be denied by the department on the basis that the prehospital emergency medical services were not medically necessary or that a medical emergency did not exist."

Renumber accordingly

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1206

Page 2, line 8, after "review." insert "The department's final decision must conform to the requirements of section 28-32-39."

Page 2, line 9, after "28-32-42", insert ", and the district court shall review the department's final decision in the manner provided in section 28-32-46."

Renumber accordingly

Date: 3-2-05
Roll Call Vote #: 1

## 2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
## BILL/RESOLUTION NO. HB 1206

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass Amendments

Motion Made By Sen Warner Seconded By Sen Brown

| Senators | Yes | No | Senators | Yes | No |
|---|---|---|---|---|---|
| Sen. Judy Lee - Chairman | ✓ | | Sen. John Warner | ✓ | |
| Sen. Dick Dever - Vice Chairman | ✓ | | | | |
| Sen. Richard Brown | ✓ | | | | |
| Sen. Stanley Lyson | | | | | |

Total (Yes) No

Absent

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 3-2-05
Roll Call Vote #: 2

## 2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
## BILL/RESOLUTION NO. HB 1206

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass as amended

Motion Made By Sen Brown Seconded By Sen Dever

| Senators | Yes | No | Senators | Yes | No |
|---|---|---|---|---|---|
| Sen. Judy Lee - Chairman | ✓ | | Sen. John Warner | ✓ | |
| Sen. Dick Dever - Vice Chairman | ✓ | | | | |
| Sen. Richard Brown | ✓ | | | | |
| Sen. Stanley Lyson | ✓ | | | | |

Total (Yes) 5 No 0

Absent 0

Floor Assignment Sen Dever

If the vote is on an amendment, briefly indicate intent:

## REPORT OF STANDING COMMITTEE

**HB 1206, as engrossed: Human Services Committee (Sen. J. Lee, Chairman)** recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1206 was placed on the Sixth order on the calendar.

Page 1, line 2, after "denials" insert "; and to amend and reenact section 50-24.1-15 of the North Dakota Century Code, relating to prehospital emergency medical services"

Page 1, after line 3, insert:

"**SECTION 1. AMENDMENT.** Section 50-24.1-15 of the North Dakota Century Code is amended and reenacted as follows:

**50-24.1-15. Prehospital emergency medical services.** Medical assistance coverage must include prehospital emergency medical services benefits in the case of a medical condition that manifests itself by symptoms of sufficient severity which may include severe pain and which a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of medical attention to result in placing the person's health in jeopardy, serious impairment of a bodily function, or serious dysfunction of any body part. A medical assistance claim that meets the prudent layperson standard of this section may not be denied by the department on the basis that the prehospital emergency medical services were not medically necessary or that a medical emergency did not exist."

Page 1, underscore lines 6 through 23

Page 2, underscore lines 1 through 7

Page 2, line 8, underscore "receipt of the notice of request for review." and insert immediately thereafter "The department's final decision must conform to the requirements of section 28-32-39." and underscore "A provider may appeal the final decision"

Page 2, line 9, underscore "of the department to the district court in the manner provided in section 28-32-42" and insert immediately thereafter ", and the district court shall review the department's final decision in the manner provided in section 28-32-46" and underscore the period

Page 2, underscore lines 10 through 21

Renumber accordingly

2005 TESTIMONY

HB 1206

**TESTIMONY BEFORE THE HOUSE HUMAN SERVICES COMMITTEE**
**REGARDING HOUSE BILL 1206**
**JANUARY 12, 2005**

Chairman Price and members of the Committee, I am Melissa Hauer. I am an attorney for the Department of Human Services which is the agency that administers the Medicaid program in North Dakota. I am here today to testify regarding House Bill 1206 and to point out some concerns that the Department has regarding this bill. I will be brief in addressing these concerns because David Zentner, the Department's Medicaid Director, and I met with Representative Porter to discuss these concerns and we hope to work together to resolve them.

The language of the bill provides an appeal right to any Medicaid provider for "any adverse action taken by the department with respect to a medical assistance claim . . .". This language is very broad and could be interpreted to allow any Medicaid provider to appeal not only denials of payment but also any payment made by Medicaid. For instance, if Medicaid provides $5,000 reimbursement to a provider but the provider feels it should be paid $6,000 instead, the language of the bill could be interpreted to allow such an appeal. Or it could allow a nursing facility to appeal a County Social Services' determination of Medicaid ineligibility of a resident of that facility. The amount of appeals that have to be handled by the Department, the Office of Administrative Hearings, and the Attorney General's office could increase substantially.

It is also unclear whether the intent is to provide an appeal right under chapter 28-32 (the Administrative Practices Act) or whether the intent is that this be some other, more informal, type of review to be done internally by the Department. If the intent is to provide an Administrative Practices

Act hearing, the costs reflected in the fiscal note would be incurred for payment to the Office of Administrative Hearings and the Attorney General. A less formal, internal review could be performed by the Department instead. The record would be developed in the Department for the internal review process which would reduce the costs not only to the Department but also to providers. Providers that are unsatisfied with the Department's internal review of a denial, could then be given the ability to appeal that determination to a district court and to the state supreme court.

The bill also provides that in order for a provider to be awarded attorneys' fees and costs, ". . . the provider must be successful on more than fifty percent of the dollar amount involved in the issues identified in the provider's notice of appeal." It is somewhat unclear as to what this means. For example, if a provider appeals multiple denials of reimbursement, must it successfully prevail on fifty percent of each claim or in the aggregate on all claims decided by the appeal? In addition, notices of appeals do not usually contain a dollar amount in question. They merely summarize the issue to be decided, for example, whether payment for a certain service was properly denied. If a provider fails to identify the amount in dispute, can it never recover attorneys' fees and costs? In addition, current state law allows a court to assess attorneys' fees and costs against an agency if the agency acted without substantial justification. (See N.D.C.C. § 28-32-50).

The Department would like to work with Representative Porter and any others who are interested to try to address these concerns. This concludes my testimony. I would be happy to try to answer any questions the committee members may have. Thank you.

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1206

Page 1, replace lines 6 though 16 with:

**"Provider appeals.**

1. For purposes of this section:

   a. "Denial of payment" means that the department has denied payment for a medical assistance claim or reduced the level of service payment for a service provided to an individual who was an eligible medical assistance recipient at the time the service was provided;

   b. "Department" means the department of human services; and

   c. "Provider" means an individual, entity, or facility that furnishes medical or remedial services or supplies pursuant to a provider agreement with the department.

2. A provider may request a review of denial of payment under this section by filing within thirty days of the date of the department's denial of the claim a written notice with the department that includes a statement of each disputed item and the reason or basis for the dispute. A provider may not request review under this section of the rate paid for a particular service.

3. Within thirty days after requesting a review, a provider shall provide to the department all documents, written statements, exhibits and other written information that support its request for review, together with a computation and the dollar amount that reflects the provider's claim as to the correct computation and dollar amount for each disputed item.

4. The department shall assign to a provider's request for review someone other than any individual who was involved in the initial denial of the claim. A provider who has requested review may contact the Department for an informal conference regarding the review any time before the Department has issued its final decision.

5. The department shall make and issue its final decision within seventy-five days of receipt of the notice of request for review. A provider may appeal the final decision of the department to the district court in the manner provided in section 28-32-42. The judgment of the district court in an appeal from a request for review may be reviewed in the supreme court on appeal by any party in the same manner as provided in section 28-32-49.

6. Upon receipt of notice that the provider has appealed its final decision to the district court, the department shall make a record of all documents, written statements, exhibits and other written information submitted by the

provider or the department in connection with the request for review and the department's final decision on review, which shall constitute the entire record. Within thirty days after an appeal has been taken to district court as provided in this section, the department shall prepare and file in the office of the clerk of the district court in which the appeal is pending the original and a certified copy of the entire record, and that record shall be treated as the record on appeal for purposes of section 28-32-44."

1204

1. "Certification of need" means a regulatory review process that requires specific health care providers to obtain prior authorization for provision of services for medicaid applicants or eligible recipients. Certification of need applications are required for all residential treatment center applicants or recipients of a psychiatric hospital or an inpatient psychiatric program in a hospital and a psychiatric facility, including residential treatment centers to determine the medical necessity of the proposed services. The certification of need evaluates the recipient's capacity to benefit from proposed services, the efficacy of proposed services, and consideration of the availability of less restrictive services to meet the individual's needs.

2. "County agency" means the county social service board.

3. "Department" means the North Dakota department of human services.

4. "Drug use review board" means the board established pursuant to North Dakota Century Code chapter 50-24.6.

5. "Home health agency" means a public or private agency or organization, or a subdivision of such an agency or organization, which is qualified to participate as a home health agency under title XVIII of the Social Security Act, or is determined currently to meet the requirements for participation.

6. "Medical emergency" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

7. "Medically necessary" includes only medical or remedial services or supplies required for treatment of illness, injury, diseased condition, or impairment; consistent with the patient's diagnosis or symptoms; appropriate according to generally accepted standards of medical practice; not provided only as a convenience to the patient or provider; not investigational, experimental, or unproven; clinically appropriate in terms of scope, duration, intensity, and site; and provided at the most appropriate level of service that is safe and effective.

8. "Provider" means an individual, entity, or facility furnishing medical or remedial services or supplies pursuant to a provider agreement with the department.

9. "Recipient" means an individual approved as eligible for medical assistance.

north dakota
department of
human services

John Hoeven, Governor
Carol K. Olson, Executive Director

**Legal Advisory Unit**

Fax (701) 328-2173
Legal (701) 328-2311
Appeals (701) 328-2341
TTY (701) 328-3480

#1206

May 26, 2004

Todd Porter
Metro-Area Ambulance Service, Inc.
Box 595
Mandan, ND 58554-0595

Re: Letter requesting formal hearings

Dear Mr. Porter:

Your request for formal hearings for and dated April 28, 2004, cannot be processed by this office.

An opportunity for a fair hearing is available to any **applicant for or recipient** of Medicaid pursuant to section 75-01-03-03(1) of the North Dakota Administrative Code. However, the individuals you have identified may authorize you to assist them in appealing the denial of their claims. You may also wish to inform and of their right to appeal the denial of their claims. Any such request for a hearing must be filed within thirty (30) days after the order or action with which the claimant is dissatisfied.

Thank you.

Sincerely,

Melissa Hauer

Melissa Hauer, Director
Legal Advisory Unit

MH/tlsh

c: Kay Dahl, Medical Services

## RECONSIDERATION

**You may request reconsideration within thirty days of this denial notice before making a hearing request. Simply contact the Medical Services Division of the Department of Human Services and ask to have the request or claim resubmitted for reconsideration. Additional information may need to be sent to the department along with the resubmitted claim. The department will reconsider the request or claim, make a decision and notify you.**

## RIGHT TO HEARING

The North Dakota Department of Human Services provides an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly or if action is taken to suspend, terminate or reduce services.

You may request a hearing if you believe the department made an error in denying a request for services. The request for a hearing must be made within 30 days from the date of notice. Please send your appeal request to:

Appeals Supervisor
North Dakota Department of Human Services
600 E Boulevard Ave – Dept 325
Bismarck, ND 58505

If the department's decision reduces, suspends or terminates a service you were already receiving and you request a hearing within 10 days of the date of the notice, the action will not be taken until after the hearing decision unless:

a. a notice is not required,
b. you withdraw your request for a hearing,
c. you do not appear at a scheduled hearing, or
d. it is decided at the hearing that the only issue is the appeal is one of federal or state law or department policy.

If the hearing decision is not in your favor, the total additional cost of those services will be considered an overpayment and you will be responsible to pay those costs.

Any person who believes he/she has been discriminated against because of race, color, religion, sex, national origin, age, political beliefs, handicap, or status with respect to marriage or public assistance may file a written complaint with the county social service board; the North Dakota Department of Human Services for Civil Rights; or the Office of Civil Rights, Department of Health and Human Services, Federal Office Building, 1961 Stout Street, Denver, CO 80294.

You may have an attorney, relative, friend or other person assist you in your hearing. If you do not have money to pay for an attorney, you may contact a free legal service organization in your area to see if they can assist you. It is advisable that you contact them as soon as possible if you would like them to represent you. The North Dakota Department of Human Services provides this listing of Legal Aid organizations for your information.

Attachment 2

Executive Offices
1622 E. Interstate Ave.
Bismarck, ND 58503

(701) 221-0567 Voice
(701) 221-0693 Fax
(877) 221-3672 Toll Free

# 59th North Dakota Legislative Assembly
# Senate Human Services Committee
# HB 1206, Provider Appeals of Reimbursement Denials – Feb. 16, 2005

**North Dakota Emergency Medical Services Association**
**In Support – With Amendments**

Good morning, Chairperson Lee and members of the committee. My name is Dean Lampe, and I am the Executive Director of the North Dakota EMS Association. Our association represents approximately 1500 individual EMS provider members throughout the state. On behalf of our membership, I am pleased to share with you this morning our thoughts concerning this bill and the amendments as presented.

We, of course, agree with the basic tenet of providing an equitable appeals process; especially when it involves the adjudication of claims regarding medical assistance. The bill before your committee is concise and straightforward. It provides an equitable appeals process for disputed reimbursements and our association supports this legislation on its merits.

That being said, I would like to concentrate my testimony on the amendments offered by Representative Porter. As the committee is aware, on behalf of the EMS Association, I had previously testified before this committee regarding SB 2192 which concerned reimbursements and the "prudent layperson" threshold which N.D.C.C. unambiguously sets forth as the standard by which the citizens of North Dakota can reasonably expect pre-hospital emergency care. Our association understands the language in SB 2192 may have been too broad and why this committee recommended a Do Not Pass to the floor.

The amendments presented on the bill before you do nothing more than establish more proper and reasonable language which accomplishes the same goal; the department should not be able to circumvent the intent of N.D.C.C. "prudent layperson" intent in the department's administrative rules. We urge the committee to recommend a Do Pass to this bill with these amendments.

Attachment 3

Good morning Chairman Lee and members of the Senate Human Services Committee.

For the record I am Rep. Bill Devlin, District 23 from Finley.

HB 1206 was brought to the session to try and rectify a problem some rural ambulances and other providers were having getting their Medicaid claims approved for reimbursement.

The issue has come up where a Medicaid eligible person was taken by ambulance from their home or a facility to a hospital. In the case of an ambulance service, like the one in my home, town a volunteer crew picks up the person, makes a medical decision based on the condition of the patient that they need hospitalization. The crew then takes person to a hospital for emergency care which often means to Fargo which is about 90 miles away.

If that trip is later denied because it is not deemed to be medically necessary it creates a real financial burden on the ambulance service as they are out not only 180 miles but other expenses for the EMTs and others. They could bill the person involved directly but they often do not have the money to pay for trip either so the provider is left holding the bag.

The way it works now, the Medicaid recipient would have to make the appeal. In many cases they are unable to do so for health or other reasons.

On the House side we worked with the Department of Human Service provide a better appeal process that allows the provider as well as Medicaid recipient to appeal to the department again. At that time it will be reviewed by someone that was not involved in the initial claim rejection.

If the case is still denied a provider may still appeal the final decision of the department to the courts if they should desire.

Hopefully that won't happen often or ever under the appeal process that is being set up in HB 1206. The Department was supportive on the House side of the final language in the bill and in fact helped us work out the compromise language.

We believe this is very good legislation for the citizens of our great state and hope this committee will give the bill a do pass recommendation. I think the department and others are here to testify, if needed, but I would certainly be happy to answer any questions you might have at this time.

Attachment 4

# TESTIMONY BEFORE THE SENATE HUMAN SERVICES COMMITTEE REGARDING HOUSE BILL 1206 FEBRUARY 16, 2005

Chairman Lee and members of the Committee, my name is Melissa Hauer. I am an attorney for the Department of Human Services. I am here today to testify in support of House Bill 1206.

The Department had some concerns about the bill as introduced. Representatives from the Department met with one of the sponsors of the bill to discuss those concerns and we were able to work together to resolve them. The engrossed bill that you have before you is the result of our discussions and it embodies a process that the Department can support to give Medicaid providers a review process when the Department has denied payment for a claim or reduced the level of service payment for a service provided to a Medicaid recipient.

This concludes my testimony. I would be happy to try to answer any questions the committee members may have. Thank you.

Attachment 5

## ENGROSSED HOUSE BILL NO. 1206 - TESTIMONY

Engrossed House Bill No. 1206 appears intended to establish, under NDCC Ch. 28-32, an essentially paper process for the review of the denial of reimbursement for medical assistance providers. An "informal conference" may be held as part of the paper review process. The bill does not appear to provide for an administrative hearing in the traditional sense, providing instead for an informal final determination by the Department of Human Services regarding whether the denial was appropriate. The bill is clear, however, in providing for an appeal to the district court, and to the Supreme Court, of the department's final decision following the informal paper review (Section 1, subsections 5 and 6). The responsibilities of the courts in the appellate process are, however, unclear.

NDCC Ch. 28-32, the Administrative Agencies Practices Act, generally addresses adjudicative proceedings by administrative agencies. The informal, paper review process provided for under the bill does not appear to be a kind of adjudicative proceeding. With respect to normal adjudicative proceedings under Ch. 28-32, Section 28-32-39 requires the agency to "make and state concisely and explicitly its findings of fact and its separate conclusions of law and the order of the agency based upon its findings and conclusions."

While House Bill 1206, as amended, provides for a "final decision" by the department, it does not appear to require findings of fact or conclusions of law in the traditional sense, which raises an important question concerning what the appellate court must review and how it should review it. Section 28-32-46, not referenced in the bill, defines the scope of review for the district court on appeal from a determination by an administrative agency. Of the 8 enumerated items that describe what the district court must consider, two have traditionally been central to a court's review: were the findings of fact made by the agency supported by a preponderance of evidence and were the conclusions of law and order by the agency supported by its findings of fact. In recognition of the constitutional principle that a court cannot be required to perform non-judicial functions, the

court's review must be of the agency's fact-finding results, not an independent original estimate of or decision on the evidence reviewed by the agency. In essence, the court cannot put itself in the place of the executive agency and determine the facts. This analytical review, which recognizes important institutional balances under the separation of powers, is complicated considerably if there are no findings or conclusions for the court to review. The North Dakota Supreme Court long ago cautioned that "de novo" reviews of executive agency decisions pose significant issues concerning the separation of powers. *Power Fuels, Inc. V. Elkin*, 283 N.W.2d 214 (N.D. 1979); also *Shaw v. Burleigh County*, 286 N.W.2nd 792 (N.D. 1979)

House Bill 1206, as amended, provides for the creation of a "record" to be submitted to the court when an appeal is taken. What might finally constitute the record is uncertain, but it appears it may be decidedly unlike the record required under Section 28-32-44 for appeals of normal adjudicative proceedings, which includes such things as the complaint, answer, pleadings, notices, transcripts, exhibits, and any recommended orders, findings, or conclusions. Consequently, the nature of the record, which is critically linked to the court's ability to determine if the agency's determination was appropriate, is unclear. As noted above, the scope and standard of review to be applied by the court is also uncertain.

In summary, Eng. House Bill1206, in providing for an appeal to district court and the Supreme Court of the department's denial of reimbursement after the informal process, does not link the availability of appeal to existing statutory provisions describing the appeal process, nor does it offer an alternative description of what constitutes the record, the scope of review, or the standard of review to be applied by the appellate court. As a consequence, the bill may invite substantive questions concerning the role of the courts in the appellate process.

Submitted by: Jim Ganje, Office of State Court Administrator, February 16, 2005