

**SUBSTITUTE FOR
SENATE BILL NO. 938**

A bill to amend 1939 PA 280, entitled
"The social welfare act,"
by amending sections 111a and 111b (MCL 400.111a and 400.111b),
section 111a as amended by 1986 PA 227 and section 111b as
amended by 1994 PA 74, and by adding section 111i.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 111a. (1) The director, after appropriate consultation
2 with affected providers and the medical care advisory council
3 established pursuant to federal regulations, may establish poli-
4 cies and procedures that he or she considers appropriate, relat-
5 ing to the conditions of participation and requirements for pro-
6 viders established by section 111b and to applicable federal law
7 and regulations, to assure that the implementation and
8 enforcement of state and federal laws are all of the following:

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

2 (b) In conformance with law.

3 (c) In conformance with the state plan for medical assist-
4 ance adopted pursuant to section 10 and approved by the United
5 States department of health and human services.

6 (2) The consultation required by this section shall be con-
7 ducted in accordance with guidelines adopted by the state depart-
8 ment pursuant to section 24 of the administrative procedures act
9 of 1969, ~~Act No. 306 of the Public Acts of 1969, being section~~
10 ~~24.224 of the Michigan Compiled Laws~~ 1969 PA 306, MCL 24.224.

11 (3) ~~The~~ EXCEPT AS OTHERWISE PROVIDED IN SECTION 111I, THE
12 director shall develop, after appropriate consultation with
13 affected providers in accordance with guidelines, forms and
14 instructions to be used in administering the program. Forms
15 developed by the director shall be, to the extent administra-
16 tively feasible, compatible with forms providers are required to
17 file with 1 or more other third party payers or with 1 or more
18 regulatory agencies and, to the extent administratively feasible,
19 shall be designed to facilitate use of a single form to satisfy
20 requirements imposed on providers by more than 1 payer, agency,
21 or other entity. The forms and instructions shall relate, at a
22 minimum, to standards of performance by providers, conditions of
23 participation, methods of review of claims, and administrative
24 requirements and procedures that the director considers reason-
25 able and proper to assure all of the following:

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

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

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

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

7 (e) That the state is a prudent buyer.

8 (f) That access and availability of services to the medi-
9 cally indigent are reasonable.

10 (4) As used in subsection (3), "prudent buyer" means a pur-
11 chaser who does 1 or more of the following:

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

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

20 (c) Seeks to economize by minimizing cost.

21 (5) The director shall select providers to participate in
22 arrangements such as case management, in supervision of services
23 for recipients who misutilize or abuse the medical services pro-
24 gram, and in special projects for the delivery of medical serv-
25 ices to eligible recipients. Providers shall be selected based
26 upon criteria that may include a comparison of services and
27 related costs with those of the provider's peers and a review of

1 previous participation warnings or sanctions undertaken against
2 the provider or the provider's employer, employees, related busi-
3 ness entities, or others who have a relationship to the provider,
4 by the medicaid, medicare, or other health-related programs. The
5 director may consult with the appropriate peer review advisory
6 committees as appointed by the department.

7 (6) The director shall give notice to each provider of a
8 change in a policy, procedure, form, or instruction established
9 or developed pursuant to this section ~~which~~ THAT affects the
10 provider. ~~In the case of~~ FOR a change ~~which~~ THAT affects 1
11 or more types of providers, a departmental bulletin or updating
12 insert to a departmental manual mailed 30 days before the effec-
13 tive date of the change shall constitute sufficient notice.

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

15 (a) Enroll in the program for medical assistance only a pro-
16 vider who has entered into an agreement of enrollment required by
17 section 111b(4), and enter into an agreement only with a provider
18 who satisfies the conditions of participation and requirements
19 for a provider established by ~~section 111b~~ SECTIONS 111B AND
20 111I and the administrative requirements established or developed
21 pursuant to subsections (1), (2), and (3) with the appropriate
22 consultation required by this section.

23 (b) Enforce the requirements established pursuant to this
24 act by applying the procedures of sections 111c to 111f. ~~When,~~
25 IF in these procedures the director is required to consult with
26 professionals or experts ~~,~~ prior to first utilizing these
27 individuals in the program, the director shall have given the

1 opportunity to review their professional credentials to the
2 appropriate medicaid peer review advisory committee.

3 (c) ~~Develop,~~ EXCEPT AS OTHERWISE PROVIDED IN SECTION 111I,
4 DEVELOP with the appropriate consultation required by this sec-
5 tion ~~,~~ and require the form or format for claims, applications,
6 certifications, or certifications and recertifications of medical
7 necessity required by section 108, and develop specifications for
8 and require supporting documentation that is compatible with the
9 approved state medical assistance plan under title XIX.

10 (d) Recover payments to a provider in excess of the reim-
11 bursement to which the provider is entitled. The department
12 shall have a priority lien on any assets of a provider for any
13 overpayment, as a consequence of fraud or abuse, ~~which~~ THAT is
14 not reimbursed to the department.

15 (e) Notwithstanding any other provisions of this act, before
16 payment of claims, identify for examination for compliance with
17 the program of medical assistance, including but not limited to
18 medical necessity, the claims submitted by a particular provider
19 based upon a determination that the provider's claims for dis-
20 puted services exceed the average program dollar amount or volume
21 of the same type of services, submitted by the same type of pro-
22 vider, performed in the same setting, and submitted during the
23 same period. In order to carry out the authority conferred by
24 this subdivision, the director shall notify the provider in the
25 form of registered mail, receipted by the addressee, or by proof
26 of service to the provider, or representative of the provider, of
27 the state department's intent to impose specific conditions and

1 controls prior to authorizing payment for specific claims for
2 services. The notice shall contain all of the following:

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

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

10 (iii) A date certain for an informal conference between the
11 provider or representative of the provider and the state depart-
12 ment to resolve the differences surrounding the disputed practice
13 or practices.

14 (iv) A statement that unless the provider or representative
15 of the provider demonstrates at the informal conference that the
16 disputed practice or practices are medically necessary, or are in
17 compliance with other program coverages, specific conditions and
18 controls may be imposed on future payments for the disputed prac-
19 tice or practices, and claims may be rejected, beginning on the
20 sixteenth day after delivery of this notice.

21 (8) For any provider who is subject to a notice of intent to
22 impose specific conditions and controls prior to authorizing pay-
23 ment for specific claims for services, as specified in subsection
24 (7)(e), the state department shall afford that provider an oppor-
25 tunity for an informal conference before the sixteenth day after
26 delivery of the notice under subsection (7)(e). If the provider
27 fails to appear at the conference, or fails to demonstrate that

1 the disputed practice or practices are medically necessary or are
2 in compliance with program coverages, the state department begin-
3 ning on the sixteenth day following receipt of notice by the pro-
4 vider, is authorized to impose specific conditions and controls
5 prior to payment for the disputed practice or practices and may
6 reject claims for payments for ~~such~~ THE practice or practices.
7 The state department, within 5 days following the informal con-
8 ference, shall notify the provider of its decision regarding the
9 imposition of special conditions and controls prior to payment
10 for the disputed practice or practices. Upon the imposition of
11 specific conditions and controls prior to payment, the provider
12 upon request shall be entitled to an immediate hearing held in
13 conformity with chapter 4 and chapter 6 of the administrative
14 procedures act of 1969, ~~Act No. 306 of the Public Acts of 1969,~~
15 ~~being sections 24.271 to 24.287 and 24.301 to 24.306 of the~~
16 ~~Michigan Compiled Laws~~ 1969 PA 306, MCL 24.271 TO 24.287 AND
17 24.301 TO 24.306, if any of the following occurs:

18 (a) The claim for services rendered is not paid within
19 30 days of the provider's compliance with the conditions
20 imposed.

21 (b) The claim is rejected.

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

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

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

19 (11) If in the department's opinion, the provider shifts his
20 or her claims from the disputed services addressed under subsec-
21 tion (7)(e) to other claims ~~which~~ THAT fall under the purview
22 of subsection (7)(e), the director may impose the claims review
23 process of this section immediately upon delivery of the notice
24 of that imposition to the provider as provided in
25 subsection (7)(e).

26 (12) If in the department's opinion, claims similar to the
27 disputed services addressed under subsection (7)(e) are shifted

1 to another provider in the same corporation, partnership, clinic,
2 provider group, or to another provider in the employ of the same
3 employer or contractor, the director may impose the claims review
4 process of this section immediately upon delivery of notice of
5 that imposition to the new provider as provided in
6 subsection (7)(e). The department shall afford the new provider
7 an opportunity for an immediate informal conference within 7 days
8 pursuant to subsection (8) after the initiation of the claims
9 process.

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

19 (14) The director shall not pay for services, supplies, or
20 equipment furnished by a provider, or shall recover for payment
21 made, during a period in which the provider does not have on file
22 with the state department disclosure forms as required by section
23 111b(19).

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

1 make payments directly to, and collect overpayments from, the
2 provider's employer.

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

8 (17) If the director decides that a payment under the pro-
9 gram has been made to which a provider is not or may not be enti-
10 tled, or that the amount of a payment is or may be greater or
11 less than the amount to which the provider is entitled, the
12 director, except as otherwise provided in this subsection or
13 under other applicable law or regulation, shall promptly notify
14 the provider of this decision. The director shall withhold noti-
15 fication to the provider of the decision upon advice from the
16 department of attorney general or other state or federal enforce-
17 ment agency in a case where action by the department of attorney
18 general or other state or federal enforcement agency may be com-
19 promised by the notification. If the director notifies a pro-
20 vider of a decision that the provider has received an underpay-
21 ment, the state department shall reimburse the provider, either
22 directly or through an adjustment of payments, in the amount
23 found to be due.

24 Sec. 111b. (1) As a condition of participation, a provider
25 shall meet all of the requirements specified in this section
26 except as provided in subsections (25), (26), and (27).

1 (2) A provider shall comply with all licensing and
2 registration laws of this state applicable to the provider's
3 practice or business. For a facility that is periodically
4 inspected by a licensing authority, maintenance of licensure
5 ~~shall constitute~~ CONSTITUTES compliance.

6 (3) A provider shall be certified, if the provider is of the
7 type for which certification is required by title XVIII or XIX.

8 (4) A provider shall enter into an agreement of enrollment
9 specified by the director.

10 (5) A provider who renders a reimbursable service described
11 in section 109 to a medically indigent individual shall provide
12 the individual with service of the same scope and quality as
13 would be provided to the general public.

14 (6) A provider shall maintain records necessary to document
15 fully the extent and cost of services, supplies, or equipment
16 provided to a medically indigent individual and to substantiate
17 each claim and, in accordance with professionally accepted stan-
18 dards, the medical necessity, appropriateness, and quality of
19 service rendered for which a claim is made.

20 (7) Upon request and at a reasonable time and place, a pro-
21 vider shall make available any record required to be maintained
22 by subsection (6) for examination and photocopying by authorized
23 agents of the director, the department of attorney general, or
24 federal authorities whose duties and functions are related to
25 state programs of medical assistance under title XIX. If a pro-
26 vider releases records in response to a request by the director
27 made pursuant to section 111a(13) or in compliance with this

1 subsection, that provider is not civilly liable in damages to a
2 patient or to another provider to whom, respectively, the records
3 relate solely, on account of the response or compliance.

4 (8) A provider shall retain each record required to be main-
5 tained by subsection (6) for a period of 6 years after the date
6 of service. A provider who no longer personally retains the
7 records due to death, retirement, change in ownership, or other
8 reason, shall insure that a suitable person retains the records
9 and provides access to the records as required in subsection
10 (7).

11 (9) A provider shall require, as a condition of any contract
12 with a person, sole proprietorship, clinic, group, partnership,
13 corporation, association, or other entity, for the purpose of
14 generating billings in the name of the provider or on behalf of
15 the provider to the state department, that the person, partner-
16 ship, corporation, or other entity, its representative, succes-
17 sor, or assignee, retain for not less than 6 years, copies of all
18 documents used in the generation of billings, including the cer-
19 tifications required by subsection (17), and, if applicable, com-
20 puter billing tapes when returned by the state department.

21 (10) A provider shall submit all claims for services
22 rendered under the program on a form or in a format and with the
23 supporting documentation specified and required by the director
24 under section 111a(7)(c) AND BY THE COMMISSIONER OF INSURANCE
25 UNDER SECTION 111I. Submission of a claim or claims for services
26 rendered under the program does not establish in the provider a
27 right to receive payment from the program.

1 (11) A provider shall submit initial claims for services
2 rendered within 12 months after the date of service, or within a
3 shorter period that the director may establish OR THAT THE COM-
4 MISSIONER OF INSURANCE MAY ESTABLISH UNDER SECTION 111I. The
5 director shall not delegate the authority to establish a time
6 period for submission of claims under this subsection. ~~The~~
7 EXCEPT AS OTHERWISE PROVIDED IN SECTION 111I, THE director, with
8 the consultation required by section 111a, may prescribe the con-
9 ditions under which a provider may qualify for a waiver of the
10 time period established pursuant to this subsection with respect
11 to a particular submission of a claim. ~~Liability shall not be~~
12 ~~imposed upon~~ NEITHER this state ~~or~~ NOR the medically indigent
13 individual IS LIABLE for payment of claims submitted after the
14 period established pursuant to this subsection.

15 (12) A provider shall not charge the state more for a serv-
16 ice rendered to a medically indigent individual than the
17 provider's customary charge to the general public or another
18 third party payer for the same or similar service.

19 (13) A provider shall submit information on estimated costs
20 and charges on a form or in a format and at times that the direc-
21 tor may specify and require pursuant to section 111a(16).

22 (14) Except for copayment authorized by the state department
23 and in conformance with applicable state and federal law, a pro-
24 vider shall accept payment from the state as payment in full by
25 the medically indigent individual for services received. A pro-
26 vider shall not seek payment from the medically indigent

1 individual, the family, or representative of the individual for
2 either of the following:

3 (a) Authorized services provided and reimbursed under the
4 program.

5 (b) Services determined to be medically unnecessary in
6 accordance with professionally accepted standards.

7 (15) A provider may seek payment from a medically indigent
8 individual for services not covered nor reimbursed by the program
9 if the individual elected to receive the services with the knowl-
10 edge that the services would not be covered nor reimbursed under
11 the program.

12 (16) A provider promptly shall notify the director of a pay-
13 ment received by the provider to which the provider is not enti-
14 tled or ~~which~~ THAT exceeds the amount to which the provider is
15 entitled. If the provider makes or should have made notification
16 under this subsection or receives notification of overpayment
17 under section 111a(17), the provider shall repay, return,
18 restore, or reimburse, either directly or through adjustment of
19 payments, the overpayment in the manner required by the
20 director. Failure to repay, return, restore, or reimburse the
21 overpayment or a consistent pattern of failure to notify the
22 director shall constitute a conversion of the money by the
23 provider.

24 (17) As a condition of payment for services rendered to a
25 medically indigent individual, a provider shall certify that a
26 claim for payment is true, accurate, prepared with the knowledge
27 and consent of the provider, and does not contain untrue,

1 misleading, or deceptive information. A provider ~~shall be~~ IS
2 responsible for the ongoing supervision of an agent, officer, or
3 employee who prepares or submits the provider's claims. A
4 provider's certification required under this subsection shall be
5 prima facie evidence that the provider knows that the claim or
6 claims are true, accurate, prepared with his or her knowledge and
7 consent, do not contain misleading or deceptive information, and
8 are filed in compliance with the policies, procedures, and
9 instructions, and on the forms established or developed pursuant
10 to this act. Certification shall be made in the following
11 manner:

12 (a) For an invoice or other prescribed form submitted
13 directly to the state department by the provider in claim for
14 payment for the provision of services, by an indelible mark made
15 by hand, mechanical or electronic device, stamp, or other means
16 by the provider, or an agent, officer, or employee of the
17 provider.

18 (b) For an invoice or other form submitted in claim for pay-
19 ment for the provision of services submitted indirectly by the
20 provider to the state department through a person, sole proprie-
21 torship, clinic, group, partnership, corporation, association, or
22 other entity that generates and files claims on a provider's
23 behalf, by the indelible written name of the provider on a certi-
24 fication form developed by the director for submission to the
25 state department with each group of invoices or forms in claim
26 for payment. The certification form shall indicate the name of

1 the person, if other than the provider, who signed the provider's
2 name.

3 (c) For a warrant issued in payment of a claim submitted by
4 a provider, by the handwritten indelible signature of the payee,
5 if the payee is a natural person; by the handwritten indelible
6 signature of an officer, if the payee is a corporation; or by
7 handwritten indelible signature of a partner, if the payee is a
8 partnership.

9 (18) A provider shall comply with all requirements estab-
10 lished under section 111a(1), (2), and (3).

11 (19) A provider shall file with the state department, on
12 disclosure forms provided by the director, a complete and truth-
13 ful statement of all of the following:

14 (a) The identity of each individual having, directly or
15 indirectly, an ownership or beneficial interest in a partnership,
16 corporation, organization, or other legal entity, except a com-
17 pany registered pursuant to the securities exchange act of 1934,
18 chapter 404, 48 Stat. 881, through which the provider engages in
19 practice or does business related to claims or charges against
20 the program. This subdivision does not apply to a health facil-
21 ity or agency that is required to comply with and has complied
22 with the disclosure requirements of section 20142(3) of the
23 public health code, ~~Act No. 368 of the Public Acts of 1978,~~
24 ~~being section 333.20142 of the Michigan Compiled Laws 1978~~
25 PA 368, MCL 333.20142. With respect to a company registered pur-
26 suant to the securities exchange act of 1934, CHAPTER 404, 48
27 STAT. 881, a provider shall disclose the identity of each

1 individual having, directly or indirectly, separately or in
2 combination, a 5% or greater ownership or beneficial interest.

3 (b) The identity of each partnership, corporation, organiza-
4 tion, legal entity, or other affiliate whose practice or business
5 is related to a claim or charge against the program in which the
6 provider has, directly or indirectly, an ownership or beneficial
7 interest, trust agreement, or a general or perfected security
8 interest. This subdivision does not apply to a health facility
9 or agency that is required to comply with and has complied with
10 the disclosure requirements of section 20142(4) of the public
11 health code, ~~Act No. 368 of the Public Acts of 1978, being sec-~~
12 ~~tion 333.20142 of the Michigan Compiled Laws~~ 1978 PA 368,
13 MCL 333.20142.

14 (c) If applicable to the provider, a copy of a disclosure
15 form identifying ownership and controlling interests submitted to
16 the United States department of health and human services in ful-
17 fillment of a condition of participation in programs established
18 pursuant to title V, XVIII, XIX, and XX. To the extent that
19 information disclosed on this form duplicates information
20 required to be filed under subdivision (a) or (b), filing a copy
21 of the form shall satisfy the requirements under those
22 subdivisions.

23 (20) If requested by the director, a provider shall supply
24 complete and truthful information as to his or her professional
25 qualifications and training, and his or her licensure in each
26 jurisdiction in which the provider is licensed or authorized to
27 practice.

1 (21) In the interest of review and control of utilization of
2 services, a provider shall identify each attending, referring, or
3 prescribing physician, dentist, or other practitioner by means of
4 a program identification number on each claim or adjustment of a
5 claim submitted to the state department.

6 (22) It is the obligation of a provider to assure that serv-
7 ices, supplies, or equipment provided to, ordered, or prescribed
8 on behalf of a medically indigent individual by that provider
9 will meet professionally accepted standards for the medical
10 necessity, appropriateness, and quality of health care.

11 (23) If any service, supply, or equipment provided directly
12 by a provider, or any service, supply, or equipment prescribed or
13 ordered by a provider and delivered by someone other than that
14 provider, is determined not to be medically necessary, not appro-
15 priate, or not otherwise in accordance with medical assistance
16 program coverages, the provider who directly provided, ordered,
17 or prescribed the service, supply, or equipment shall be respon-
18 sible for direct and complete repayment of any program payment
19 made to the provider or to any other person for that service,
20 supply, or equipment. Services, supplies, or equipment provided
21 by a consulting provider based upon his or her independent evalu-
22 ation or assessment of the recipient's needs is the responsibil-
23 ity of the consulting provider. This subsection does not apply
24 to the repayment by a provider who has ordered a nursing home or
25 hospital admission of the service billed by and reimbursed to a
26 nursing home or hospital. This section also does not apply to a
27 nursing home or hospital unless the nursing home or hospital

1 acted on its own initiative in providing the service, supply, or
2 equipment as opposed to following the order or prescription of
3 another.

4 (24) A provider shall satisfy or make acceptable arrangement
5 to satisfy all previous adjudicated program liabilities including
6 those adjudicated pursuant to section 111c or established by
7 agreement between the department and the provider, and restitu-
8 tion ordered by a court. As used in this subsection, provider
9 includes, but is not limited to, the provider, the provider's
10 corporation, partnership, business associates, employees, clinic,
11 laboratory, provider group, or successors and assignees. For a
12 nursing home or hospital, "business associates", as used in this
13 subsection, means those persons whose identity is required to be
14 disclosed pursuant to section 20142(3) of the public health code,
15 ~~Act No. 368 of the Public Acts of 1978, being section 333.20142~~
16 ~~of the Michigan Compiled Laws~~ 1978 PA 368, MCL 333.20142.

17 (25) A provider who is a physician, dentist, or other indi-
18 vidual practitioner shall file with the state department a com-
19 plete and factual disclosure of the identity of each employer or
20 contractor to whom the provider is required to submit, in whole
21 or in part, payment for services provided to a medically indigent
22 individual as a condition of the provider's agreement of employ-
23 ment or other agreement. A provider who has properly disclosed
24 the required information by filing a form or forms has 30 busi-
25 ness days in which to report changes in the list of identified
26 individuals and entities. The disclosure required by this

1 subsection may serve as the provider's authorization for the
2 department to make direct payments to the employer.

3 (26) As a condition of receiving payment for services
4 rendered to a medically indigent individual, a provider may
5 enter, as an employee, into agreements of employment of the type
6 described in subsection (25) only with an employer who has
7 entered into an agreement as described in subsection (27).

8 (27) An employer described in subsection (25) shall enter
9 into an agreement on a form prescribed by the department, in
10 which, as a condition of directly receiving payment for services
11 provided by its employee provider to a medically indigent indi-
12 vidual, the employer agrees to all of the following:

13 (a) To require as a condition of employment that the
14 employee provider submit, in whole or in part, payments received
15 for services provided to medically indigent individuals.

16 (b) To advise the department within 30 days after any
17 changes in the employment relationship.

18 (c) To comply with the conditions of participation estab-
19 lished by this subsection and subsections (6) to (19), and (21).

20 (d) To agree to be jointly and severally responsible with
21 the employee provider for any overpayments resulting from the
22 department's direct payment under this section.

23 (e) To agree that disputed claims relative to overpayments
24 shall be adjudicated in administrative proceedings convened pur-
25 suant to section 111c.

26 (28) If a provider who is a nursing home intends to withdraw
27 from participation in the title XIX program, the provider shall

1 notify the department in writing. However, the provider shall
2 continue to participate in the title XIX program for each patient
3 who was admitted to the nursing home before the date notice is
4 given under this subsection and who is or may become eligible to
5 receive medical assistance under this act.

6 SEC. 111I. (1) THE COMMISSIONER OF INSURANCE SHALL ESTAB-
7 LISH A TIMELY CLAIMS PAYMENT PROCEDURE TO BE USED BY HEALTH PRO-
8 FESSIONALS AND FACILITIES IN BILLING FOR, AND QUALIFIED HEALTH
9 PLANS IN PAYING CLAIMS FOR, MEDICAID SERVICES RENDERED. THE COM-
10 MISSIONER SHALL CONSULT WITH THE DEPARTMENT OF COMMUNITY HEALTH,
11 HEALTH PROFESSIONALS AND FACILITIES, AND QUALIFIED HEALTH PLANS
12 IN ESTABLISHING THIS TIMELY PAYMENT PROCEDURE.

13 (2) THE TIMELY CLAIMS PAYMENT PROCEDURE ESTABLISHED BY THE
14 COMMISSIONER UNDER SUBSECTION (1) SHALL PROVIDE FOR ALL OF THE
15 FOLLOWING:

16 (A) THAT A "CLEAN CLAIM" MEANS A CLAIM THAT DOES AT A MINI-
17 MUM ALL OF THE FOLLOWING:

18 (i) IDENTIFIES THE HEALTH PROFESSIONAL OR HEALTH FACILITY
19 THAT PROVIDED TREATMENT OR SERVICE, INCLUDING A MATCHING IDENTI-
20 FYING NUMBER.

21 (ii) IDENTIFIES THE PATIENT AND PLAN SUBSCRIBER.

22 (iii) LISTS THE DATE AND PLACE OF SERVICE.

23 (iv) IS FOR COVERED SERVICES.

24 (v) IS CERTIFIED PURSUANT TO SECTION 111B(17) AND HAS THE
25 IDENTIFYING INFORMATION REQUIRED UNDER SECTION 111B(21).

26 (vi) IF NECESSARY, SUBSTANTIATES THE MEDICAL NECESSITY AND
27 APPROPRIATENESS OF THE CARE OR SERVICE PROVIDED.

1 (vii) IF PRIOR AUTHORIZATION IS REQUIRED FOR CERTAIN PATIENT
2 CARE OR SERVICES, INCLUDES THE DATE, TIME, TYPE OF CARE OR SERV-
3 ICES AUTHORIZED, AND THE NAME OF THE PERSON AUTHORIZING THAT CARE
4 OR SERVICE.

5 (viii) INCLUDES ADDITIONAL DOCUMENTATION BASED UPON SERVICES
6 RENDERED AS REASONABLY REQUIRED BY THE PAYER.

7 (B) A UNIVERSAL SYSTEM OF CODING TO BE USED FOR ALL MEDICAID
8 CLAIMS SUBMITTED TO QUALIFIED HEALTH PLANS.

9 (C) THAT A CLAIM MUST BE TRANSMITTED ELECTRONICALLY OR AS
10 OTHERWISE SPECIFIED BY THE COMMISSIONER AND A QUALIFIED HEALTH PLAN
11 MUST BE ABLE TO RECEIVE A CLAIM TRANSMITTED ELECTRONICALLY.

12 (D) THE NUMBER OF DAYS AFTER A SERVICE WAS PROVIDED WITHIN
13 WHICH A HEALTH PROFESSIONAL AND FACILITY MUST BILL A QUALIFIED
14 HEALTH PLAN FOR THE CLAIM.

15 (E) THAT A CLEAN CLAIM MUST BE PAID WITHIN 45 DAYS AFTER
16 RECEIPT OF THE CLAIM BY THE QUALIFIED HEALTH PLAN. A CLEAN CLAIM
17 THAT IS NOT PAID WITHIN 45 DAYS SHALL BEAR SIMPLE INTEREST AT A
18 RATE OF 12% PER ANNUM.

19 (F) THAT A QUALIFIED HEALTH PLAN MUST STATE IN WRITING TO
20 THE HEALTH PROFESSIONAL OR FACILITY ANY DEFECT IN THE CLAIM
21 WITHIN 30 DAYS AFTER RECEIPT OF THE CLAIM.

22 (G) THAT A HEALTH PROFESSIONAL AND A HEALTH FACILITY HAVE 30
23 DAYS AFTER RECEIPT OF A NOTICE THAT A CLAIM OR A PORTION OF A
24 CLAIM IS DEFECTIVE WITHIN WHICH TO CORRECT THE DEFECT. THE QUAL-
25 IFIED HEALTH PLAN SHALL PAY THE CLAIM WITHIN 15 DAYS AFTER THE
26 DEFECT IS CORRECTED.

27 (H) THAT A QUALIFIED HEALTH PLAN MUST NOTIFY THE HEALTH
PROFESSIONAL OR FACILITY AND THE COMMISSIONER OF THE DEFECT IF A

1 CLAIM OR A PORTION OF A CLAIM IS RETURNED FROM A HEALTH
2 PROFESSIONAL OR FACILITY UNDER SUBDIVISION (G) AND REMAINS DEFEC-
3 TIVE FOR THE ORIGINAL REASON OR A NEW REASON.

4 (I) AN EXTERNAL REVIEW PROCEDURE FOR ADVERSE DETERMINATIONS
5 OF PAYMENT AS PROVIDED IN SUBSECTIONS (4) AND (5). THE COSTS FOR
6 THE EXTERNAL REVIEW PROCEDURE SHALL BE ASSESSED AS DETERMINED BY
7 THE COMMISSIONER.

8 (J) PENALTIES TO BE APPLIED TO HEALTH PROFESSIONALS, HEALTH
9 FACILITIES, AND QUALIFIED HEALTH PLANS FOR FAILING TO ADHERE TO
10 THE TIMELY CLAIMS PAYMENT PROCEDURE ESTABLISHED UNDER THIS
11 SECTION.

12 (K) A SYSTEM FOR NOTIFYING THE LICENSING ENTITY IF A PENALTY
13 IS INCURRED UNDER SUBDIVISION (J).

14 (3) IF A QUALIFIED HEALTH PLAN DETERMINES THAT 1 OR MORE
15 COVERED SERVICES LISTED ON A CLAIM ARE PAYABLE, THE QUALIFIED
16 HEALTH PLAN SHALL PAY FOR THOSE SERVICES AND SHALL NOT DENY THE
17 ENTIRE CLAIM BECAUSE 1 OR MORE OTHER COVERED SERVICES LISTED ON
18 THE CLAIM ARE DEFECTIVE.

19 (4) THE COMMISSIONER SHALL ESTABLISH AN EXTERNAL REVIEW PRO-
20 CEDURE AS PROVIDED IN THIS SUBSECTION AND SUBSECTION (5). A
21 HEALTH PROFESSIONAL OR FACILITY MAY REQUEST AN EXTERNAL REVIEW BY
22 THE COMMISSIONER OF A QUALIFIED HEALTH PLAN'S ADVERSE DETERMINA-
23 TION IF THE HEALTH PROFESSIONAL OR FACILITY MAKES THE REQUEST NOT
24 LATER THAN 30 DAYS AFTER RECEIPT OF A NOTICE UNDER
25 SUBSECTION (2)(H). NOT LATER THAN 5 BUSINESS DAYS AFTER RECEIPT
26 OF ANY INFORMATION REQUESTED BY THE COMMISSIONER, THE
27 COMMISSIONER SHALL COMPLETE A PRELIMINARY REVIEW TO DETERMINE

1 WHETHER THE EXTERNAL REVIEW MAY PROCEED. IF THE COMMISSIONER
2 DETERMINES THE EXTERNAL REVIEW MAY NOT PROCEED, THE COMMISSIONER
3 SHALL NOTIFY IN WRITING THE HEALTH PROFESSIONAL OR FACILITY OF
4 THE SPECIFIC REASONS FOR THE DETERMINATION AND MAY PERMIT THE
5 HEALTH PROFESSIONAL OR FACILITY TO REAPPLY FOR A PRELIMINARY
6 REVIEW BY THE COMMISSIONER. IF THE COMMISSIONER DETERMINES THE
7 EXTERNAL REVIEW MAY PROCEED, THE COMMISSIONER SHALL NOTIFY IN
8 WRITING THE HEALTH PROFESSIONAL OR FACILITY AND THE QUALIFIED
9 HEALTH PLAN AND SHALL REQUIRE THE QUALIFIED HEALTH PLAN TO PRO-
10 VIDE NOT LATER THAN 7 BUSINESS DAYS AFTER THE NOTICE ANY INFORMA-
11 TION USED BY THE QUALIFIED HEALTH PLAN IN MAKING THE ADVERSE
12 DETERMINATION. FAILURE BY A HEALTH PROFESSIONAL OR FACILITY OR
13 QUALIFIED HEALTH PLAN TO PROVIDE THE COMMISSIONER WITH REQUESTED
14 INFORMATION PERMITS THE COMMISSIONER TO TERMINATE A REVIEW AND
15 ISSUE A DECISION REVERSING OR AFFIRMING AN ADVERSE DECISION.

16 (5) IF THE COMMISSIONER DETERMINES THAT AN EXTERNAL REVIEW
17 MAY PROCEED, THE COMMISSIONER SHALL IMMEDIATELY ASSIGN AN INDE-
18 PENDENT REVIEW ORGANIZATION TO CONDUCT THE EXTERNAL REVIEW. ONLY
19 AN INDEPENDENT REVIEW ORGANIZATION MEETING QUALIFICATIONS ESTAB-
20 LISHED BY THE COMMISSIONER SHALL BE ASSIGNED TO CONDUCT AN EXTER-
21 NAL REVIEW. THE INDEPENDENT REVIEW ORGANIZATION MAY REQUEST THE
22 HEALTH PROFESSIONAL OR FACILITY AND THE QUALIFIED HEALTH PLAN TO
23 PROVIDE INFORMATION AND SHALL REVIEW ALL PERTINENT INFORMATION
24 SUBMITTED BY THE HEALTH PROFESSIONAL OR FACILITY AND THE QUALI-
25 FIED HEALTH PLAN ALONG WITH THE TERMS OF COVERAGE UNDER THE MEDI-
26 CAID PLAN. THE INDEPENDENT REVIEW ORGANIZATION SHALL MAKE A
27 WRITTEN RECOMMENDATION THAT INCLUDES THE RATIONALE AND SUPPORTING

1 DOCUMENTATION AND ANY RECOMMENDATION FOR AN ASSESSMENT OF
2 INTEREST TO THE COMMISSIONER NOT LATER THAN 30 DAYS AFTER BEING
3 ASSIGNED AS THE REVIEW ORGANIZATION. THE COMMISSIONER SHALL
4 NOTIFY IN WRITING THE HEALTH PROFESSIONAL OR FACILITY AND THE
5 QUALIFIED HEALTH PLAN OF HIS OR HER DECISION REVERSING OR AFFIRM-
6 ING THE QUALIFIED HEALTH PLAN'S ADVERSE DETERMINATION AND SHALL
7 INCLUDE THE PRINCIPAL REASONS FOR THE DECISION NOT LATER THAN 15
8 DAYS AFTER RECEIPT OF THE ASSIGNED INDEPENDENT REVIEW
9 ORGANIZATION'S RECOMMENDATION. IF AN ADVERSE DETERMINATION IS
10 REVERSED, THE QUALIFIED HEALTH PLAN SHALL IMMEDIATELY PAY THE
11 CLAIM AND ANY INTEREST ASSESSED BY THE COMMISSIONER.

12 (6) BY NOT LATER THAN OCTOBER 1, 2000, THE DEPARTMENT OF
13 COMMUNITY HEALTH SHALL NOT ENTER INTO OR RENEW A CONTRACT WITH A
14 QUALIFIED HEALTH PLAN UNLESS THE QUALIFIED HEALTH PLAN AGREES TO
15 FOLLOW THE TIMELY CLAIMS PAYMENT PROCEDURE ESTABLISHED UNDER THIS
16 SECTION AND REQUIRES HEALTH PROFESSIONALS AND FACILITIES UNDER
17 CONTRACT WITH THE QUALIFIED HEALTH PLAN TO FOLLOW THE TIMELY
18 CLAIMS PAYMENT PROCEDURE ESTABLISHED UNDER THIS SECTION. THE
19 DEPARTMENT OF COMMUNITY HEALTH SHALL NOT ENTER INTO OR RENEW A
20 CONTRACT WITH A QUALIFIED HEALTH PLAN UNLESS THE COMMISSIONER
21 DETERMINES THAT THE QUALIFIED HEALTH PLAN SATISFIES ALL OF THE
22 FOLLOWING:

23 (A) IS A HEALTH MAINTENANCE ORGANIZATION LICENSED UNDER PART
24 210 OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.21001 TO
25 333.21098.

1 (B) USES STANDARDIZED CLAIMS AS OUTLINED IN THE PROVIDER
2 CONTRACT AND ACCEPTS CLAIMS SUBMITTED ELECTRONICALLY IN A
3 GENERALLY ACCEPTED FORMAT.

4 (C) DEMONSTRATES THE ABILITY TO PROVIDE REQUIRED MEDICAID
5 SERVICES TO THE ESTIMATED NUMBER OF ENROLLEES ON A REGIONAL
6 BASIS.

7 (D) MEETS THE CRITERIA FOR DELIVERING THE COMPREHENSIVE
8 PACKAGE OF SERVICES UNDER THE DEPARTMENT OF COMMUNITY HEALTH'S
9 COMPREHENSIVE HEALTH PLAN.

10 (7) THE COMMISSIONER SHALL REPORT TO THE SENATE AND HOUSE OF
11 REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEES ON COMMUNITY HEALTH
12 BY OCTOBER 1, 2001 AND ANNUALLY THEREAFTER ON THE TIMELY CLAIMS
13 PAYMENT PROCEDURE ESTABLISHED UNDER THIS SECTION.

14 (8) AS USED IN THIS SECTION:

15 (A) "MEDICAID" MEANS THE PROGRAM OF MEDICAL ASSISTANCE
16 ESTABLISHED UNDER SECTION 105.

17 (B) "QUALIFIED HEALTH PLAN" MEANS, AT A MINIMUM, AN ORGANI-
18 ZATION THAT MEETS THE CRITERIA FOR DELIVERING THE COMPREHENSIVE
19 PACKAGE OF SERVICES UNDER THE DEPARTMENT OF COMMUNITY HEALTH'S
20 COMPREHENSIVE HEALTH PLAN.