LB835
2018

LEGISLATURE OF NEBRASKA

ONE HUNDRED FIFTH LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 835

Introduced by Howard, 9.

Read first time January 04, 2018

Committee:

1 A BILL FOR AN ACT relating to the Nebraska Behavioral Health Services
2 Act; to amend sections 71-801 and 71-804, Revised Statutes
3 Cumulative Supplement, 2016; to require patient encounter data upon
4 request as prescribed; to provide for independent audits and
5 external independent third-party reviews of payment denials by
6 managed care organizations as prescribed; to harmonize provisions;
7 to repeal the original sections; and to declare an emergency.
8 Be it enacted by the people of the State of Nebraska,

1 Section 1. Section 71-801, Revised Statutes Cumulative Supplement,
2 2016, is amended to read:
3 71-801 Sections 71-801 to 71-831 and sections 3 and 4 of this act
4 shall be known and may be cited as the Nebraska Behavioral Health
5 Services Act.
6 Sec. 2. Section 71-804, Revised Statutes Cumulative Supplement,
7 2016, is amended to read:
8 71-804 For purposes of the Nebraska Behavioral Health Services Act:
9 (1) Behavioral health disorder means mental illness or alcoholism,
10 drug abuse, or other addictive disorder;
11 (2) Behavioral health region means a behavioral health region
12 established in section 71-807;
13 (3) Behavioral health services means services, including, but not
14 limited to, consumer-provided services, support services, inpatient and
15 outpatient services, and residential and nonresidential services,
16 provided for the prevention, diagnosis, and treatment of behavioral
17 health disorders and the rehabilitation and recovery of persons with such
18 disorders;
19 (4) Community-based behavioral health services or community-based
20 services means behavioral health services that are not provided at a
21 regional center;
22 (5) Department means the Department of Health and Human Services;
23 (6) Director means the Director of Behavioral Health;
24 (7) Division means the Division of Behavioral Health of the
25 department;
26 (8) Managed care organization means an organization that contracts
27 with the department to provide managed care behavioral health services
28 pursuant to the medical assistance program;
29 (9) ~~(8)~~ Medical assistance program means the program established
30 pursuant to the Medical Assistance Act;
31 (10) ~~(9)~~ Public behavioral health system means the statewide array

1 of behavioral health services for children and adults provided by the
2 public sector or private sector and supported in whole or in part with
3 funding received and administered by the department, including behavioral
4 health services provided under the medical assistance program;

5 (11) ~~(10)~~ Regional center means one of the state hospitals for the
6 mentally ill designated in section 83-305; and

7 (12) ~~(11)~~ Regional center behavioral health services or regional
8 center services means behavioral health services provided at a regional
9 center.

10 Sec. 3. (1) Upon request by a participating behavioral health care
11 provider under the medical assistance program, the Director of Medicaid
12 and Long-Term Care of the Division of Medicaid and Long-Term Care of the
13 department shall provide accurate and uniform patient encounter data that
14 complies with the federal Health Insurance Portability and Accountability
15 Act of 1996 and applicable federal and state statutory and regulatory
16 requirements, including, but not limited to:

17 (a) The managed care organization claim number;

18 (b) The patient’s medicaid identification number;

19 (c) The patient’s name;

20 (d) The type of claim;

21 (e) The amount billed, by revenue code and procedure code;

22 (f) The amount paid to the managed care organization and paid date;
23 and

24 (g) The hospital’s patient account number.

25 (2) Upon receiving a request for patient encounter data pursuant to
26 subsection (1) of this section, the department shall furnish to the
27 participating behavioral health care provider all requested information
28 within sixty calendar days after receiving the request for the data. The
29 department may charge as a fee the actual cost of any computer services
30 or staff time required to furnish such data.

31 (3)(a) The Director of Medicaid and Long-Term Care shall require any

1 managed care organization providing behavioral health services pursuant
2 to the medical assistance program or the state Children’s Health
3 Insurance Program to provide documentation to a behavioral health care
4 provider when the managed care organization denies any portion of the
5 claim for reimbursement submitted by the provider, including specific
6 explanation of the reasons for denial and utilization of remark codes,
7 remittance advice, and standard denial reasons under the federal Health
8 Insurance Portability and Accountability Act of 1996.

9 (4) The Director of Medicaid and Long-Term Care shall develop
10 uniform standards to be utilized by each managed care organization
11 providing behavioral health services described in subsection (3) of this
12 section regarding:

13 (a) A standardized enrollment form and a uniform process for
14 credentialing and re-credentialing behavioral health care providers who
15 have signed contracts or participation agreements with any such managed
16 care organization;

17 (b) Procedures, requirements, periodic review, and reporting of
18 reductions in and limitations for prior authorization for behavioral
19 health care services and prescriptions;

20 (c) Retrospective utilization review readmissions that comply with
21 any applicable federal statutory or regulatory requirements for the
22 medical assistance program or the state Children’s Health Insurance
23 Program, prohibiting such review for any recipient of medical assistance
24 who is readmitted with a related medical condition as an inpatient to a
25 hospital more than fifteen days after the recipient patient’s discharge;

26 (d) A grievance, appeal, and hearing process that complies with
27 applicable federal and state statutory and regulatory procedure
28 requirements, including any statutory remedies for timely resolution of
29 grievances, appeals, and hearings, imposed upon managed care
30 organizations providing services described in subsection (3) of this
31 section; and

1 (e) Requirements that each managed care organization, within sixty
2 calendar days after receiving an appeal request, provide notice and
3 resolve one hundred percent of provider appeals, subject to remedies,
4 including, but not limited to, liquidated damages, if provider appeals
5 are not resolved within the required time.
6 (5)(a) The Director of Medicaid and Long-Term Care shall provide the
7 services of an independent auditor for the purpose of reviewing, at least
8 once per calendar year, a random sample of all claims paid and denied by
9 each managed care organization and each managed care organization's
10 subcontractors.
11 (b) Each managed care organization and each managed care
12 organization's subcontractors shall be required to pay any claim that the
13 independent auditor determines to be incorrectly denied. Each managed
14 care organization and each managed care organization's subcontractors may
15 also be required to pay liquidated damages, as determined by the
16 department.
17 (c) Each managed care organization and each managed care
18 organization's subcontractors shall be required to pay the cost of audits
19 conducted under this subsection.
20 (d) The provisions of this subsection terminate on January 1, 2022.
21 (6) The department shall adopt and promulgate rules and regulations
22 to implement this section prior to January 1, 2019.
23 Sec. 4. (1)(a) Any managed care organization providing behavioral
24 health services under the medical assistance program shall include in any
25 letter to a participating health care provider reflecting a final
26 decision of the managed care organization's internal appeal process:
27 (i) A statement that the provider's internal appeal rights within
28 the managed care organization have been exhausted;
29 (ii) A statement that the provider is entitled to an external
30 independent third-party review pursuant to this section; and
31 (iii) The requirements to request an external independent third-

1 party review.

2 (b) For each instance that a letter sent pursuant to subdivision (a)
3 of this subsection does not comply with the requirements of such
4 subdivision, the managed care organization shall pay to the participating
5 behavioral health care provider a penalty not to exceed one thousand
6 dollars.

7 (2)(a) On and after January 1, 2020, a behavioral health care
8 provider who or which (i) has been denied a payment for a behavioral
9 health care service to a recipient under the medical assistance program
10 or a claim for reimbursement to the provider for a behavioral health care
11 service rendered to a recipient under the medical assistance program and
12 (ii) has exhausted the internal written appeals process of a managed care
13 organization providing services pursuant to a contract with the medical
14 assistance program is entitled to an external independent third-party
15 review of the managed care organization's final decision.

16 (b) To request an external independent third-party review of a final
17 decision by a managed care organization, an aggrieved behavioral health
18 care provider shall submit a written request for such review to the
19 managed care organization within sixty calendar days after receiving the
20 managed care organization's final decision resulting from the managed
21 care organization's internal review process. A behavioral health care
22 provider's request for review shall:

23 (i) Identify each specific issue and dispute directly related to the
24 final decision by the managed care organization;

25 (ii) State the basis upon which the provider believes the managed
26 care organization's decision to be erroneous; and

27 (iii) Include the behavioral health care provider's designated
28 contact information, including name, mailing address, telephone number,
29 facsimile number, and email address.

30 (c) Within five business days after receiving a request for review
31 pursuant to this section, the managed care organization shall:

(i) Confirm to the behavioral health care provider's designated contact, in writing, that the managed care organization received the request for review;

(ii) Notify the department of the request for review; and

(iii) Notify the recipient of medical assistance of the request for review, if related to the denial of a behavioral health care service.

If the managed care organization fails to satisfy the requirements of this subdivision (c), the behavioral health care provider shall automatically prevail in the review.

(d) Within fifteen days after receiving a request for external independent third-party review, the managed care organization shall:

(i) Submit to the department all documentation submitted by the behavioral health care provider in the course of the managed care organization's internal appeal process; and

(ii) Provide to the department the managed care organization's designated contact information, including name, mailing address, telephone number, facsimile number, and email address.

If the managed care organization fails to satisfy any of the requirements of this subdivision (d), the behavioral health care provider shall automatically prevail in the review.

(e) Upon receiving notification of a request for an external third-party review, the department shall:

(i) Assign the review to an external independent third-party reviewer; and

(ii) Notify the managed care organization and the behavioral health care provider's designated contact of the identity of the external independent third-party reviewer.

(f) The department shall deny a request for external third-party review if the requesting behavioral health care provider fails to:

(i) Exhaust the managed care organization's internal appeal process; or

1 (ii) Submit a timely request for an external independent third-party
2 review pursuant to this section.
3 (3)(a) Multiple appeals to the external independent third-party
4 review process regarding the same recipient of medical assistance, a
5 common question of fact, or interpretation of common applicable
6 regulations or reimbursement requirements may be determined in one action
7 upon request of a party in accordance with rules and regulations adopted
8 and promulgated by the department. The behavioral health care provider
9 that initiated a request for an external independent third-party review
10 process, or one or more other behavioral health care providers, may add
11 other initial denials of claims to such review prior to final decision
12 and after exhaustion of any applicable written internal appeals process
13 of the managed care organization if the claims involve a common question
14 of fact or interpretation of common applicable regulations or
15 reimbursement requirements.
16 (b) Documentation reviewed by the external independent third-party
17 reviewer shall be limited to documentation submitted pursuant to
18 subdivision (2)(d)(i) of this section.
19 (c) An external independent third-party reviewer shall:
20 (i) Conduct an external independent third-party review of any claim
21 submitted to the reviewer pursuant to this section; and
22 (ii) Within thirty calendar days after receiving the request for
23 review from the department and the documentation submitted pursuant to
24 subdivision (2)(d)(i) of this section, issue the reviewer’s final
25 decision to the behavioral health care provider’s designated contact, the
26 managed care organization's designated contact, and the department. The
27 reviewer may extend the time to issue a final decision by fourteen
28 calendar days upon agreement of both parties to the external independent
29 third-party review.
30 (4) Within ten business days after receiving a final decision of an
31 external independent third-party reviewer, the managed care organization

1 shall notify the impacted recipient of medical assistance and the
2 participating behavioral health care provider of the final decision, if
3 it is related to the denial of a behavioral health care service.

4 (5) The final decision of any external independent third-party
5 review conducted pursuant to this section shall also direct the
6 unsuccessful party to pay an amount equal to the costs of the external
7 independent third-party review to the reviewer. Any payment ordered
8 pursuant to this subsection shall be stayed pending any appeal of the
9 external independent third-party review. If the final outcome of any
10 appeal is to reverse the decision of the external independent third-party
11 review, the unsuccessful party shall be required to pay the costs of the
12 external independent third-party review to the third-party reviewer
13 within forty-five days after entry of the final decision.

14 (6) The department shall adopt and promulgate rules and regulations
15 to implement this section prior to January 1, 2020.

16 Sec. 5. Original sections 71-801 and 71-804, Revised Statutes
17 Cumulative Supplement, 2016, are repealed.

18 Sec. 6. Since an emergency exists, this act takes effect when
19 passed and approved according to law.