Senate Bill 857: Impact to Medi-Cal Providers

On January 1, 2004, Senate Bill 857 will take effect and amend the laws that the Department of Health Services (DHS) uses to review applications for participation in the Medi-Cal program.

Impact of Senate Bill 857 on Provider Enrollment

One major change is that a new provisional provider status will be established. This is intended to enable DHS to enroll qualified providers more efficiently and to remove fraudulent provisional providers from the Medi-Cal program.

DHS currently enrolls health care providers into the Medi-Cal program while adhering to established time frames. DHS is required to notify an applicant or provider of the status of an application, as well as specify the information that must be submitted and requirements that must be met to participate in the Medi-Cal program.

Provider applications for enrollment must be processed within 180 days, at which time provisional provider status will be extended for a period of 12 months. Once the provisional period is deemed complete with no infractions, the provisional provider status defaults to enrolled provider status. Provider applications received from physicians and surgeons qualifying for preferred provider status will be processed within 90 days. Preferred provider status can be obtained only if the application package includes a cover letter requesting such status and the applicant or provider meets all the criteria specified in this statute to be considered a preferred provider.

These new provisions result in revisions to the provider enrollment application forms. Until new forms are adopted, the current application forms will continue to be accepted by the DHS Provider Enrollment Branch.

Due to the processing changes in the enrollment of providers, budget constraints and volume of applications received, program staff is unable to reply to requests for the status of applications in process. For more information about the application forms, provider updates and regulatory requirements for participation in the Medi-Cal program, please visit the Medi-Cal Web site at **www.medi-cal.ca.gov** and click the "Provider Enrollment" link.

Impact of Senate Bill 857 on Cost Reporting

If DHS determines that a provider presents or causes claims for payment by the Medi-Cal program to be billed improperly, and/or are for a service or item for which DHS solicits provider costs for use in calculating Medi-Cal reimbursement or in calculating and assigning Medi-Cal reimbursement rates, and the provider has received two or more warning notices of improper billing, the provider may, in addition to any other penalties that may be prescribed by law, be subject to a civil money penalty ranging from one hundred dollars ($100) per claim or per adjustment to one thousand dollars ($1,000) per claim or adjustment by DHS to the costs submitted by the provider, or up to three times the amount improperly claimed for each item or service, whichever is greater.

Summary of New or Amended Welfare and Institutions Code Sections

Section 14043.1 adds several definitions and amends the definition for the business address of a provider. The "business address" must be a physical location where services, goods, supplies or merchandise are provided directly or indirectly to a Medi-Cal recipient. A post office box or commercial box is not a business address.

Section 14043.15 requires that a natural person, who operates a clinic or office for the practice of his or her profession, enroll in the Medi-Cal program as an individual or rendering provider in a group. The provider cannot enroll as an exempt clinic. In addition, enrolling applicants or providers whose practice solely includes the rendering of services, goods, supplies or merchandise from a single location, with a place of service noted on the claim as being a health facility, clinic, medical therapy unit, residence of the provider's patient, or office of a physician and surgeon involved in the care of the provider's patient, may state so on the application and will not be required to obtain separate provider numbers for each of those offsite locations. If DHS is notified, a qualifying intermittent site or mobile health unit that is operated by a licensed primary care clinic is not required to enroll as a separate site.

Section 14123.25 is amended to allow DHS the ability to issue a written warning notice of improper billing or improper cost report computation and apply civil money penalties whenever a review of the provider's paid claims or a provider's cost report demonstrate a pattern of improper billing or improper cost report computation.

Section 14043.26 requires that new applicants, providers undergoing continued enrollment or providers who are moving or adding a new location submit a complete application for enrollment at the new location. Licensed clinics, health facilities,

adult day health care providers, home health agencies and hospices are exempt from the enrollment process, since their process is already handled through the Licensing and Certification division of the Department of Health Services.

This section also establishes preferred provisional provider status for physicians and surgeons for a period of no longer than 18 months, effective from the date on the notice from DHS. Within 90 days of receipt of the application and the request for preferred provider status, the applicant or provider will be notified of the status of the application.

All other applications must be processed within 180 days and, if approved, are given provisional provider status for 12 months.

Subject to a few exceptions, a provider number is exclusive to the location for which it is issued. However, an enrolled provider applying for an additional location may provide services as the owner at the new location and bill using his or her existing provider number while the application for the new location is pending. During the application review period for the new location, the provider will be placed on provisional provider status at all locations.

Section 14043.27 addresses termination of provisional and preferred provisional provider status. Termination includes deactivation of some or all provider numbers used by the provider at any location to obtain reimbursement from the Medi-Cal program, depending on the circumstances. Grounds for termination include, but are not limited to, the following:

(1) The provider, a person with ownership or control interest, or a director, officer or managing employee is convicted of a felony or misdemeanor involving fraud or abuse, or is found liable for fraud or abuse in a civil proceeding
(2) DHS discovers a material discrepancy that cannot be fixed because it occurred in the past
(3) The provider gave material information that was false or misleading
(4) The provider failed to have an established place of business at the business address
(5) The provider is a clinic but is not properly licensed
(6) Clinical Laboratory Improvement Amendment (CLIA) or state clinical laboratory requirements are not met.
(7) The provider does not have the necessary licenses, permits, certificates or other approvals
(8) The provider commits two or more violations that demonstrate a pattern or practice of fraud, abuse or provision of unnecessary or substandard medical services
(9) The provider commits any violation that represents a threat of immediate jeopardy or significant harm to a recipient or the public welfare
(10) The provider bills for services provided by another provider who has been suspended from the Medi-Cal program
(11) The provider bills for goods or services not provided at the location for which the provider number was issued, unless certain other requirements are met
(12) The provider has not paid a fine or debt to any federal, state or local government entity relating to a health care program or has not made satisfactory arrangements to make the payment or has not been excused by legal processes from making a payment

Section 14043.28 lists the time bars for reapplying for enrollment following denial of an application or termination of provisional provider status. In certain situations, an applicant may be permanently barred from the program.

Section 14043.29 removes the provisional aspect of the provider's status at the end of the provisional status period if the provider has not had its status terminated, continues to meet the standards for enrollment and has demonstrated an appropriate volume of business. Provisional provider status will be automatically granted to those applications submitted before May 1, 2003, that have not been approved, denied or noticed for background checks or inspections by January 1, 2004. Applications received after May 1, 2003, and before January 1, 2004, will be treated as if they were received on January 1, 2004, and will be processed under the new statutes.

Section 14043.341 requires, with certain listed exceptions, that a provider who dispenses or furnishes a drug, device or supply to, or who obtains a biological specimen from, a Medi-Cal recipient must maintain certain information, including the signature of the recipient of the drug, device or supply and the signature of the recipient providing the specimen.

Exceptions are made for a licensed pharmacy or clinical laboratory that is owned and operated by a nonprofit health care service plan that has at least 3,500,000 enrollees, or is owned or operated by a nonprofit hospital.

If the dispensing or furnishing of a drug, device or supply, or laboratory test occurs on a periodic basis, within an established provider-patient relationship, the signature shall only be required upon the initial order of the drug or laboratory test, so long as an appropriate record of each dispensing or furnishing is entered in the patient's chart. A signature is not required when a

sample is dispensed from the provider's office at no charge to the patient and an appropriate record is entered in the patient's chart.

Section 14043.47 requires that a physician or physician group provider not be enrolled at more than three business addresses unless there is at least one physician providing supervision for every three locations. A provider, whether acting as a sole proprietorship, professional corporation, partnership or group that uses non-physician medical staff and who fails to comply with the requirements of this section will be subject to temporary suspension from the Medi-Cal program and deactivation of all provider numbers.

Section 14043.65 establishes the provisions to file a written appeal when a provider's provisional status is terminated for cause.

Section 14043.75 is amended to allow DHS the ability to implement certain enrollment statutes without using the regulation procedures.

Section 14044 requires that if DHS determines by audit or investigation that excessive services, billing or abuse has occurred, or a provider's licensing authority or a court of competent jurisdiction limits a licensee's practice of medicine, where the limitation precludes the licensee from performing services that could otherwise be reimbursed by Medi-Cal, then the involved provider may have claims denied for one or more procedure codes, or any combination of procedure codes, as determined by DHS.

A provider will have 45 days after receiving notice of action by DHS to submit an appeal of the limitation by providing to DHS reliable evidence that excessive services or billings, or abuse did not occur. If the appeal is denied, the procedure code limitations will begin on the 15th day after the provider receives notice.

In a situation where limitations established by DHS could interfere with the provider's or other prescriber's ability to provide health care services to a recipient, the burden to transfer a patient's care to another qualified provider shall remain the responsibility of the licensee.

Note: The full text of Senate Bill 857 can be viewed at: **http://www.leginfo.ca.gov/pub/bill/sen/sb_0851-0900/sb_857_bill_20030929_chaptered.html**.