POLICY AND PROCEDURE

POLICY NAME: Arkansas Medical Audit Bill of Rights Act Policy	POLICY ID: AR.BO.04
BUSINESS UNIT: Arkansas Health and Wellness/QualChoice	FUNCTIONAL AREA: Operations
EFFECTIVE DATE: 8/5/2025	PRODUCT(S): Marketplace, Commercial
REVIEWED/REVISED DATE: 8/25	
REGULATOR MOST RECENT APPROVAL DATE(S):	

POLICY STATEMENT:
This policy incorporates the Arkansas Act 512 of 2025 amending AR §§ 23-99-1901 The Arkansas Medical Audit Bill of Rights Act.

PURPOSE:
Clarify what is considered an audit and what is considered is considered fraud and abuse as it relates to the Arkansas Medical Audit Bill of Rights Act.

SCOPE:
This policy applies to all directors, officers, and employees of Centene Corporation, its affiliates, health plans, and subsidiary companies (collectively, the "Company").

DEFINITIONS:
Abuse: A pattern of healthcare provider conduct that is inconsistent with sound fiscal, business, or medical practices and that results in:

- An unnecessary cost to the health plan; or
- Reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Audit: an investigation or review of a claim submitted by a healthcare provider if the investigation or review:

- It is conducted by an auditor; and
- Involves records, documents, or information other than the filed claim.

Auditor: Is an entity that reviews or investigates claims submitted by a healthcare provider, including:

- The health plan.
- A third-party payor; or
- An entity that represents the health plan, including a company or group that administers claims services

Clerical (Record Keeping) Error: An error in a claim that is provided by a healthcare provider, including without limitation:

- A typographical error;
- A scrivener's error; or
- A computer error.

Fraud: An intentional representation that is untrue or made in disregard of its truthfulness for the purpose of inducing reliance in order to obtain or retain anything of value.

Healthcare Provider: A person who is licensed, certified, or otherwise authorized by the laws of this state to administer healthcare services. Healthcare provider does not include a pharmacy that is subject to AR § 17-92-1201.

POLICY:

Centene has implemented routine payment integrity processes targeted at fraud and abuse to ensure appropriateness of billing practices and medical necessity. These processes are not considered audits and are excluded from audit requirements detailed in HB 1314.

In the event Centene identifies concern warranting an audit of a provider, the following provisions, outlined in HB 1314 will be followed;

(a) Notwithstanding any other law, when an audit is conducted by an auditor, the audit shall be conducted according to the following bill of rights:

(1) An auditor conducting the initial audit shall give the healthcare provider notice of the audit at least one (1) week before conducting the initial audit for each audit cycle;

(2) An audit that involves the application of clinical or professional judgment shall be conducted by or in consultation with a healthcare provider of the same specialty as the healthcare provider being audited;

(3)(A) A clerical or recordkeeping error shall not:

(i) Constitute fraud; or

(ii) Be subject to criminal penalties without proof of intent to commit fraud.

- A claim arising under subdivision (a)(3)(A) of this section may be subject to recoupment;

(4) (A) A finding of an overpayment or underpayment of a filed claim may be a projection based on the number of patients served by the healthcare provider having a similar diagnosis

(B) Recoupment of claims under subdivision (a)(4)(A) of this section shall be based on the actual overpayment unless the projection for overpayment or underpayment is part of a settlement by the healthcare provider;

(5) (A) When an audit is for a specifically identified problem that has been disclosed to the healthcare provider, the audit shall be limited to a claim that is identified by a claim number.

(B) For an audit other than that described in subdivision (b)(5)(A) of this section, the audit shall be limited to the greater of:

(i) Fifty (50) claims; or

(ii) Twenty-five one-hundredths of one percent (0.25%) of the number of claims billed by the healthcare provider to the auditor in the previous calendar year.

(C) If an audit reveals the necessity for a review of additional claims, the audit shall be conducted by one (1) of the following methods at the discretion of the healthcare provider:

(i) On-site;

(ii) Electronically; or

(iii) By the same method as the initial audit.

(D) Except for an audit initiated under subdivision (b)(5)(A) of this section, an auditor shall not initiate an audit of a healthcare provider more than two (2) times in a calendar year;

(6) A recoupment shall not be based on:

(A) Documentation requirements in addition to the requirements for creating or maintaining documentation prescribed by state law or rule or federal law or regulation; or

(B) A requirement that a healthcare provider perform professional duties prescribed by state law or rule or federal law or regulation;

(7) (A) Recoupment shall only occur following the correction of a claim and shall be limited to amounts paid in excess of amounts payable under the corrected claim.

(B) An auditor may recoup the entire overpaid claim if payment is issued for the corrected claim on the same date.

(C) Following a notice of overpayment, a healthcare provider shall have at least sixty (60) days to file a corrected claim;

(8) Approval of a healthcare service, healthcare provider, or patient eligibility upon adjudication of a claim shall not be reversed unless the healthcare provider obtained the adjudication by fraud or misrepresentation of claim elements;

(9) Each healthcare provider shall be audited under the same standards and parameters as other similarly situated healthcare providers audited by the auditor;

(10) A healthcare provider shall be allowed at least sixty (60) days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during the audit;

(11) The period covered by an audit shall not exceed twenty-four (24) months from the date the claim was submitted to or adjudicated by an auditor;

(12) (A) The preliminary audit report under subdivision (a)(10) of this section shall be delivered to a healthcare provider within one hundred twenty (120) days after the conclusion of the audit.

(B) A final audit report shall be delivered to the healthcare provider within six (6) months after receipt of the preliminary audit report or receipt of the final appeal as provided for in this subsection, whichever is later; and

(13) Notwithstanding any other provision in this section, the auditor conducting the audit shall not use the accounting practice of extrapolation in calculating recoupments or penalties for audits.

(b) A recoupment of any disputed funds shall only occur after final internal disposition of the audit, including the appeals process as described in subsection (c) of this section.

(c)(1) An auditor that conducts an audit shall:

(A) Establish an appeals process under which a healthcare provider may appeal an unfavorable preliminary audit report to the auditor; and

(B) Provide a copy of the final audit report to the health benefit plan sponsor after the completion of any review process.

(2) If following the appeal under subdivision (c)(1)(A) of this section the auditor finds that an unfavorable audit report or any portion of the unfavorable audit report is unsubstantiated, the auditor shall dismiss the audit report or the unsubstantiated portion of the audit report without any further proceedings.

(d) The total amount of any recoupment on an audit shall be refunded to the party responsible for payment of the claim.

(e) This section does not apply to:

(1) Any audit on behalf of the Arkansas Medicaid Program conducted by the Department of Human Services or its designee; or

(2) Any audit, review, or investigation that involves alleged fraud, willful misrepresentation, or abuse, including without limitation:

(A) Fraud involving the Arkansas Medicaid Program as described in § 5-55-111;

(B) Abuse as defined in § 20-77-1702;

(C) Fraud as defined in § 20-77-1702; or

(D) Insurance fraud.

(f) The Insurance Commissioner shall promulgate rules to implement, administer, and enforce this subchapter.

Centene has implemented routine payment integrity processes targeted at fraud and abuse to ensure appropriateness of billing practices and medical necessity. These processes are not considered audits and are excluded from audit requirements detailed in the Arkansas Medical Audit Bill of Rights Act.

PROCEDURE:

The procedure provides the prescribed method to follow. It includes who, what, when, where, and how steps are to be completed.

REFERENCES:

AR § 5-55-111
AR § 20-77-1702
AR § 17-92-1201
AR §§ 23-99-1901

ATTACHMENTS:

ROLES & RESPONSIBILITIES:

REGULATORY REPORTING REQUIREMENTS:

Which regulator(s) require reporting, what should be reported, when to report, and how to report/who to contact.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy		8/1/2025

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.