HOUSE BILL 51
By Matheny

SENATE BILL 133

By Bowling

AN ACT to amend Tennessee Code Annotated, Title 56, relative to TennCare managed care organizations.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-32-126(b)(2)(A), is amended by deleting the first sentence of the subdivision and substituting the following:

If a provider's claim is partially or totally denied in a remittance advice or other appropriate written or electronic notice from an HMO, or a provider's previously allowed claim is subsequently partially or totally denied by an HMO by an appropriate written or electronic notice, then the provider may either seek review of a grievance under subsection (c) or file a written request to the commissioner to submit the claim denial to an independent reviewer as provided in subdivision (b)(3). If the provider fails to reach an acceptable resolution of a disputed provider claim from a grievance filed under subsection (c), then the provider may seek review under subdivision (b)(3).

SECTION 2. Tennessee Code Annotated, Section 56-32-126, is further amended by adding the following as a new subsection:

(c)

(1) Notwithstanding chapter 61 of this title, for an HMO involved in a TennCare line of business or a subcontractor of that HMO, the written internal appeals process of the HMO or subcontractor shall include:

(A) Establishing provider access to a designated contact for prompt claims resolution and in-person telephonic utilization review eight (8) hours per day, seven (7) days a week to receive requests for

authorization of covered services and for initiating resolution of matters related to the payment or nonpayment of submitted claims;

(B) Establishing and maintaining an interactive website operated by the HMO that allows providers to file grievances, appeals, and documents in support thereof electronically in an encrypted HIPAA compliant format and that allows a provider to check on the status of matters on appeal or grievance; and

(C) Establishing procedures that:

(i) Ensure the timely consideration of any grievance and any appeal of a provider related to the payment or nonpayment of any claim for services;

(ii) Require a written reply in detail sufficient to inform the provider of the reasons for any claims determination or matter related to a filed grievance. Providers shall receive the reply not later than ten (10) days following the day upon which it first was filed and may file for timely reconsideration of any claims determination;

(iii) Consider and pay claims for the same or similar medical conditions of a patient that previously were paid but that have been denied and resubmitted by the provider for reconsideration outside any timely filing limitations of the managed care organization; and

(iv) Afford providers the opportunity for an in-person meeting with an informed representative of the HMO on any claim or set of claims that remain unpaid sixty (60) days or more past the date of the first determination and that individually or in the aggregate exceed ten thousand dollars ($10,000).

(2) For purposes of this subsection (c) and review under subdivision (b)(3), a decision by an HMO operating a TennCare line of business on an authorization or pre-authorization of requested physical, behavioral, or other medically necessary services shall be made in a consistent manner such that patients with comparable medical needs receive a comparable, consistent level, amount, and duration of services as supported by the patient's medical condition, records, and previous affirmative coverage decisions.

(3) Any HMO operating a TennCare line of business found by the commissioner to have violated any provision of this subsection (c) shall be subject to revocation or suspension of its certificate of authority under § 56-32-116 or, in the alternative, the imposition of the penalties and other remedies set forth at § 56-32-120 for each claim that is a violation.

SECTION 3. Tennessee Code Annotated, Section 56-32-126, is further amended by adding the following as new subsection (d):

(d) Each HMO operating a TennCare line of business shall annually file on or before March 1 for activity in the immediately prior calendar year a written report with the department of commerce and insurance which details the number of claims considered, denied, reconsidered, or approved for payment under this section, and the number of claims appealed internally and grievances filed along with a statement of their resolution.

SECTION 4. This act shall take effect upon becoming a law, the public welfare requiring it.

000179