SENATE BILL 1397

By Johnson

AN ACT to amend Tennessee Code Annotated, Title 56, Chapter 7, relative to contracts with health care providers.

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

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding Sections 2 through 6 of this act as a new part.

SECTION 2.

As used in this part, unless the context otherwise requires:

(1) "Health insurance entity" has the same meaning as in § 56-7-109;

(2) "Health care provider" or “provider” means any person or entity performing services regulated pursuant to title 63 or title 68, chapter 11;

(3) "Person or entity" means a person or entity that has a primary business purpose of contracting with health care providers for the delivery of health care services; and

(4) “Recoup” or “recoupment” means recovery or partial recovery of a previously allowed claim by a person or entity.

SECTION 3. A person or entity shall ensure that any new policies, procedures, or guidelines or material change to policies, procedures, or guidelines from the person or entity’s previously-released provider manual shall be clearly identified in any revised or annually-generated provider manual through the use of bold print and a font being the same or larger size as the font generally used throughout the manual.

SECTION 4.

(a) Every health insurance entity shall establish and maintain an Internet web site which shall be accessible to health care providers only.

(b) No later than July 1, 2010, every health insurance entity shall make available on the Internet web site established pursuant to subsection (a) a web-based pre-adjudication tool to be used by a health care provider prior to the provider's submitting either a clean claim as defined in § 56-7-109 or a claim combination to the claims adjudication system utilized by the health insurance entity. The pre-adjudication tool shall be designed in such a manner as to be capable of:

(1) Providing accurate information to a health care provider regarding the manner in which the health insurance entity's claim system adjudicates invoices for specific billing codes or combinations of codes; and

(2) Providing accurate information to a health care provider regarding the amount that the health care provider will be paid for those services based on the health care provider's fee schedule for which the claim will be submitted if the claim is determined to be a clean claim.

(c) Health insurance entity policies affecting the information available to a provider pursuant to subsection (b) shall be easily accessible by a health care provider on the web site established by the health insurance entity pursuant to subsection (a).

(d) Failure of an insurance entity to timely comply with this section, or a pattern of failing to maintain accuracy and operability of this tool are grounds for the commissioner to issue penalties against the insurance entity pursuant to § 56-2-305.

SECTION 5.

Every person or entity shall have in place a procedure for a health care provider's claims denied or partially denied or recouped to undergo, at the discretion of the health care provider, an internal reconsideration and an independent review process which comports to the following provisions:

(1) **Internal Reconsideration**.

(A) If a health care provider's claim is partially or totally denied in a remittance advice or other appropriate written or electronic notice from a person or entity, or a health care provider's previously allowed claim is subsequently partially or totally denied by a person or entity by an appropriate written or electronic notice (recouped), then the provider may file a written request for internal reconsideration to the person or entity which denied or partially denied the claim. The health care provider must send a written request for reconsideration to the person or entity which identifies the claim or claims in dispute, the reasons for the dispute and any documentation supporting the health care provider's request.

(B) The person or entity shall acknowledge receipt of the health care provider’s request in writing or electronically to the health care provider within three (3) business days of receiving such request and such acknowledgement shall indicate the date of receipt of the health care provider’s reconsideration request. No acknowledgment shall be post-dated but must accurately reflect the date of receipt. If no acknowledgment is generated, receipt shall be determined to be three (3) business days from the date the request for reconsideration is submitted by the health care provider.

(C) The person or entity shall make a final reconsideration decision within thirty (30) calendar days after the date of receipt of the request. Prior to the expiration of such thirty (30) calendar days, if the person or entity determines that more than thirty (30) calendar days are needed to render a final reconsideration decision to the health care provider, the person or entity shall send notice to the provider that the person or entity's reconsideration decision shall be issued within sixty (60) calendar days after receipt of the reconsideration request, unless a longer

time to render a reconsideration decision is agreed upon in writing by the provider and the person or entity on a case by case basis.

(D) If a person or entity does not acknowledge an internal reconsideration request or issue a final reconsideration decision within the time required by subdivision (1)(B) and (C), then the dispute shall be deemed to be resolved in favor of the health care provider and the person or entity shall remit to the provider the total amount of the disputed claim within twenty (20) calendar days from the date the request was submitted by the health care provider.

(E) Claims payment disputes involving a TennCare member are governed by § 56-32-126.

(2) **Independent Review**.

(A) A health care provider may submit a written request for independent review as provided in this section and Section 6 if:

(i) The person or entity issues a final reconsideration decision upholding the total or partial denial or recoupment of a claim or limits total recovery of the amount of the claim in any way; or

(ii) The health care provider receives no remittance advice or other appropriate written or electronic notice within sixty (60) calendar days of the person or entity's receipt of a claim.

(B) The health care provider shall include a copy of the written request for internal reconsideration and any correspondence documenting the individual or entity's internal review decision with the request for independent review. The provider shall also furnish any other information needed to process the provider's request for independent review.

(C) The health care provider shall file a request for independent review within three hundred sixty-five (365) calendar days of the date:

(i) The health care provider received the initial claim denial or recoupment if the request is submitted pursuant to subdivision (2)(A)(i); or

(ii) Sixty (60) calendar days from the date the entity or provider received the claim if the request is pursuant to subdivision (2)(A)(ii).

(D) The disputed claims of a health care provider involving the same person or entity may be aggregated and submitted for simultaneous review to an independent reviewer when the specific reason for non-payment of the claims aggregated involve a dispute regarding a common substantive question of fact or law. The fact that a claim is not paid does not create a common substantive question of fact or law, unless the health care provider has received no remittance advice or other appropriate written or electronic notice from a person or entity within sixty (60) calendar days of the person or entity's receipt of the claim and such claims regard a common substantive question of fact or law.

(E) If there is a dispute between the health care provider and the reviewer as to whether disputed claims are properly aggregated, such dispute shall be resolved by the commissioner upon written petition by the reviewer. The health care provider shall have an opportunity to respond before the commissioner’s decision is issued.

(F) The independent reviewer shall, within fourteen (14) calendar days of receipt of the disputed claim or aggregated claims, request in writing that both the health care provider and the person or entity provide the independent reviewer any and all information and documentation regarding the disputed claim or claims. The independent reviewer shall

request the health care provider and person or entity to identify all information and documentation that has been submitted by the health care provider to the person or entity regarding the disputed claim or claims, and advise that the independent reviewer will not consider any information or documentation not received within thirty (30) calendar days of receipt of the independent reviewer's request unless the person or entity or health care provider requests the independent reviewer for additional time to complete the investigation of independent review requests when a health care provider elected to aggregate their claims. Thereupon, the independent reviewer may grant the person or entity or health care provider an additional thirty (30) calendar days. The independent reviewer shall then examine all materials submitted and render a decision on the dispute within sixty (60) calendar days of the receipt of the disputed claim or claims, unless the independent reviewer requests and receives an extension of time from the commissioner to resolve the dispute.

(G) The independent reviewer shall ensure that any individual reviewing any dispute based on a claim denial, partial denial, or recoupment based on reasons related to medical necessity or that the medical service was experimental or investigational on behalf of the independent reviewer, is certified in the same medical specialty as the health care provider who submitted the claim for independent review.

(H) The independent reviewer shall send the person or entity and the health care provider a copy of the decision. Once the independent reviewer makes a decision requiring a person or entity to pay any claims or portion thereof, then the person or entity must send the payment in full to the provider within twenty (20) calendar days of receipt of the reviewer's decision.

(I) Within sixty (60) calendar days of an independent reviewer's decision, either party to the dispute may file suit in any court having jurisdiction to review the independent reviewer's decision and to recover any funds awarded by the independent reviewer to the other party. Any suit concerning an independent reviewer's decision not brought within sixty (60) calendar days of the independent reviewer's decision will be forever barred. Suits filed pursuant to this section will be conducted in accordance with the Tennessee Rules of Civil Procedure, and the review by the court shall be de novo without regard to the independent reviewer's decision. The independent reviewer shall not be required to testify at the court proceeding considering the independent reviewer's decision. Venue and jurisdiction will be in accordance with Tennessee law. If the dispute between the parties is not fully resolved prior to the entry of a final decision by the court initially hearing the dispute, then the prevailing party shall be entitled to an award of reasonable attorney's fees and expenses from the non-prevailing party.

(J) Except as provided in subdivision (2)(J)(ii), all costs associated with implementing these procedures shall be paid by the applicable person or entity.

(i) The person or entity shall compensate the independent reviewer within thirty (30) calendar days of the person or entity's receipt of the independent reviewer's bill for services rendered. If the person or entity fails to pay any such bill for the independent reviewer's services, then it shall be grounds for the commissioner to take action pursuant to Section 6(b).

(ii) If the independent reviewer finds that the person or entity properly denied the claim being reviewed, the health care provider shall reimburse the person or entity the independent

reviewer's fee within twenty (20) calendar days of receipt from the person or entity substantiating proof of payment to the independent reviewer's decision in accordance with subdivision (2)(J)(i). If a health care provider fails to properly or timely reimburse the person or entity, the person or entity may offset the award from pending claims from the same health care provider provided such person or entity provides reasonable notice to the health care provider or the person or entity may pursue such other remedies available to it by law.

(3) All claims resolved pursuant to internal reconsideration or independent review in accordance with the provisions of this part shall be subject to the provisions of the Timely Reimbursement of Health Insurance Claims Act, codified in § 56-7-109. Participation in the internal reconsideration, the independent review process, or both, shall not toll the obligation of any person or entity from paying the health care provider any interest due pursuant to § 56-7-109(b)(4).

(4) In lieu of requesting Independent Review in accordance with subdivision (2), a health care provider may pursue any appropriate legal or contractual remedy available to the health care provider to contest the partial or total denial of the claim or recoupment.

SECTION 6.

(a)

(1) The commissioner of commerce and insurance shall maintain a list of qualified independent reviewers to resolve disputed health care provider claims. Such list shall contain information about fees associated with independent reviews.

(2) The commissioner shall, by the promulgation of rules, develop criteria by which an independent reviewer will be considered qualified to conduct

independent reviews of provider health care claims in this state and thereby be included on the commissioner's list of qualified independent reviewers.

(3) The commissioner shall develop a conflict of interest statement form to be completed by qualified independent reviewers as determined by the commissioner to help ensure that any independent reviewers determined to be qualified shall not have any material conflict of interest or appearance of conflict of interest with any person, entity, or party of which it might conduct reviews.

(4) No independent reviewer shall subcontract the responsibilities under this section to any other independent reviewer.

(5) No compensation paid to an independent reviewer shall be tied to the outcome of any independent review performed.

(6) The fact that an independent reviewer previously decided a dispute involving one (1) or more of the parties does not in and of itself constitute a conflict of interest.

(7) By no later than May 1 of each year, every person or entity shall report to the commissioner the number of requests for independent review filed for such person or entity during the prior calendar year. Such report by the person or entity shall also include a general report of the nature of the disputes and outcomes of these independent review requests. Such reports shall be public records.

(b) Any person or entity found by the commissioner to be in violation of this section shall be subject to the imposition of civil penalties and other remedies set forth at § 56-2-305.

SECTION 7. This act shall not apply to a contract between a health care provider and the state or federal government or their agencies for health care services provided through a program for medicare; the state group insurance program; TennCare or any successor program provided for in Title 71, Chapter 5; the Cover Kids Act of 2006 provided for in title 71, chapter 3, part 11; or the Cover Tennessee Act of 2006 provided for in title 56, chapter 7, part 30.

SECTION 8. For the purposes of promulgating rules this act shall take effect upon becoming a law, the public welfare requiring it. Section 6 of this act shall take effect upon becoming a law, the public welfare requiring it. For all other purposes, this act shall take effect October 1, 2009, the public welfare requiring it, and shall apply to provider network contracts entered into, renewed or materially amended on or after that date.