

SENATE BILL _____

By _____

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 7 of this act as a new part.

SECTION 2. As used in this act, unless the context otherwise requires:

(a) "Health care provider" or "provider" means any person or entity performing services regulated pursuant to title 63 or title 68, chapter 11.

(b) "Health insurance entity" has the same meaning as in section 56-7-109.

(c) "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.

SECTION 3. The person or entity shall assure that any new policies, procedures, or guidelines or material change to such policies, procedures, or guidelines from the entity's previously-released provider manual shall be clearly identifiable in bold print with the font being the same or larger size as the font in any revised or annually-generated provider manual.

SECTION 4.

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

(b) Every health insurance entity shall make available no later than July 1, 2010 on its internet website accessible to health care providers only a web-based pre-adjudication tool designed so that before a clean claim as defined in TCA §56-7-109 or claim combination is submitted by the provider to the claims adjudication system utilized by the health insurance entity, such pre-adjudication tool will:

(1) provide accurate information to providers regarding the manner in which the entity's claim system adjudicates invoices for specific CPT codes or combinations of codes;

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

(c) Health insurance entity policies affecting the information available to providers pursuant to subsection (b) shall be easily accessible by such provider on the health insurance entity's internet website.

SECTION 5 (a) A person or entity as herein defined shall have in place a procedure for health care providers' 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. 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 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 position or request by the person or entity.

(2) The person or entity must acknowledge receipt of the health care provider's request in writing or electronically to the health care provider within three (3) business days 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 business days from the date the request for reconsideration is submitted by the health care provider.

(3) The person or entity must make a final decision as to the health care provider's reconsideration request within thirty (30) calendar days after the date of receipt of the request. If the person or entity then determines that it needs longer than thirty (30) calendar days to render a final reconsideration decision to the health care provider, it 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.

(4) External Review. If the person or entity continues to deny or partially deny the health care provider's claims or uphold a recoupment pursuant to internal reconsideration allowed in this section, then the health care provider may file a written request with the commissioner to submit the claims to an independent reviewer as provided herein. In order for a health care provider to access the independent review process, the health care provider must have first undergone the internal reconsideration process described in (a)(1) – (3) above. If the person or entity does not respond to the internal reconsideration request within the time frames allowed in this section, then the dispute shall be deemed in favor of the health care provider and the person or entity shall pay the disputed claim within twenty (20) days.

(5) 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; and the health care provider has undergone the internal reconsideration process described in (a)(1) – (3) above, then the health care provider may file a written request to the commissioner of commerce and insurance to submit the claim denial to an independent reviewer as provided for herein.

(6) The health care provider must include a copy of the written request for internal reconsideration with the request for an independent review. The provider shall also furnish the commissioner any other information needed by the commissioner to process the provider's request for independent review.

(7) The health care provider must file a request for independent review within three hundred sixty-five (365) calendar days after the person or entity denies the claim for the first time or recoups the claims payment.

(b) Claims payment disputes involving a TennCare member are governed by the provisions of T.C.A. § 56-32-226.

(c) The commissioner, on behalf of the department of commerce and insurance, shall contract with independent reviewers to implement the following procedures to resolve disputed health care provider claims:

(1) The commissioner shall use best efforts to ensure that any independent reviewer(s) with which the commissioner contracts shall not have any material conflict of interest or appearance of conflict of interest with any person or entity of which it might conduct reviews. No independent reviewer shall subcontract

the responsibilities under this section to any other independent reviewer without the prior written consent of the commissioner who shall ensure that there is no material conflict of interest or appearance of conflict of interest with any person or entity of which the subcontractor might conduct reviews. The commissioner shall ensure that no compensation paid to an independent reviewer is tied to the outcome of any independent review performed.

(2) The commissioner shall use best efforts to refer an equal proportion of the total disputed claims to each independent reviewer. A health care provider may request, and the commissioner may allow, the claims of a health care provider involving the same person or entity to be aggregated and submitted for simultaneous review by 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 mere 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, either partially or totally denying a claim, 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.

(3) The independent reviewer shall, within fourteen (14) calendar days of receipt of the disputed claim or 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 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 shall be certified in the same medical specialty as the health care provider. 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.

(4) The independent reviewer shall send the person or entity, the health care provider, and the commissioner 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.

(5) 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 claim 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 will 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.

(6) In lieu of requesting independent review, 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.

(7) All costs associated with implementing these procedures shall be paid by the applicable person or entity. However, the health care provider shall reimburse the person or entity the independent reviewer's fee within twenty (30) calendar days of receipt of the independent reviewer's decision, if the independent reviewer finds that the person or entity properly denied the claim being reviewed. If a health care provider fails to properly 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 may pursue such other remedies available to it by law.

(8) 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 subsection (d).

(9) By no later than May 1 of each year, any 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.

(10) All claims resolved by this process shall be subject to the provisions of the prompt pay act, T.C.A. § 56-7-109. Participation in the internal reconsideration and/or the independent review process shall not toll the obligation of any person or entity from paying the health care provider any interest due pursuant to T.C.A. § 56-7-109(b)(4).

(d) 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 6. 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 7. Notwithstanding Section 4, this act shall apply to provider network contracts entered into, renewed or materially amended on or after the effective date of October 1, 2009, the public welfare requiring it.