

Amendment No. 1 to SB0937

McNally
Signature of Sponsor

AMEND Senate Bill No. 937

House Bill No. 963*

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 56-7-3301, is amended by adding the following language as new subdivisions:

() “Fee schedule” means a complete list of rates or pricing amounts that correspond to specific billing codes used by healthcare providers, including, but not limited to, any CPT, HCPCS, and ICD-9-CM or ICD-10 codes, or any other reimbursement mechanism, at which a health insurance entity agrees to reimburse a healthcare provider pursuant to a contract between a health insurance entity and a healthcare provider;

() “Hospital” means a licensed public or private institution as defined in § 68-11-201;

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 7, Part 33, is amended by adding the following language as new sections:

56-7-3305.

(a) No health insurance entity shall make a change to a provider’s fee schedule except as follows:

(1) Up to one (1) time during a consecutive twelve-month period. After a health insurance entity makes a change to the provider’s fee schedule, it is prohibited from doing so again for at least twelve (12) months following the effective date of the change; or

Amendment No. 1 to SB0937

McNally
Signature of Sponsor

AMEND Senate Bill No. 937

House Bill No. 963*

(2) If the health insurance entity and a hospital agree to a change in writing.

(b) Subsection (a) does not apply to the following changes to a fee schedule:

(1) Changes in the provider's fee schedule due solely to a change effected by the federal or state government to its healthcare fee schedule if the provider and health insurance entity have previously agreed that the provider's fee schedule is based on a percentage, or some other formula, of a current government healthcare fee schedule, such as Medicare;

(2) Changes in the provider's reimbursement for drugs, immunizations, or injectables if the provider and health insurance entity have previously agreed that any reimbursement for drugs, immunizations, or injectables will be based on a percentage, or some other formula, of a price index not established by the health insurance entity, such as the average wholesale price or average sales price;

(3) Changes in the healthcare provider's fee schedule due to a change to the provider's chargemaster if the healthcare provider and health insurance entity have previously agreed that the provider's fee schedule is based on a percentage, or some other formula, of the chargemaster and that the health insurance entity may amend the provider's fee schedule in the event of a change to such chargemaster, as long as the change is made in accordance with the agreement between the healthcare provider and the health insurance entity;

(4) Any changes or additions to the list of Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) as established by the American Medical Association (AMA) or the Centers for Medicare and Medicaid Services (CMS) that are adopted by the health insurance entity into the provider's fee schedule; and

(5) Any changes or additions to revenue codes as established by the National Uniform Billing Committee (NUBC).

(c) Nothing in this section prohibits a health insurance entity from entering into an agreement with a healthcare provider that includes one (1) or more of the following:

(1) Payments based on the value or quality of care provided to the health insurance entity's members;

(2) Escalator or de-escalator clauses; or

(3) Provisions that require adjustments to payment due to population health management performance or results.

(d) Nothing in this section shall apply to an enrollee's benefit package, or coverage terms and conditions, unrelated to application of fee schedules and reimbursements, including, but not limited to, provisions regarding eligibility for coverage, deductibles and copayments, coordination of benefits, and coverage limitations and exclusions.

(e) Nothing in this section shall apply to any contract between a health insurance entity and healthcare provider for items or services to be provided for individuals covered by any federal Medicare program, including Medicare Advantage, Medicare Select, Medicare Supplement, Medicare and Medicaid Enrollees (MME), Medicare Dual Special Needs, and Medicare Private Fee for Service; the state, local government, and local education insurance plans established under title 8, chapter 27; the TennCare or Medicaid waiver program established under title 71, chapter 5; and any other health plan

managed by the health care finance and administration division of the department of finance and administration.

(f) Nothing in this section shall apply to any entity that is subject to delinquency proceedings and for which the commissioner of commerce and insurance has been appointed receiver, or any entity placed under administrative supervision by order of the commissioner pursuant to the Insurers Rehabilitation and Liquidation Act, compiled in chapter 9 of this title.

56-7-3306.

(a) A health insurance entity may effect a change only to any of the policies, procedures, or methodologies described in § 56-7-3302 on two (2) dates during a given year, those dates being April 1 and October 1.

(b) The following changes are excluded from the restriction in subsection (a) and may be effected by a health insurance entity at any time during a calendar year:

(1) Changes to the coding standards and claims edits published by the National Correct Coding Initiative (NCCI); the Healthcare Common Procedure Coding System (HCPCS) published by the Centers for Medicare and Medicaid Services (CMS); the Current Procedural Terminology (CPT) published by the American Medical Association (AMA); and revenue codes published by the National Uniform Billing Committee (NUBC) if adopted by the health insurance entity in their entirety when they are released. The health insurance entity shall publish on its web site the effective date for each change;

(2) Any changes related to utilization review, as defined in § 56-6-703 and addressed in the Health Care Service Utilization Review Act, compiled in chapter 6, part 7 of this title; or

(3) If the health insurance entity and a hospital agree to a change in writing.

(c) Nothing in this section prohibits a health insurance entity from entering into an agreement with a healthcare provider that includes one (1) or more of the following:

- (1) Payments based on the value or quality of care provided to the health insurance entity's members;
- (2) Escalator or de-escalator clauses; or
- (3) Provisions that require adjustments to payment due to population health management performance or results.

(d) Nothing in this section shall apply to an enrollee's benefit package, or coverage terms and conditions, unrelated to application of fee schedules and reimbursements, including, but not limited to, provisions regarding eligibility for coverage, deductibles and copayments, coordination of benefits, and coverage limitations and exclusions.

(e) A health insurance entity shall notify a healthcare provider of its intent to effect a change as described in subsection (a) at least forty-five (45) calendar days prior to the effective date of the change. The notice shall be provided to the individual or address stipulated in the parties' contract pursuant to § 56-7-1013(g) and shall contain an explanation of the change and the Internet address of the specific page in the health insurance entity's policy or manual that will be affected once the change goes into effect.

(f) Actions taken by a health insurance entity to determine, based on a reasonable belief, whether a healthcare provider is committing healthcare fraud are exempt from the scope of subsection (a). For purposes of this subsection (f), "healthcare fraud" means to knowingly and willfully execute, or attempt to execute, a scheme or artifice to defraud any health insurance entity or program designed to provide healthcare benefits or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health insurance entity or program designed to provide

healthcare benefits, in connection with the delivery of or payment for healthcare benefits, items, or services.

(g) Actions taken by a health insurance entity to determine, based on a reasonable belief, whether a healthcare provider is abusing the billing for reimbursement for healthcare services provided are exempt from the scope of subsection (a). For purposes of this subsection (g), “abuse” means billing for services that fail to meet professionally recognized standards of care or that are medically unnecessary as defined in a health insurance entity’s benefit and payment policies, and provided for the financial benefit of the healthcare provider.

(h) Nothing in this section shall apply to any contract between a health insurance entity and healthcare provider for items or services to be provided for individuals covered by any federal Medicare program, including Medicare Advantage, Medicare Select, Medicare Supplement, Medicare and Medicaid Enrollees (MME), Medicare Dual Special Needs, and Medicare Private Fee for Service; the state, local government, and local education insurance plans established under title 8, chapter 27; the TennCare or Medicaid waiver program established under title 71, chapter 5; and any other health plan managed by the health care finance and administration division of the department of finance and administration.

(i) Nothing in this section shall apply to any entity that is subject to delinquency proceedings and for which the commissioner of commerce and insurance has been appointed receiver or any entity placed under administrative supervision by order of the commissioner pursuant to the Insurers Rehabilitation and Liquidation Act, compiled in chapter 9 of this title.

56-7-3307.

(a)

(1) If a health insurance entity offers a healthcare provider, via a contract amendment, the opportunity to participate in a health plan or provider network with which the provider is not currently participating, the health insurance entity shall send the contract amendment, including the information listed in subdivision (a)(2), at least sixty (60) days prior to the effective date of the amendment to the individual or address stipulated in the parties' contract pursuant to § 56-7-1013(g).

(2) In addition to the contract amendment, the health insurance entity shall also disclose:

(A) The fee schedule associated with the new health plan or provider network, if the fee schedule is not one under which the provider is already contracted; and

(B) Whether the provider will be terminated from all or any other of the health insurance entity's health plans or provider networks with which the provider is currently participating if the provider chooses not to participate in the new health plan or provider network.

(b) Any amendment shall require the signature of both the healthcare provider and the health insurance entity before becoming effective.

56-7-3308.

(a) To report alleged noncompliance with this part, § 56-7-110, or § 56-7-1013, the complainant shall first send a written notice to the respondent that identifies the conduct comprising the alleged noncompliance and any information and documentation supporting the complainant's position. The respondent shall respond to the notice within thirty (30) calendar days after receipt of the notice. The response may be a letter acknowledging the noncompliance, which shall include an explanation of measures the

respondent will take to rectify or compensate for the noncompliance, or a letter disputing the alleged noncompliance.

(b) If the respondent does not respond to the complainant's notice within thirty (30) calendar days, then the respondent shall be considered out of compliance with this part and shall submit an explanation to the complainant of the measures the respondent will take to rectify or compensate for the noncompliance within thirty (30) calendar days. If the respondent fails to timely submit its explanation to the complainant, then the independent reviewer shall render a decision in favor of the complainant pursuant to the process described in subsections (c)–(e).

(c) The complainant may file a written request with the commissioner to submit the issue to an independent reviewer after the respondent responds with a letter disputing the notice or if the respondent does not timely respond to the complainant's notice as required under subsection (b). A complainant's request for independent review shall be filed within sixty (60) calendar days or after the thirty-day timeframe for the respondent's response has lapsed, whichever comes first. The complainant shall include a copy of the original notice submitted to the respondent with the request for review.

(d) Each health insurance entity shall contract with independent reviewers selected in accordance with subsection (h), and implement the following procedures to resolve any disputed compliance issue:

(1) The independent reviewer shall, within fourteen (14) calendar days of receipt of the request for review, request in writing that both the complainant and the respondent provide all information and documentation regarding the alleged noncompliance;

(2) The independent reviewer shall request the complainant and respondent to identify all information and documentation that has been submitted

by the complainant to the respondent regarding the alleged noncompliance, 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; and

(3) 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 request for review.

(e) The independent reviewer shall send the respondent, the complainant, and the commissioner a copy of the independent reviewer's decision. If the independent reviewer finds that the respondent was not in compliance with §§ 56-7-110 and 56-7-1013 and this part, then the independent reviewer's decision shall also include measures the respondent shall take to rectify or compensate the complainant for the noncompliance. The independent reviewer's decision shall designate the prevailing party.

(f) Within sixty (60) calendar days of the 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 but not yet paid to the other party. Any claim concerning the independent reviewer's decision not brought within sixty (60) calendar days of the 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, or any person assisting the independent reviewer in reaching a decision, shall be prohibited from testifying at the court proceeding considering the independent reviewer's decision. Unless the contract between the parties specifies otherwise, 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 nonprevailing party. For purposes of this subsection (f), "reasonable attorney's fees" means the number of hours reasonably expended on the dispute multiplied by a reasonable hourly rate, and shall not exceed ten percent (10%) of the total monetary amount in dispute or five hundred dollars (\$500), whichever amount is greater.

(g) The nonprevailing party shall pay the independent reviewer the required independent reviewer's fee within thirty (30) calendar days of receipt of the independent reviewer's decision. If a provider fails to properly pay the independent reviewer's fee to the independent reviewer, the commissioner may prohibit that provider from future participation in the independent review process and may permit the health insurance entity to collect the amount of the independent reviewer's fee from the provider's pending or future claims.

(h) The commissioner shall appoint a panel of five (5) persons, known as the selection panel for health insurance reviewers. The panel shall consist of two (2) provider representatives, one (1) representative from each of the two (2) health insurance entities with the largest number of covered Tennessee lives, and the commissioner or the commissioner's duly designated representative. The panel shall select a chair, and all decisions of the panel shall be made by a majority vote of the members of the panel. The panel shall select and identify an appropriate number of independent reviewers to be retained by each health insurance entity. The panel shall negotiate the rate of compensation for each independent reviewer, and the rate of compensation shall be the same for each independent reviewer. Each health insurance entity shall contract with each independent reviewer and agree to pay the rate of compensation negotiated by the panel. The members of the panel shall not be paid.

The panel shall meet at least twice a year. Each health insurance entity shall accurately publish the rate of compensation for the independent review process under this part on its provider web site.

(i) By no later than May 1 of each year, the commissioner shall publish a report that includes the number of requests for independent review filed for each health insurance entity during the prior calendar year. The commissioner shall also generally report the outcome of these independent review requests for each health insurance entity.

56-7-3309. Nothing in this part shall prohibit either a health insurance entity or a provider from terminating a contract for the provision or payment of healthcare services in accordance with mutually agreed-upon terms.

SECTION 3. Tennessee Code Annotated, Section 56-7-1013, is amended by deleting subsections (a), (b), and (c) and substituting the following language:

(a) As used in this section:

(1) "Fee schedule" shall have the same meaning as set forth in § 56-7-3301;

(2) "Healthcare provider" or "provider" shall have the same meaning as set forth in § 56-7-110(a); and

(3) "Health insurance entity" shall have the same meaning as set forth in § 56-7-109(a).

(b) Health insurance entities shall provide or make available to a healthcare provider, when contracting or renewing an existing contract with the provider, the payment or fee schedules and all other information sufficient to enable the healthcare provider to determine the manner and amount of payments under the contract for the healthcare provider's services prior to final execution or renewal of the contract. The payment or fee schedule and all other information submitted to a healthcare provider

pursuant to this section shall include a description of processes and factors that may be applicable and that may affect actual payment, including copayments, coinsurance, deductibles, risk-sharing arrangements, and liability of third parties. A health insurance entity, upon request of a healthcare provider, shall make available to the healthcare provider examples of actual payment for procedures frequently performed by the provider that involve combinations of services or payment codes, if the actual payment for the procedures cannot be ascertained from the fee schedule or other information submitted to a healthcare provider pursuant to this section.

(c) Health insurance entities shall provide a healthcare provider access, free of charge, to that provider's individual fee schedule in a format readily adaptable to the provider's practice management system by the following means:

(1) Maintaining the provider's fee schedule on a secure web site, so that the provider may access the fee schedule at any time throughout the term of the provider's contract with the health insurance entity;

(2) At the request of the provider, delivering the provider's fee schedule via electronic mail to an address stipulated in the provider's contract with the health insurance entity. The fee schedule shall be sent within ten (10) business days of the provider's request; or

(3) At the request of the provider, delivering the provider's fee schedule via U.S. mail. The health insurance entity may charge the provider a reasonable fee to mail the fee schedule. The fee schedule shall be sent within fifteen (15) business days of the provider's request.

(d) Health insurance entities shall provide notice of and identify any change to a provider's fee schedule at least ninety (90) days prior to the effective date of the change using the notice procedures in the healthcare provider's contract with the health insurance entity.

(e) Health insurance entities shall provide notice of and identify any changes described in § 56-7-3305(b)(1), (4), and (5) as soon as reasonably possible using the notice procedures in the healthcare provider's contract with the health insurance entity. The notice shall include a statement indicating that the changes identified are excluded from the ninety-day notice requirement in subsection (d).

(f) A health insurance entity shall not require any hospital, by contract, reimbursement, or otherwise, to notify the health insurance entity of a hospital inpatient admission within less than one (1) business day of the hospital inpatient admission if the notification or admission occurs on a weekend or federal holiday. Nothing in this subsection (f) shall affect the applicability or administration of other provisions of a contract between a hospital and a health insurance entity, including, but not limited to, preauthorization requirements for scheduled inpatient admissions.

(g) The health insurance entity shall stipulate in its contract with the healthcare provider the specific name or position and the address, either electronic or physical, to which the healthcare provider shall send any notices or requests contemplated or required by this section or under the parties' contract. The healthcare provider shall stipulate in its contract with the health insurance entity the individual, the specific name or position, and the address, either electronic or physical, to which the health insurance entity shall send any notices or requests contemplated or required by this section or under the parties' contract.

(h) The healthcare provider or the health insurance entity, as applicable, shall notify the other party within ten (10) business days of any change in the individual or address stipulated in the contract pursuant to subsection (g).

SECTION 4. Tennessee Code Annotated, Section 56-7-3302, is amended by deleting the section and substituting the following language:

(a) The health insurance entity shall maintain on its web site at all times, at a minimum, the following information:

(1) A detailed description and copy of coding guidelines, policies, methodologies, and processes, whether standard or nonstandard, including, but not limited to, any bundling, recoding, multiple services discounts, discounts applicable when multiple providers are involved in the same treatment or procedure, down-coding guidelines, policies, methodologies, and any other processes that would impact coverage or payment of items and services that the health insurance entity expects to apply to the claims the provider will submit;

(2) A description of any other applicable policies or procedures the health insurance entity may use that affect the payment of specific claims submitted by the provider, including, but not limited to, policies or procedures affecting recoupment, copayment, coinsurance, deductibles, risk arrangements, and the liability of third parties to the provider;

(3) Information that will enable the provider to determine what effect the application of claim edits and payment rules will have on payment prior to the provider's providing an item or service or submitting a claim; and

(4) Information that will enable the provider to determine:

(A) Each potential basis for the health insurance entity's claim denial, reduction, or delay;

(B) Any additional documentation needed by the health insurance entity that is necessary for payment; and

(C) Any patient data or act that is a precondition to claim payment.

(b) If the health insurance entity uses an information source outside of its control as a basis for determining the amount of payments to healthcare providers, such as

Medicare, the health insurance entity shall clearly identify the source and explain the procedure by which the provider may readily access the source electronically.

(c) The health insurance entity shall at all times maintain in an electronic format on its web site the payment rules and policies, including, at a specific code level where applicable, that it uses to pay claims submitted by healthcare providers, including, but not limited to:

- (1) Consolidation of multiple services or charges;
- (2) Payment adjustments due to coding changes;
- (3) Payment for multiple procedures;
- (4) Payment for assistant surgeons;
- (5) Payment for the administration of immunizations and injectable medications;
- (6) Recognition or nonrecognition of CPT code modifiers and the maximum number of modifiers that can be applied;
- (7) Definition of global surgery periods; and
- (8) Payment based on the relationship of procedure code to diagnosis code.

(d) The health insurance entity shall at all times maintain in an electronic format on its web site any methodology used to determine payment amounts under the provider's contract, including, but not limited to, any methodology using relative value system and conversion factor, percentage of amounts paid by the Medicare program, or a percentage of billed charges. If the methodology uses a relative value system, then information shall include:

- (1) The name of the relative value system;
- (2) The system's version, edition, or publication date;

(3) Any applicable conversion factor, geographic factor, or adjustment applied to that relative value system; and

(4) To the extent that payment is based in whole or in part on the Medicare Resource Based Relative Value System (RBRVS), the Medicare RBRVS year.

(e) The health insurance entity shall at all times maintain in an electronic format on its web site the publisher, product name, edition, and model version of the software the health insurance entity uses to edit claims submitted by the provider.

(f) Any denials, edits, or adjustments to a healthcare provider's payment based on any guideline, policy, procedure, methodology, or process required to be disclosed under this section, but not so disclosed, shall be void, and the provider's claims shall be re-adjudicated and paid without regard to the guideline, policy, procedure, methodology, or process.

SECTION 5. Tennessee Code Annotated, Section 56-7-110, is amended by deleting subsection (h) and substituting the following language:

(h)

(1) Any notice sent to a healthcare provider pursuant to subsection (g) regarding a recoupment or completed audit from a health insurance entity shall include a statement that the healthcare provider may request a copy of the policies or any other information listed in § 56-7-3302 that relate to and were in effect during the dates referenced in the recoupment or audit notice, within ten (10) business days of receipt of the notice. The notice shall be provided to the individual or address stipulated in the parties' contract pursuant to § 56-7-1013(g).

(2) The provider's request shall be made in writing to the individual or address of the health insurance entity either stipulated in the parties' contract or provided in the notice.

(3) The health insurance entity shall furnish or make available the payment policies within ten (10) business days after receiving the healthcare provider's written request.

(4) The provider shall have sixty (60) days to respond to a recoupment or audit notice. The sixty (60) days shall begin to run upon receipt of the notice or upon receipt of the requested payment policies, whichever is later.

SECTION 6. This act shall take effect January 1, 2016, and shall apply to all contracts, renewals, and amendments entered into by a healthcare provider and a health insurance entity on or after that date.