HOUSE SUBSTITUTE FOR

SENATE BILL NO. 938

A bill to amend 1939 PA 280, entitled

"The social welfare act,"

by amending sections 111a and 111b (MCL 400.111a and 400.111b), section 111a as amended by 1986 PA 227 and section 111b as amended by 1994 PA 74, and by adding section 111i.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 111a. (1) The director, after appropriate consultation with affected providers and the medical care advisory council established pursuant to federal regulations, may establish policies and procedures that he or she considers appropriate, relating to the conditions of participation and requirements for providers established by section 111b and to applicable federal law and regulations, to assure that the implementation and enforcement of state and federal laws are all of the following:

(a) Reasonable, fair, effective, and efficient.

(b) In conformance with law.

(c) In conformance with the state plan for medical assistance adopted pursuant to section 10 and approved by the United States department of health and human services.

(2) The consultation required by this section shall be conducted in accordance with guidelines adopted by the state department pursuant to section 24 of the administrative procedures act of 1969, ~~Act No. 306 of the Public Acts of 1969, being section 24.224 of the Michigan Compiled Laws~~ 1969 PA 306, MCL 24.224.

(3) ~~The~~ EXCEPT AS OTHERWISE PROVIDED IN SECTION 111I, THE director shall develop, after appropriate consultation with affected providers in accordance with guidelines, forms and instructions to be used in administering the program. Forms developed by the director shall be, to the extent administratively feasible, compatible with forms providers are required to file with 1 or more other third party payers or with 1 or more regulatory agencies and, to the extent administratively feasible, shall be designed to facilitate use of a single form to satisfy requirements imposed on providers by more than 1 payer, agency, or other entity. The forms and instructions shall relate, at a minimum, to standards of performance by providers, conditions of participation, methods of review of claims, and administrative requirements and procedures that the director considers reasonable and proper to assure all of the following:

(a) That claims against the program are timely, substantiated, and not false, misleading, or deceptive.

(b) That reimbursement is made for only medically appropriate services.

(c) That reimbursement is made for only covered services.

(d) That reimbursement is not made to those providers whose services, supplies, or equipment cost the program in excess of the reasonable value received.

(e) That the state is a prudent buyer.

(f) That access and availability of services to the medically indigent are reasonable.

(4) As used in subsection (3), "prudent buyer" means a purchaser who does 1 or more of the following:

(a) Buys from only those providers of services, supplies, or equipment to medically indigent individuals whose performance, in terms of quality, quantity, cost, setting, and location is appropriate to the specific needs of those individuals, and who, in the case of providers who receive payment on the basis of costs, comply with the prudent buyer concept of titles XVIII and XIX.

(b) Pays for only those services, supplies, or equipment that are needed or appropriate.

(c) Seeks to economize by minimizing cost.

(5) The director shall select providers to participate in arrangements such as case management, in supervision of services for recipients who misutilize or abuse the medical services program, and in special projects for the delivery of medical services to eligible recipients. Providers shall be selected based upon criteria that may include a comparison of services and related costs with those of the provider’s peers and a review of

previous participation warnings or sanctions undertaken against the provider or the provider's employer, employees, related business entities, or others who have a relationship to the provider, by the medicaid, medicare, or other health-related programs. The director may consult with the appropriate peer review advisory committees as appointed by the department.

(6) The director shall give notice to each provider of a change in a policy, procedure, form, or instruction established or developed pursuant to this section ~~which~~ THAT affects the provider. ~~In the case of~~ FOR a change ~~which~~ THAT affects 1 or more types of providers, a departmental bulletin or updating insert to a departmental manual mailed 30 days before the effective date of the change shall constitute sufficient notice.

(7) The director may do all of the following:

(a) Enroll in the program for medical assistance only a provider who has entered into an agreement of enrollment required by section 111b(4), and enter into an agreement only with a provider who satisfies the conditions of participation and requirements for a provider established by ~~section 111b~~ SECTIONS 111B AND 111I and the administrative requirements established or developed pursuant to subsections (1), (2), and (3) with the appropriate consultation required by this section.

(b) Enforce the requirements established pursuant to this act by applying the procedures of sections 111c to 111f. ~~When,~~ IF in these procedures the director is required to consult with professionals or experts ~~,~~ prior to first utilizing these individuals in the program, the director shall have given the

opportunity to review their professional credentials to the appropriate medicaid peer review advisory committee.

(c) ~~Develop,~~ EXCEPT AS OTHERWISE PROVIDED IN SECTION 111I, DEVELOP with the appropriate consultation required by this section ~~,~~ and require the form or format for claims, applications, certifications, or certifications and recertifications of medical necessity required by section 108, and develop specifications for and require supporting documentation that is compatible with the approved state medical assistance plan under title XIX.

(d) Recover payments to a provider in excess of the reimbursement to which the provider is entitled. The department shall have a priority lien on any assets of a provider for any overpayment, as a consequence of fraud or abuse, ~~which~~ THAT is not reimbursed to the department.

(e) Notwithstanding any other provisions of this act, before payment of claims, identify for examination for compliance with the program of medical assistance, including but not limited to medical necessity, the claims submitted by a particular provider based upon a determination that the provider's claims for disputed services exceed the average program dollar amount or volume of the same type of services, submitted by the same type of provider, performed in the same setting, and submitted during the same period. In order to carry out the authority conferred by this subdivision, the director shall notify the provider in the form of registered mail, receipted by the addressee, or by proof of service to the provider, or representative of the provider, of the state department's intent to impose specific conditions and

controls prior to authorizing payment for specific claims for services. The notice shall contain all of the following:

(*i*) A list of the particular practice or practices disputed by the state department and a factual description of the nature of the dispute.

(*ii*) A request for specific medical records and any other relevant supporting information that fully discloses the basis and extent to which the disputed practice or practices were rendered.

(*iii*) A date certain for an informal conference between the provider or representative of the provider and the state department to resolve the differences surrounding the disputed practice or practices.

(*iv*) A statement that unless the provider or representative of the provider demonstrates at the informal conference that the disputed practice or practices are medically necessary, or are in compliance with other program coverages, specific conditions and controls may be imposed on future payments for the disputed practice or practices, and claims may be rejected, beginning on the sixteenth day after delivery of this notice.

(8) For any provider who is subject to a notice of intent to impose specific conditions and controls prior to authorizing payment for specific claims for services, as specified in subsection (7)(e), the state department shall afford that provider an opportunity for an informal conference before the sixteenth day after delivery of the notice under subsection (7)(e). If the provider fails to appear at the conference, or fails to demonstrate that

the disputed practice or practices are medically necessary or are in compliance with program coverages, the state department beginning on the sixteenth day following receipt of notice by the provider, is authorized to impose specific conditions and controls prior to payment for the disputed practice or practices and may reject claims for payments for ~~such~~ THE practice or practices. The state department, within 5 days following the informal conference, shall notify the provider of its decision regarding the imposition of special conditions and controls prior to payment for the disputed practice or practices. Upon the imposition of specific conditions and controls prior to payment, the provider upon request shall be entitled to an immediate hearing held in conformity with chapter 4 and chapter 6 of the administrative procedures act of 1969, ~~Act No. 306 of the Public Acts of 1969, being sections 24.271 to 24.287 and 24.301 to 24.306 of the Michigan Compiled Laws~~ 1969 PA 306, MCL 24.271 TO 24.287 AND 24.301 TO 24.306, if any of the following occurs:

(a) The claim for services rendered is not paid within 30 days of the provider's compliance with the conditions imposed.

(b) The claim is rejected.

(c) The provider notifies the state department by registered mail that the provider does not intend to comply with the specific conditions and controls imposed, and the claim for services rendered is not paid within 30 days after delivery of this notice.

(9) The hearing provided for under subsection (8) shall be conducted in a prompt and expeditious manner. At the hearing, the provider may contest the state department's decision to impose specific conditions and controls prior to payment. Subsequent hearings may be conducted at the provider's request only if the claims have not been considered at a prior hearing and reflect issues that also have not been considered at a prior hearing, or if a claim for services rendered is not paid within 60 days after the provider's compliance with the conditions imposed.

(10) The authority conferred in subsection (8) with respect to the claims submitted by a particular provider does not prohibit the state department from examining claims or portions of claims before payment of the claims to determine their compliance with the program of medical assistance, in compliance with law. The director may take additional action pursuant to subsection (8) during the pendency of an appeal taken pursuant to subsection (8).

(11) If in the department's opinion, the provider shifts his or her claims from the disputed services addressed under subsection (7)(e) to other claims ~~which~~ THAT fall under the purview of subsection (7)(e), the director may impose the claims review process of this section immediately upon delivery of the notice of that imposition to the provider as provided in subsection (7)(e).

(12) If in the department's opinion, claims similar to the disputed services addressed under subsection (7)(e) are shifted

to another provider in the same corporation, partnership, clinic, provider group, or to another provider in the employ of the same employer or contractor, the director may impose the claims review process of this section immediately upon delivery of notice of that imposition to the new provider as provided in subsection (7)(e). The department shall afford the new provider an opportunity for an immediate informal conference within 7 days pursuant to subsection (8) after the initiation of the claims process.

(13) The director may request a provider to open books and records in accordance with section 111b(7) and may photocopy, at the state department's expense, the records of a medically indigent individual. The records shall be confidential, and the state department shall use the records only for purposes directly and specifically related to the administration of the program. The immunity from liability of a provider subject to the director's authority under this subsection ~~shall be~~ IS governed by section 111b(7).

(14) The director shall not pay for services, supplies, or equipment furnished by a provider, or shall recover for payment made, during a period in which the provider does not have on file with the state department disclosure forms as required by section 111b(19).

(15) The director shall make payments to, and collect overpayments from, the provider, unless the provider and the provider's employer satisfy the conditions prescribed in section 111b(25), (26), and (27), in which case the director may

make payments directly to, and collect overpayments from, the provider's employer.

(16) The director, with the appropriate consultation required by this section, may develop specifications for and require estimated cost and charge information to be submitted by a provider under section 111b(13) and the form or format for submission of the information.

(17) If the director decides that a payment under the program has been made to which a provider is not or may not be entitled, or that the amount of a payment is or may be greater or less than the amount to which the provider is entitled, the director, except as otherwise provided in this subsection or under other applicable law or regulation, shall promptly notify the provider of this decision. The director shall withhold notification to the provider of the decision upon advice from the department of attorney general or other state or federal enforcement agency in a case where action by the department of attorney general or other state or federal enforcement agency may be compromised by the notification. If the director notifies a provider of a decision that the provider has received an underpayment, the state department shall reimburse the provider, either directly or through an adjustment of payments, in the amount found to be due.

Sec. 111b. (1) As a condition of participation, a provider shall meet all of the requirements specified in this section except as provided in subsections (25), (26), and (27).

(2) A provider shall comply with all licensing and registration laws of this state applicable to the provider's practice or business. For a facility that is periodically inspected by a licensing authority, maintenance of licensure ~~shall constitute~~ CONSTITUTES compliance.

(3) A provider shall be certified, if the provider is of the type for which certification is required by title XVIII or XIX.

(4) A provider shall enter into an agreement of enrollment specified by the director.

(5) A provider who renders a reimbursable service described in section 109 to a medically indigent individual shall provide the individual with service of the same scope and quality as would be provided to the general public.

(6) A provider shall maintain records necessary to document fully the extent and cost of services, supplies, or equipment provided to a medically indigent individual and to substantiate each claim and, in accordance with professionally accepted standards, the medical necessity, appropriateness, and quality of service rendered for which a claim is made.

(7) Upon request and at a reasonable time and place, a provider shall make available any record required to be maintained by subsection (6) for examination and photocopying by authorized agents of the director, the department of attorney general, or federal authorities whose duties and functions are related to state programs of medical assistance under title XIX. If a provider releases records in response to a request by the director made pursuant to section 111a(13) or in compliance with this

subsection, that provider is not civilly liable in damages to a patient or to another provider to whom, respectively, the records relate solely, on account of the response or compliance.

(8) A provider shall retain each record required to be maintained by subsection (6) for a period of 6 years after the date of service. A provider who no longer personally retains the records due to death, retirement, change in ownership, or other reason, shall insure that a suitable person retains the records and provides access to the records as required in subsection (7).

(9) A provider shall require, as a condition of any contract with a person, sole proprietorship, clinic, group, partnership, corporation, association, or other entity, for the purpose of generating billings in the name of the provider or on behalf of the provider to the state department, that the person, partnership, corporation, or other entity, its representative, successor, or assignee, retain for not less than 6 years, copies of all documents used in the generation of billings, including the certifications required by subsection (17), and, if applicable, computer billing tapes when returned by the state department.

(10) A provider shall submit all claims for services rendered under the program on a form or in a format and with the supporting documentation specified and required by the director under section 111a(7)(c) AND BY THE COMMISSIONER OF INSURANCE UNDER SECTION 111I. Submission of a claim or claims for services rendered under the program does not establish in the provider a right to receive payment from the program.

(11) A provider shall submit initial claims for services rendered within 12 months after the date of service, or within a shorter period that the director may establish OR THAT THE COMMISSIONER OF INSURANCE MAY ESTABLISH UNDER SECTION 111I. The director shall not delegate the authority to establish a time period for submission of claims under this subsection. ~~The~~ EXCEPT AS OTHERWISE PROVIDED IN SECTION 111I, THE director, with the consultation required by section 111a, may prescribe the conditions under which a provider may qualify for a waiver of the time period established pursuant to this subsection with respect to a particular submission of a claim. ~~Liability shall not be imposed upon~~ NEITHER this state ~~or~~ NOR the medically indigent individual IS LIABLE for payment of claims submitted after the period established pursuant to this subsection.

(12) A provider shall not charge the state more for a service rendered to a medically indigent individual than the provider's customary charge to the general public or another third party payer for the same or similar service.

(13) A provider shall submit information on estimated costs and charges on a form or in a format and at times that the director may specify and require pursuant to section 111a(16).

(14) Except for copayment authorized by the state department and in conformance with applicable state and federal law, a provider shall accept payment from the state as payment in full by the medically indigent individual for services received. A provider shall not seek payment from the medically indigent

individual, the family, or representative of the individual for either of the following:

(a) Authorized services provided and reimbursed under the program.

(b) Services determined to be medically unnecessary in accordance with professionally accepted standards.

(15) A provider may seek payment from a medically indigent individual for services not covered nor reimbursed by the program if the individual elected to receive the services with the knowledge that the services would not be covered nor reimbursed under the program.

(16) A provider promptly shall notify the director of a payment received by the provider to which the provider is not entitled or ~~which~~ THAT exceeds the amount to which the provider is entitled. If the provider makes or should have made notification under this subsection or receives notification of overpayment under section 111a(17), the provider shall repay, return, restore, or reimburse, either directly or through adjustment of payments, the overpayment in the manner required by the director. Failure to repay, return, restore, or reimburse the overpayment or a consistent pattern of failure to notify the director shall constitute a conversion of the money by the provider.

(17) As a condition of payment for services rendered to a medically indigent individual, a provider shall certify that a claim for payment is true, accurate, prepared with the knowledge and consent of the provider, and does not contain untrue,

misleading, or deceptive information. A provider ~~shall be~~ IS responsible for the ongoing supervision of an agent, officer, or employee who prepares or submits the provider's claims. A provider's certification required under this subsection shall be prima facie evidence that the provider knows that the claim or claims are true, accurate, prepared with his or her knowledge and consent, do not contain misleading or deceptive information, and are filed in compliance with the policies, procedures, and instructions, and on the forms established or developed pursuant to this act. Certification shall be made in the following manner:

(a) For an invoice or other prescribed form submitted directly to the state department by the provider in claim for payment for the provision of services, by an indelible mark made by hand, mechanical or electronic device, stamp, or other means by the provider, or an agent, officer, or employee of the provider.

(b) For an invoice or other form submitted in claim for payment for the provision of services submitted indirectly by the provider to the state department through a person, sole proprietorship, clinic, group, partnership, corporation, association, or other entity that generates and files claims on a provider's behalf, by the indelible written name of the provider on a certification form developed by the director for submission to the state department with each group of invoices or forms in claim for payment. The certification form shall indicate the name of

the person, if other than the provider, who signed the provider's name.

(c) For a warrant issued in payment of a claim submitted by a provider, by the handwritten indelible signature of the payee, if the payee is a natural person; by the handwritten indelible signature of an officer, if the payee is a corporation; or by handwritten indelible signature of a partner, if the payee is a partnership.

(18) A provider shall comply with all requirements established under section 111a(1), (2), and (3).

(19) A provider shall file with the state department, on disclosure forms provided by the director, a complete and truthful statement of all of the following:

(a) The identity of each individual having, directly or indirectly, an ownership or beneficial interest in a partnership, corporation, organization, or other legal entity, except a company registered pursuant to the securities exchange act of 1934, chapter 404, 48 Stat. 881, through which the provider engages in practice or does business related to claims or charges against the program. This subdivision does not apply to a health facility or agency that is required to comply with and has complied with the disclosure requirements of section 20142(3) of the public health code, ~~Act No. 368 of the Public Acts of 1978, being section 333.20142 of the Michigan Compiled Laws~~ 1978 PA 368, MCL 333.20142. With respect to a company registered pursuant to the securities exchange act of 1934, CHAPTER 404, 48 STAT. 881, a provider shall disclose the identity of each

individual having, directly or indirectly, separately or in combination, a 5% or greater ownership or beneficial interest.

(b) The identity of each partnership, corporation, organization, legal entity, or other affiliate whose practice or business is related to a claim or charge against the program in which the provider has, directly or indirectly, an ownership or beneficial interest, trust agreement, or a general or perfected security interest. This subdivision does not apply to a health facility or agency that is required to comply with and has complied with the disclosure requirements of section 20142(4) of the public health code, ~~Act No. 368 of the Public Acts of 1978, being section 333.20142 of the Michigan Compiled Laws~~ 1978 PA 368, MCL 333.20142.

(c) If applicable to the provider, a copy of a disclosure form identifying ownership and controlling interests submitted to the United States department of health and human services in fulfillment of a condition of participation in programs established pursuant to title V, XVIII, XIX, and XX. To the extent that information disclosed on this form duplicates information required to be filed under subdivision (a) or (b), filing a copy of the form shall satisfy the requirements under those subdivisions.

(20) If requested by the director, a provider shall supply complete and truthful information as to his or her professional qualifications and training, and his or her licensure in each jurisdiction in which the provider is licensed or authorized to practice.

(21) In the interest of review and control of utilization of services, a provider shall identify each attending, referring, or prescribing physician, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim submitted to the state department.

(22) It is the obligation of a provider to assure that services, supplies, or equipment provided to, ordered, or prescribed on behalf of a medically indigent individual by that provider will meet professionally accepted standards for the medical necessity, appropriateness, and quality of health care.

(23) If any service, supply, or equipment provided directly by a provider, or any service, supply, or equipment prescribed or ordered by a provider and delivered by someone other than that provider, is determined not to be medically necessary, not appropriate, or not otherwise in accordance with medical assistance program coverages, the provider who directly provided, ordered, or prescribed the service, supply, or equipment shall be responsible for direct and complete repayment of any program payment made to the provider or to any other person for that service, supply, or equipment. Services, supplies, or equipment provided by a consulting provider based upon his or her independent evaluation or assessment of the recipient’s needs is the responsibility of the consulting provider. This subsection does not apply to the repayment by a provider who has ordered a nursing home or hospital admission of the service billed by and reimbursed to a nursing home or hospital. This section also does not apply to a nursing home or hospital unless the nursing home or hospital

acted on its own initiative in providing the service, supply, or equipment as opposed to following the order or prescription of another.

(24) A provider shall satisfy or make acceptable arrangement to satisfy all previous adjudicated program liabilities including those adjudicated pursuant to section 111c or established by agreement between the department and the provider, and restitution ordered by a court. As used in this subsection, provider includes, but is not limited to, the provider, the provider's corporation, partnership, business associates, employees, clinic, laboratory, provider group, or successors and assignees. For a nursing home or hospital, "business associates", as used in this subsection, means those persons whose identity is required to be disclosed pursuant to section 20142(3) of the public health code, ~~Act No. 368 of the Public Acts of 1978, being section 333.20142 of the Michigan Compiled Laws~~ 1978 PA 368, MCL 333.20142.

(25) A provider who is a physician, dentist, or other individual practitioner shall file with the state department a complete and factual disclosure of the identity of each employer or contractor to whom the provider is required to submit, in whole or in part, payment for services provided to a medically indigent individual as a condition of the provider's agreement of employment or other agreement. A provider who has properly disclosed the required information by filing a form or forms has 30 business days in which to report changes in the list of identified individuals and entities. The disclosure required by this

subsection may serve as the provider's authorization for the department to make direct payments to the employer.

(26) As a condition of receiving payment for services rendered to a medically indigent individual, a provider may enter, as an employee, into agreements of employment of the type described in subsection (25) only with an employer who has entered into an agreement as described in subsection (27).

(27) An employer described in subsection (25) shall enter into an agreement on a form prescribed by the department, in which, as a condition of directly receiving payment for services provided by its employee provider to a medically indigent individual, the employer agrees to all of the following:

(a) To require as a condition of employment that the employee provider submit, in whole or in part, payments received for services provided to medically indigent individuals.

(b) To advise the department within 30 days after any changes in the employment relationship.

(c) To comply with the conditions of participation established by this subsection and subsections (6) to (19), and (21).

(d) To agree to be jointly and severally responsible with the employee provider for any overpayments resulting from the department's direct payment under this section.

(e) To agree that disputed claims relative to overpayments shall be adjudicated in administrative proceedings convened pursuant to section 111c.

(28) If a provider who is a nursing home intends to withdraw from participation in the title XIX program, the provider shall

notify the department in writing. However, the provider shall continue to participate in the title XIX program for each patient who was admitted to the nursing home before the date notice is given under this subsection and who is or may become eligible to receive medical assistance under this act.

SEC. 111I. (1) THE COMMISSIONER OF [OFFICE OF FINANCIAL AND INSURANCE SERVICES] SHALL ESTABLISH A TIMELY CLAIMS PROCESSING AND PAYMENT PROCEDURE TO BE USED BY HEALTH PROFESSIONALS AND FACILITIES IN BILLING FOR, AND QUALIFIED HEALTH PLANS IN PROCESSING AND PAYING CLAIMS FOR, MEDICAID SERVICES RENDERED. THE COMMISSIONER SHALL CONSULT WITH THE DEPARTMENT OF COMMUNITY HEALTH, HEALTH PROFESSIONALS AND FACILITIES, AND QUALIFIED HEALTH PLANS IN ESTABLISHING THIS TIMELY PAYMENT PROCEDURE.

(2) THE TIMELY CLAIMS PROCESSING AND PAYMENT PROCEDURE ESTABLISHED BY THE COMMISSIONER UNDER SUBSECTION (1) SHALL PROVIDE FOR ALL OF THE FOLLOWING:

(A) THAT A "CLEAN CLAIM", FOR THE PURPOSES OF THIS SECTION, MEANS A CLAIM THAT DOES AT A MINIMUM ALL OF THE FOLLOWING:

(*i*) IDENTIFIES THE HEALTH PROFESSIONAL OR HEALTH FACILITY THAT PROVIDED TREATMENT OR SERVICE, INCLUDING A MATCHING IDENTIFYING NUMBER.

(*ii*) IDENTIFIES THE PATIENT AND PLAN.

(*iii*) LISTS THE DATE AND PLACE OF SERVICE.

(*iv*) IS FOR COVERED SERVICES.

(*v*) IS CERTIFIED PURSUANT TO SECTION 111B(17) AND HAS THE IDENTIFYING INFORMATION REQUIRED UNDER SECTION 111B(21).

(*vi*) IF NECESSARY, SUBSTANTIATES THE MEDICAL NECESSITY AND APPROPRIATENESS OF THE CARE OR SERVICE PROVIDED.

(*vii*) IF PRIOR AUTHORIZATION IS REQUIRED FOR CERTAIN PATIENT CARE OR SERVICES, INCLUDES ANY APPLICABLE AUTHORIZATION NUMBER, AS APPROPRIATE.

(*viii*) INCLUDES ADDITIONAL DOCUMENTATION BASED UPON SERVICES RENDERED AS REASONABLY REQUIRED BY THE PAYER.

(B) A UNIVERSAL SYSTEM OF CODING TO BE USED ON ALL MEDICAID CLAIMS SUBMITTED TO QUALIFIED HEALTH PLANS.

(C) THAT A CLAIM MUST BE TRANSMITTED ELECTRONICALLY OR AS OTHERWISE SPECIFIED BY THE COMMISSIONER AND A QUALIFIED HEALTH PLAN MUST BE ABLE TO RECEIVE A CLAIM TRANSMITTED ELECTRONICALLY.

[(D) THAT A HEALTH PROFESSIONAL AND FACILITY MUST BILL A QUALIFIED HEALTH PLAN WITHIN 1 YEAR AFTER THE DATE OF SERVICE OR DATE OF DISCHARGE FROM THE HEALTH FACILITY.

(E) THAT AFTER A HEALTH PROFESSIONAL OR FACILITY HAS SUBMITTED A CLAIM TO A QUALIFIED HEALTH PLAN, THE HEALTH PROFESSIONAL OR FACILITY SHALL NOT RESUBMIT THE SAME CLAIM TO THE QUALIFIED HEALTH PLAN UNLESS THE TIME FRAME IN SUBDIVISION (F) HAS PASSED OR AS PROVIDED IN SUBDIVISION (H).

(F) EXCEPT AS OTHERWISE PROVIDED IN THIS SUBDIVISION, THAT A CLEAN CLAIM MUST BE PAID WITHIN 45 DAYS AFTER RECEIPT OF THE CLAIM BY THE QUALIFIED HEALTH PLAN. FOR A PHARMACEUTICAL CLEAN CLAIM, THE CLEAN CLAIM MUST BE PAID WITHIN THE INDUSTRY STANDARD TIME FRAME FOR PAYING THE CLAIM AS OF THE EFFECTIVE DATE OF THIS SUBDIVISION OR WITHIN 45 DAYS AFTER RECEIPT OF THE CLAIM BY THE QUALIFIED HEALTH PLAN, WHICHEVER IS SOONER. A CLEAN CLAIM THAT IS NOT PAID WITHIN THIS TIME FRAME SHALL BEAR SIMPLE INTEREST AT A RATE OF 12% PER ANNUM.]

[(G)] THAT A QUALIFIED HEALTH PLAN MUST STATE IN WRITING TO THE HEALTH PROFESSIONAL OR FACILITY ANY DEFECT IN THE CLAIM WITHIN 30 DAYS AFTER RECEIPT OF THE CLAIM.

[(H)] THAT A HEALTH PROFESSIONAL AND A HEALTH FACILITY HAVE 30 DAYS AFTER RECEIPT OF A NOTICE THAT A CLAIM OR A PORTION OF A CLAIM IS DEFECTIVE WITHIN WHICH TO CORRECT THE DEFECT. THE QUALIFIED HEALTH PLAN SHALL PAY THE CLAIM WITHIN [30] DAYS AFTER THE DEFECT IS CORRECTED.

[(I)] THAT A QUALIFIED HEALTH PLAN MUST NOTIFY THE HEALTH PROFESSIONAL OR FACILITY AND THE COMMISSIONER OF THE DEFECT IF A CLAIM OR A PORTION OF A CLAIM IS RETURNED FROM A HEALTH PROFESSIONAL OR FACILITY UNDER SUBDIVISION [(H)] AND REMAINS DEFECTIVE FOR THE ORIGINAL REASON OR A NEW REASON.

[(J)] AN EXTERNAL REVIEW PROCEDURE FOR ADVERSE DETERMINATIONS OF PAYMENT AS PROVIDED IN SUBSECTIONS (4) AND (5). THE COSTS FOR THE EXTERNAL REVIEW PROCEDURE SHALL BE ASSESSED AS DETERMINED BY THE COMMISSIONER.

[(K)] PENALTIES TO BE APPLIED TO HEALTH PROFESSIONALS, HEALTH FACILITIES, AND QUALIFIED HEALTH PLANS FOR FAILING TO ADHERE TO THE TIMELY CLAIMS PROCESSING AND PAYMENT PROCEDURE ESTABLISHED UNDER THIS SECTION.

[(L)] A SYSTEM FOR NOTIFYING THE LICENSING ENTITY FOR HEALTH MAINTENANCE ORGANIZATIONS, QUALIFIED HEALTH PLANS, AND OTHER HEALTH CARE INSURERS IF A PENALTY IS INCURRED UNDER SUBDIVISION [(K)].

(3) IF A QUALIFIED HEALTH PLAN DETERMINES THAT 1 OR MORE COVERED SERVICES LISTED ON A CLAIM ARE PAYABLE, THE QUALIFIED HEALTH PLAN SHALL PAY FOR THOSE SERVICES AND SHALL NOT DENY THE ENTIRE CLAIM BECAUSE 1 OR MORE OTHER COVERED SERVICES LISTED ON THE CLAIM ARE DEFECTIVE [OR BECAUSE 1 OR MORE OTHER SERVICES LISTED ON THE CLAIM ARE NOT COVERED SERVICES].

(4) THE COMMISSIONER SHALL ESTABLISH AN EXTERNAL REVIEW PROCEDURE AS PROVIDED IN THIS SUBSECTION AND SUBSECTION (5). A HEALTH PROFESSIONAL OR FACILITY MAY REQUEST AN EXTERNAL REVIEW BY THE COMMISSIONER OF A QUALIFIED HEALTH PLAN'S ADVERSE DETERMINATION IF THE HEALTH PROFESSIONAL OR FACILITY MAKES THE REQUEST NOT LATER THAN 30 DAYS AFTER RECEIPT OF A NOTICE UNDER SUBSECTION [(2)(I)]. WITHIN 10 DAYS AFTER A REQUEST FOR AN EXTERNAL REVIEW, THE COMMISSIONER SHALL COMPLETE A PRELIMINARY REVIEW TO DETERMINE WHETHER THE EXTERNAL REVIEW MAY PROCEED OR REQUEST MORE INFORMATION FROM THE HEALTH PROFESSIONAL, FACILITY, OR THE QUALIFIED HEALTH PLAN. THE HEALTH PROFESSIONAL, FACILITY, OR THE QUALIFIED HEALTH PLAN SHALL SUPPLY THE COMMISSIONER WITH THE REQUESTED INFORMATION NOT LATER THAN 10 BUSINESS DAYS AFTER RECEIPT OF THE REQUEST FOR INFORMATION FROM THE COMMISSIONER. NOT LATER THAN 5 BUSINESS DAYS AFTER RECEIPT OF ANY INFORMATION REQUESTED BY THE COMMISSIONER, THE COMMISSIONER SHALL COMPLETE A PRELIMINARY REVIEW TO DETERMINE WHETHER THE EXTERNAL REVIEW MAY PROCEED. IF THE COMMISSIONER DETERMINES THE EXTERNAL REVIEW MAY NOT PROCEED, THE COMMISSIONER SHALL NOTIFY IN WRITING THE HEALTH PROFESSIONAL OR FACILITY OF THE SPECIFIC REASONS FOR THE DETERMINATION AND MAY PERMIT THE HEALTH PROFESSIONAL OR FACILITY TO REAPPLY FOR A PRELIMINARY REVIEW BY THE COMMISSIONER. IF THE COMMISSIONER DETERMINES THE EXTERNAL REVIEW MAY PROCEED, THE COMMISSIONER SHALL NOTIFY IN WRITING THE HEALTH PROFESSIONAL OR FACILITY AND THE QUALIFIED HEALTH PLAN AND SHALL REQUIRE THE QUALIFIED HEALTH PLAN TO PROVIDE NOT LATER THAN 7 BUSINESS DAYS AFTER THE NOTICE ANY INFORMATION USED BY THE QUALIFIED HEALTH

PLAN IN MAKING THE ADVERSE DETERMINATION. FAILURE BY A HEALTH PROFESSIONAL OR FACILITY OR QUALIFIED HEALTH PLAN TO PROVIDE THE COMMISSIONER WITH REQUESTED INFORMATION PERMITS THE COMMISSIONER TO TERMINATE A REVIEW AND ISSUE A DECISION REVERSING OR AFFIRMING AN ADVERSE DETERMINATION.

(5) IF THE COMMISSIONER DETERMINES THAT AN EXTERNAL REVIEW MAY PROCEED, THE COMMISSIONER SHALL IMMEDIATELY ASSIGN AN INDEPENDENT REVIEW ORGANIZATION TO CONDUCT THE EXTERNAL REVIEW. ONLY AN INDEPENDENT REVIEW ORGANIZATION MEETING QUALIFICATIONS ESTABLISHED BY THE COMMISSIONER SHALL BE ASSIGNED TO CONDUCT AN EXTERNAL REVIEW. THE INDEPENDENT REVIEW ORGANIZATION MAY REQUEST THE HEALTH PROFESSIONAL OR FACILITY AND THE QUALIFIED HEALTH PLAN TO PROVIDE INFORMATION AND SHALL REVIEW ALL PERTINENT INFORMATION SUBMITTED BY THE HEALTH PROFESSIONAL OR FACILITY AND THE QUALIFIED HEALTH PLAN ALONG WITH THE TERMS OF COVERAGE UNDER THE MEDICAID PLAN. THE INDEPENDENT REVIEW ORGANIZATION SHALL MAKE A WRITTEN RECOMMENDATION THAT INCLUDES THE RATIONALE AND SUPPORTING DOCUMENTATION AND ANY RECOMMENDATION FOR AN ASSESSMENT OF INTEREST TO THE COMMISSIONER NOT LATER THAN 30 DAYS AFTER BEING ASSIGNED AS THE REVIEW ORGANIZATION. THE COMMISSIONER SHALL NOTIFY IN WRITING THE HEALTH PROFESSIONAL OR FACILITY AND THE QUALIFIED HEALTH PLAN OF HIS OR HER DECISION REVERSING OR AFFIRMING THE QUALIFIED HEALTH PLAN’S ADVERSE DETERMINATION AND SHALL INCLUDE THE PRINCIPAL REASONS FOR THE DECISION NOT LATER THAN 15 DAYS AFTER RECEIPT OF THE ASSIGNED INDEPENDENT REVIEW ORGANIZATION’S RECOMMENDATION. IF AN ADVERSE DETERMINATION IS

REVERSED, THE QUALIFIED HEALTH PLAN SHALL IMMEDIATELY PAY THE CLAIM AND ANY INTEREST ASSESSED BY THE COMMISSIONER.

(6) [BEGINNING NOT LATER THAN OCTOBER 1, 2000 AND CONTINUING THEREAFTER,] THE DEPARTMENT OF COMMUNITY HEALTH SHALL NOT ENTER INTO OR RENEW A CONTRACT WITH A QUALIFIED HEALTH PLAN UNLESS THE QUALIFIED HEALTH PLAN AGREES TO FOLLOW THE TIMELY CLAIMS PROCESSING AND PAYMENT PROCEDURE ESTABLISHED UNDER THIS SECTION AND REQUIRES HEALTH PROFESSIONALS AND FACILITIES UNDER CONTRACT WITH THE QUALIFIED HEALTH PLAN TO FOLLOW THE TIMELY CLAIMS PROCESSING AND PAYMENT PROCEDURE ESTABLISHED UNDER THIS SECTION. THE DEPARTMENT OF COMMUNITY HEALTH SHALL NOT ENTER INTO OR RENEW A CONTRACT WITH A QUALIFIED HEALTH PLAN UNLESS THE COMMISSIONER DETERMINES THAT THE QUALIFIED HEALTH PLAN SATISFIES ALL OF THE FOLLOWING:

(A) IS A HEALTH MAINTENANCE ORGANIZATION LICENSED OR ISSUED A CERTIFICATE OF AUTHORITY IN THIS STATE.

(B) USES STANDARDIZED CLAIMS AS OUTLINED IN THE PROVIDER CONTRACT AND ACCEPTS CLAIMS SUBMITTED ELECTRONICALLY IN A GENERALLY ACCEPTED FORMAT.

(C) DEMONSTRATES THE ABILITY TO PROVIDE ALL REQUIRED OR COVERED MEDICAID SERVICES INCLUDING COVERED SPECIALTY CARE TO THE ESTIMATED NUMBER OF ENROLLEES ON A REGIONAL BASIS.

(D) MEETS THE CRITERIA FOR DELIVERING THE COMPREHENSIVE PACKAGE OF SERVICES UNDER THE DEPARTMENT OF COMMUNITY HEALTH'S COMPREHENSIVE HEALTH PLAN.

(7) THE COMMISSIONER SHALL REPORT TO THE SENATE AND HOUSE OF REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEES ON COMMUNITY HEALTH

BY OCTOBER 1, 2001 ON THE TIMELY CLAIMS PROCESSING AND PAYMENT PROCEDURE ESTABLISHED UNDER THIS SECTION.

(8) IT IS NOT A FRAUDULENT ACT FOR A HEALTH PROFESSIONAL OR FACILITY TO SUBMIT A CLAIM UNDER THIS SECTION THAT INCLUDES 1 OR MORE RENDERED SERVICES THAT ARE DETERMINED NOT COVERED SERVICES.

(9) AS USED IN THIS SECTION:

(A) "MEDICAID" MEANS THE PROGRAM OF MEDICAL ASSISTANCE ESTABLISHED UNDER SECTION 105.

(B) "QUALIFIED HEALTH PLAN" MEANS, AT A MINIMUM, AN ORGANIZATION THAT MEETS THE CRITERIA FOR DELIVERING THE COMPREHENSIVE PACKAGE OF SERVICES UNDER THE DEPARTMENT OF COMMUNITY HEALTH'S COMPREHENSIVE HEALTH PLAN.