House _____ **Amendment NO.**____

Offered By

_____ _____

AMEND House Committee Substitute for Senate Substitute for Senate Bill No. 580, Page 68, Section 338.200, Line 41, by inserting after all of said section and line the following:

"376.383. 1. For purposes of this section and section 376.384, the following terms shall mean:

(1) "Claimant", any individual, corporation, association, partnership or other legal entity asserting a right to payment arising out of a contract or a contingency or loss covered under a health benefit plan as defined in section 376.1350;

(2) "Clean claim", a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment;

(3) "Deny" or "denial", when the health carrier refuses to reimburse all or part of the claim;

(4) "Health care provider", health care provider as defined in section 376.1350;

(5) "Health care services", health care services as defined in section 376.1350;

(6) "Health carrier", health carrier as defined in section 376.1350 and any self-insured health plan, to the extent allowed by federal law; except that health carrier shall not include a workers' compensation carrier providing benefits to an employee pursuant to chapter 287. For the purposes of this section and section 376.384, third-party contractors are health carriers;

(7) "Processing days", number of days the health carrier or any of its agents, subsidiaries, contractors, subcontractors, or third-party contractors has the claim in its possession. Processing days shall not include days in which the health carrier is waiting for a response to a request for additional information from the claimant;

(8) "Request for additional information", a health carrier's electronic or facsimile request for additional information from the claimant specifying all of the documentation or information necessary to process all of the claim, or all of the claim on a multi-claim form, as a clean claim for payment;

(9) "Third-party contractor", a third party contracted with the health carrier to receive or process claims for reimbursement of health care services.

2. Within forty-eight hours after receipt of an electronically filed claim by a health carrier or a third-party contractor, a health carrier shall send an electronic acknowledgment of the date of receipt.

3. Within thirty processing days after receipt of a filed claim by a health carrier or a third-party contractor, a health carrier shall send an electronic or facsimile notice of the status of the claim that notifies the claimant:

(1) Whether the claim is a clean claim as defined under this section; or

(2) The claim requires additional information from the claimant.

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If the claim is a clean claim, then the health carrier shall pay or deny the claim. If the claim requires additional information, the health carrier shall include in the notice a request for additional information. If a health carrier pays the claim, this subsection shall not apply.

4. Within ten processing days after receipt of additional information by a health carrier or a third-party contractor, a health carrier shall pay the claim or any undisputed part of the claim in accordance with this section or send an electronic or facsimile notice of receipt and status of the claim:

(1) That denies all or part of the claim and specifies each reason for denial; or

(2) That makes a final request for additional information.

5. Within five processing days after the day on which the health carrier or a third-party contractor receives the additional requested information in response to a final request for information, it shall pay the claim or any undisputed part of the claim or deny the claim.

6. If the health carrier has not paid the claimant on or before the forty-fifth processing day from the date of receipt of the claim, the health carrier shall pay the claimant one percent interest per month and a penalty in an amount equal to one percent of the claim per day. The interest and penalty shall be calculated based upon the unpaid balance of the claim as of the forty-fifth processing day. On claims where the amount owed by the health carrier exceeds thirty five thousand dollars on the unpaid balance of a claim, the health carrier shall pay the claimant one percent interest per month and a penalty in an amount equal to one percent of the claim per day for a maximum of one-hundred days, and thereafter shall pay the claimant two percent interest per month. The interest and penalty paid pursuant to this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest and penalty. A health carrier may combine interest payments and make payment once the aggregate amount reaches one hundred dollars. Any claim or portion of a claim which has been properly denied before the forty-fifth processing day under this section and section 376.384 shall not be subject to interest or penalties. For a claim or any portion of such claim that was denied before the forty-fifth processing day, interest and penalties shall begin to accrue beginning on the day the first appeal is filed by the claimant with the health carrier until such claim is paid if the claim or portion of the claim is approved. If any appeal filed with the health carrier does not result in the disputed claim or portion of such claim being approved for payment to the claimant, and a petition is filed in a court of competent jurisdiction to recover payment of all or part of such claim, interest and penalties shall continue to accrue for no more than one hundred days from the day the first appeal was filed by the claimant with the health carrier, and such interest and penalties shall [~~cease to~~] continue to accrue [~~on the day~~] ten days after [~~a petition is filed in~~] a court of competent jurisdiction [~~to recover payment of such claim~~] finds that the claim or portion of the claim shall be paid to the claimant. Upon a finding by a court of competent jurisdiction that the health carrier failed to pay a claim, interest, or penalty without good cause, the court shall enter judgment for reasonable attorney fees for services necessary for recovery. Upon a finding that a health care provider filed suit without reasonable grounds to recover a claim, the court shall award the health carrier reasonable attorney fees necessary to the defense.

7. The department of commerce and insurance shall monitor denials and determine whether the health carrier acted reasonably.

8. If a health carrier or third-party contractor has reasonable grounds to believe that a fraudulent claim is being made, the health carrier or third-party contractor shall notify the department of commerce and insurance of the fraudulent claim pursuant to sections 375.991 to 375.994.

9. Denial of a claim shall be communicated to the claimant and shall include the specific reason why the claim was denied. Any claim for which the health carrier has not communicated a

specific reason for the denial shall not be considered denied under this section or section 376.384.

10. Requests for additional information shall specify all of the documentation and additional information that is necessary to process all of the claim, or all of the claims on a multi-claim form, as a clean claim for payment. Information requested shall be reasonable and pertain solely to the health carrier's liability. The health carrier shall acknowledge receipt of the requested additional information to the claimant within five calendar days or pay the claim."; and

Further amend said bill, Page 71, Section 376.1345, Line 29, by inserting after all of said section and line the following:

"376.1578. 1. Within two working days after receipt of a [~~faxed or mailed completed~~] credentialing application, the health carrier shall send a notice of receipt to the practitioner. A health carrier shall provide access to a provider web portal that allows the practitioner to receive notice of the status of an electronically submitted application.

2. If a health carrier determines the application is not a completed application the health carrier shall have ten days from the date of the notice of receipt in subsection 1 of this section to request any additional information from the practitioner. The application shall be considered a completed application upon receipt of the requested additional information from the practitioner. Within two working days of receipt of the requested additional information, the health carrier shall send a notice to the practitioner informing them that they have submitted a completed application. If the health carrier does not request additional information, the application shall be deemed completed as of the date of the notice of receipt required by subsection 1 of this section.

3. A health carrier shall assess a health care practitioner's completed credentialing [~~information~~] application and make a decision as to whether to approve or deny the practitioner's credentialing application and notify the practitioner of such decision within sixty [~~business~~]days of the date of receipt of the completed application. The sixty-day deadline established in this section shall not apply if the application or subsequent verification of information indicates that the practitioner has:

(1) A history of behavioral disorders or other impairments affecting the practitioner's ability to practice, including but not limited to substance abuse;

(2) Licensure disciplinary actions against the practitioner's license to practice imposed by any state or territory or foreign jurisdiction;

(3) Had the practitioner's hospital admitting or surgical privileges or other organizational credentials or authority to practice revoked, restricted, or suspended based on the practitioner's clinical performance; or

(4) A judgment or judicial award against the practitioner arising from a medical malpractice liability lawsuit.

4. If a practitioner's application is approved, the health carrier shall provide payments for covered health services performed by the practitioner during the credentialing period if the provision of services were on behalf of an entity that had a contract with such health carrier during the Credentialing Period. The contracted entity for whom the practitioner is providing services shall submit to the health carrier all claims for services provided by such practitioner during the credentialing period, within six months after the health carrier has approved that practitioner's credentialing application. Claims submitted for reimbursement under this section shall be sent to the carrier by the provider in a single request or as few requests as practical subject to any technical constraints or other issues out of the contracted provider's control. "Credentialing Period" shall mean the time between the date the practitioner submits a completed application to the health carrier to be credentialed and the date the practitioner's credentialing is approved by the health carrier.

5. A health carrier shall not require a practitioner to be credentialed in order to receive

payments for covered health services if the practitioner is providing coverage for an absent credentialed practitioner during a temporary period of time not to exceed sixty days. Any practitioner authorized to receive payments for covered services under this section shall provide notice to the health carrier, including but not limited to name, medical license information, estimated duration of absence, and practitioner's name and medical license information providing coverage for such absent credentialed practitioner. A health carrier may deny payments if the practitioner providing services in lieu of the credentialed provider meets one of the conditions in subdivisions 1 to 4 in subsection 3 of this section.

6. For the purposes of this section "covered health services" shall mean any services provided by a practitioner that would otherwise be covered if provided by a credentialed provider.

7. All claims eligible for payment as described in subsections 4 and 5 of this section shall be subject to section 376.383.

[~~3~~] 8. The department of commerce and insurance shall establish a mechanism for reporting alleged violations of this section to the department."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.