by the transit provider as an authorized transit provider under this section.

Sec. 5. **EFFECTIVE DATE.**

This act is effective the day following final enactment.

Presented to the governor May 18, 2004

Signed by the governor May 26, 2004, 9:50 p.m.

CHAPTER 246—H.F.No. 606

An act relating to health; modifying prior authorization requirements for health care services; establishing requirements for provider contracting; modifying provisions for payment of claims; amending Minnesota Statutes 2002, sections 62M.07; 62Q.74; 62Q.75, subdivision 2; proposing coding for new law in Minnesota Statutes, chapter 62Q; repealing Minnesota Statutes 2002, section 62Q.745.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2002, section 62M.07, is amended to read:

62M.07 **PRIOR AUTHORIZATION OF SERVICES.**

(a) Utilization review organizations conducting prior authorization of services must have written standards that meet at a minimum the following requirements:

(1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;

(2) a system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures under clause (4);

(3) compliance with section 62M.05, subdivisions 3a and 3b, regarding time frames for approving and disapproving prior authorization requests;

(4) written procedures for appeals of denials of prior authorization which specify the responsibilities of the enrollee and provider, and which meet the requirements of sections 62M.06 and 72A.285, regarding release of summary review findings; and

(5) procedures to ensure confidentiality of patient-specific information, consistent with applicable law.

(b) No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or emergency treatment. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon after the beginning of the emergency confinement or emergency treatment as reasonably possible.

(c) If prior authorization for a health care service is required, the utilization review organization, health plan company, or claim administrator must allow providers to submit requests for prior authorization of the health care services without unreasonable delay by telephone, facsimile, or voice mail or through an electronic mechanism 24 hours a day, seven days a week. This paragraph does not apply to dental service covered under MinnesotaCare, general assistance medical care, or medical assistance.

Sec. 2. **[62Q.732] CITATION.**

Sections 62Q.732 to 62Q.75 may be cited as the "Minnesota Health Plan Contracting Act."

Sec. 3. **[62Q.733] DEFINITIONS.**

Subdivision 1. **APPLICABILITY.** For purposes of sections 62Q.732 to 62Q.739, the following definitions apply.

Subd. 2. **CONTRACT.** "Contract" means a written agreement between a health care provider and a health plan company to provide health care services.

Subd. 3. **HEALTH CARE PROVIDER OR PROVIDER.** "Health care provider" or "provider" means a physician, chiropractor, dentist, podiatrist, or other provider as defined under section 62J.03, other than hospitals, ambulatory surgical centers, or freestanding emergency rooms.

Subd. 4. **HEALTH PLAN COMPANY.** (a) "Health plan company" means:

(1) a health maintenance organization operating under chapter 62D;

(2) a community integrated service network operating under chapter 62N;

(3) a preferred provider organization as defined in section 145.61, subdivision 4c; or

(4) an insurance company licensed under chapter 60A, nonprofit health service corporation operating under chapter 62C, fraternal benefit society operating under chapter 64B, or any other entity that establishes, operates, or maintains a health benefit plan or network of health care providers where the providers have entered into a contract with the entity to provide health care services.

(b) This subdivision does not apply to a health plan company with respect to coverage described in section 62A.011, subdivision 3, clauses (1) to (5) and (7) to (12).

Subd. 5. **FEE SCHEDULE.** "Fee schedule" means the total expected financial compensation paid to a health care provider for providing a health care service as determined by the contract between the health plan company and the provider, inclusive of withhold amounts and any amount for which the patient or other third party may be obligated to pay under the contract.

Sec. 4. **[62Q.734] EXEMPTION.**

Sections 62Q.735 to 62Q.739, and 62Q.74 do not apply to health plan companies whose annual Minnesota health premium revenues are less than three percent of the

total annual Minnesota health premium revenues, as measured by the assessment base of the Minnesota Comprehensive Health Association. For purposes of this percentage calculation, a health plan company's premiums include the Minnesota health premium revenues of its affiliates.

Sec. 5. **[62Q.735] PROVIDER CONTRACTING PROCEDURES.**

Subdivision 1. **CONTRACT DISCLOSURE.** (a) Before requiring a health care provider to sign a contract, a health plan company shall give to the provider a complete copy of the proposed contract, including:

(1) all attachments and exhibits;

(2) operating manuals;

(3) a general description of the health plan company's health service coding guidelines and requirement for procedures and diagnoses with modifiers, and multiple procedures; and

(4) all guidelines and treatment parameters incorporated or referenced in the contract.

(b) The health plan company shall make available to the provider the fee schedule or a method or process that allows the provider to determine the fee schedule for each health care service to be provided under the contract.

(c) Notwithstanding paragraph (b), a health plan company that is a dental plan organization, as defined in section 62Q.76, shall disclose information related to the individual contracted provider's expected reimbursement from the dental plan organization. Nothing in this section requires a dental plan organization to disclose the plan's aggregate maximum allowable fee table used to determine other providers' fees. The contracted provider must not release this information in any way that would violate any state or federal antitrust law.

Subd. 2. **PROPOSED AMENDMENTS.** (a) Any amendment or change in the terms of an existing contract between a health plan company and a provider must be disclosed to the provider at least 45 days prior to the effective date of the proposed change, with the exception of amendments required of the health plan company by law or governmental regulatory authority, when notice shall be given to the provider when the requirement is made known to the health plan company.

(b) Any amendment or change in the contract that alters the fee schedule or materially alters the written contractual policies and procedures governing the relationship between the provider and the health plan company must be disclosed to the provider not less than 45 days before the effective date of the proposed change and the provider must have the opportunity to terminate the contract before the amendment or change is deemed to be in effect.

(c) By mutual consent, evidenced in writing in amendments separate from the base contract and not contingent on participation, the parties may waive the disclosure requirements under paragraphs (a) and (b).

(d) Notwithstanding paragraphs (a) and (b), the effective date of contract termination shall comply with the terms of the contract when a provider terminates a contract.

Subd. 3. **HOSPITAL CONTRACT AMENDMENT DISCLOSURE.** (a) Any amendment or change in the terms of an existing contract between a network organization and a hospital, ambulatory surgical center, or freestanding emergency room must be disclosed to that provider.

(b) Any amendment or change in the contract that alters the financial reimbursement or alters the written contractual policies and procedures governing the relationship between the hospital, ambulatory surgical center, or freestanding emergency room and the network organization must be disclosed to that provider before the amendment or change is deemed to be in effect.

(c) For purposes of this subdivision, "network organization" means a preferred provider organization, as defined in section 145.61, subdivision 4c; a managed care organization, as defined in section 62Q.01, subdivision 5; or other entity that uses or consists of a network of health care providers.

Sec. 6. **[62Q.736] PAYMENT RATES.**

A contract between a health plan company and a provider shall comply with section 62A.64.

Sec. 7. **[62Q.737] SERVICE CODE CHANGES.**

(a) For purposes of this section, "service code" means current procedural terminology (CPT), current dental terminology (CDT), ICD-CM, diagnosis-related groups (DRGs), or other coding system.

(b) The health plan company shall determine the manner in which it adjudicates claims. The provider may request a description of the general coding guidelines applicable to the health care services the provider is reasonably expected to render pursuant to the contract. The health plan company or its designee shall provide the coding guidelines not later than 30 days after the date the health plan receives the request. The health plan company shall provide notice of material changes to the coding guidelines not later than 45 days prior to the date the changes take effect and shall not make retroactive revision to the coding guidelines, but may issue new guidelines. A provider who receives information under this section may use or disclose the information only for the purpose of practice management, billing activities, or other business operations and may not disclose the information to third parties without the consent of the health plan company.

(c) The health plan company may correct an error in a submitted claim that prevents the claim from being processed, provided that the health plan company:

(1) notifies the provider of the change and reason for the change according to federal Health Insurance Portability and Accountability Act (HIPAA) transaction standards; and

(2) offers the provider the opportunity to appeal any changes.

(d) Nothing in this section shall be interpreted to require a health plan company to violate copyright or other law by disclosing proprietary licensed software. In addition to the above, the health plan company shall, upon request of a contracted provider, disclose the name, edition, and model version of the software that the health plan company uses to determine bundling and unbundling of claims.

(e) This section does not apply to government programs, including state public programs, Medicare, and Medicare-related coverage.

Sec. 8. **[62Q.739] UNILATERAL TERMS PROHIBITED.**

(a) A contract between a health plan company and a health care provider shall not contain or require unilateral terms regarding indemnification or arbitration. Notwithstanding any prohibitions in this section, a contract between a health plan company and a health care provider may be unilaterally terminated by either party in accordance with the terms of the contract.

(b) A health plan company may not terminate or fail to renew a health care provider's contract without cause unless the company has given the provider a written notice of the termination or nonrenewal 120 days before the effective date.

Sec. 9. Minnesota Statutes 2002, section 62Q.74, is amended to read:

62Q.74 **NETWORK SHADOW CONTRACTING.**

Subdivision 1. **DEFINITIONS.** (a) For purposes of this section, ~~the terms defined in this subdivision have the meanings given.~~

~~(b)~~ "category of coverage" means one of the following types of health-related coverage:

(1) health;

(2) no-fault automobile medical benefits; or

(3) workers' compensation medical benefits.

~~(c) "Health care provider" or "provider" means an individual licensed, registered, or regulated by the Board of Medical Practice under chapter 147, a chiropractor licensed under sections 148.01 to 148.106, a dentist licensed under chapter 150A, or a hospital licensed under chapter 144.~~

~~(d) "Network organization" means a preferred provider organization as defined in section 145.61, subdivision 4e, a managed care organization as defined in section 62Q.01, subdivision 5, or other entity that uses or consists of a network of health care providers.~~

(b) "Health care provider" or "provider" means a physician, chiropractor, dentist, podiatrist, hospital, ambulatory surgical center, freestanding emergency room, or other provider, as defined in section 62J.03.

Subd. 2. **PROVIDER CONSENT REQUIRED.** (a) No ~~network organization~~ health plan company shall require a health care provider to participate in a network under a category of coverage that differs from the category or categories of coverage to which the existing contract between the ~~network organization~~ health plan company and the provider applies, without the affirmative consent of the provider obtained under subdivision 3.

(b) ~~This section does not apply to situations in which the network organization wishes~~ No health plan company shall require, as a condition of participation in any health plan, product, or other arrangement, the provider to participate in a new or different health plan, product, or other arrangement within a category of coverage that ~~is already provided for in an existing contract between the network organization and the provider~~ results in a different underlying financial reimbursement methodology without the affirmative consent of the provider obtained under subdivision 3. This paragraph does not apply to participation in health plan products or other arrangements that provide health care services to government programs, including state public programs, Medicare, and Medicare-related coverage.

(c) Compliance with this section may not be waived in a contract or otherwise.

Subd. 3. **CONSENT PROCEDURE.** (a) The ~~network organization~~ health plan company, if it wishes to apply an existing contract with a provider to a different category of coverage or health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology, shall first notify the provider in writing. The written notice must include at least the following:

(1) the ~~network organization's~~ health plan company's name, address, and telephone number, and the name of the specific network, if it differs from that of the ~~network organization~~ health plan company;

(2) a description of the proposed new category of coverage or health plan, product, or other arrangement within a category of coverage;

(3) the names of all payers expected by the ~~network organization~~ health plan company to use the network for the new category of coverage or health plan, product, or other arrangement within a category of coverage;

(4) the approximate number of current enrollees of the ~~network organization~~ health plan company in that category of coverage or health plan, product, or other arrangement within a category of coverage within the provider's geographical area;

(5) a disclosure of all contract terms of the proposed new category of coverage or health plan, product, or other arrangement within a category of coverage, including the discount or reduced fees, care guidelines, utilization review criteria, prior notification process, prior authorization process, and dispute resolution process;

(6) a form for the provider's convenience in accepting or declining participation in the proposed new category of coverage or health plan, product, or other arrangement

within a category of coverage, provided that the provider need not use that form in responding; and

(7) a statement informing the provider of the provisions of paragraph (b).

(b) Unless the provider has affirmatively agreed to participate within 60 days after the postmark date of the notice, the provider is deemed to have not accepted the proposed new category of coverage or health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology.

Subd. 4. **CONTRACT TERMINATION RESTRICTED.** A ~~network organization~~ health plan company must not terminate an existing contract with a provider, or fail to honor the contract in good faith, based solely on the provider's decision not to accept a proposed new category of coverage or health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology. The most recent agreed-upon contractual obligations remain in force until the existing contract's renewal or termination date.

Subd. 5. **REMEDY.** If a ~~network organization~~ health plan company violates this section by reimbursing a provider as if the provider had agreed under this section to participate in the network under a category of coverage or health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology to which the provider has not agreed, the provider has a cause of action against the ~~network organization~~ health plan company to recover two times the difference between the reasonable charges for claims affected by the violation and the amounts actually paid to the provider. The provider is also entitled to recover costs, disbursements, and reasonable attorney fees.

Subd. 6. **BENEFIT DESIGN CHANGES.** For purposes of this section, "different underlying financial reimbursement methodology" does not include health plan benefit design changes, including, but not limited to, changes in co-payment or deductible amounts or other changes in member cost-sharing requirements.

Sec. 10. Minnesota Statutes 2002, section 62Q.75, subdivision 2, is amended to read:

Subd. 2. **CLAIMS PAYMENTS.** (a) This section applies to clean claims submitted to a health plan company or third-party administrator for services provided by any:

(1) health care provider, ~~except~~ as defined in section 62Q.74, but does not include a provider licensed under chapter 151;

(2) home health care provider, as defined in section 144A.43, subdivision 4; or

(3) health care facility.

All health plan companies and third-party administrators must pay or deny claims that are clean claims within 30 calendar days after the date upon which the health plan company or third-party administrator received the claim.

(b) The health plan company or third-party administrator shall, upon request, make available to the provider information about the status of a claim submitted by the provider consistent with section 62J.581.

(c) If a health plan company or third-party administrator does not pay or deny a clean claim within the period provided in paragraph (a), the health plan company or third-party administrator must pay interest on the claim for the period beginning on the day after the required payment date specified in paragraph (a) and ending on the date on which the health plan company or third-party administrator makes the payment or denies the claim. In any payment, the health plan company or third-party administrator must itemize any interest payment being made separately from other payments being made for services provided. ~~The health plan company or third-party administrator may, at its discretion, require the health care provider to bill the health plan company or third-party administrator for the interest required under this section before any interest payment is made.~~ Interest payments must be made to the health care provider no less frequently than quarterly.

~~(c)~~ (d) The rate of interest paid by a health plan company or third-party administrator under this subdivision shall be 1.5 percent per month or any part of a month.

~~(d)~~ (e) A health plan company or third-party administrator is not required to make an interest payment on a claim for which payment has been delayed for purposes of reviewing potentially fraudulent or abusive billing practices.

~~(e) The commissioner may not assess a financial administrative penalty against a health plan company for violation of this subdivision.~~

(f) The commissioner may assess a financial administrative penalty against a health plan company for violation of this subdivision when there is a pattern of abuse that demonstrates a lack of good faith effort and a systematic failure of the health plan company to comply with this subdivision.

Sec. 11. **REPEALER.**

Minnesota Statutes 2002, section 62Q.745, is repealed.

Sec. 12. **EFFECTIVE DATE.**

Sections 1, 2, and 4 are effective for provider contracts issued, renewed, or amended on or after July 1, 2004. Sections 3, 6, 8, and 10 are effective for provider contracts issued, renewed, or amended on or after January 1, 2005. Sections 5, 7, 9, and 11 are effective for provider contracts issued, renewed, or amended on or after July 1, 2006.

Presented to the governor May 18, 2004

Signed by the governor May 29, 2004, 3:10 p.m.

New language is indicated by underline, deletions by ~~strikeout.~~