CHAPTER 62D

HEALTH MAINTENANCE ORGANIZATIONS

62D.108 PROMPT PAYMENTS TO HOME CARE PROVIDERS.

Subdivision 1. **Applicability.** This section applies to health maintenance organizations regulated under this chapter.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them:

(1) "clean claim" means an original paper or electronic claim with correct data elements, prepared in accordance with the health maintenance organization's published specifications for claims preparation, that does not require an attachment or text information to pay or deny the claim;

(2) "home care provider" has the meaning given in section 144A.43, subdivision 4; and

(3) "valid home care provider claim" means a clean claim submitted directly to the health maintenance organization by an eligible home care provider for home care services provided to an eligible enrollee.

Subd. 3. **Claims payments to home care providers.** A health maintenance organization must pay or deny a valid home care provider claim for home care services within 30 days of receiving the claim and all other information from third parties required to process the claim in accordance with the health maintenance organization's specifications for claims processing. A health maintenance organization must notify a home care provider of an incorrect, defective, or improper claim within 30 days of receipt of the original claim. If the health maintenance organization is unable to pay or deny the claim within 30 days because additional information, other than information from the home care provider, is required to complete the processing of the claim, the health maintenance organization shall disclose to the home care provider the nature of the additional information needed to process the claim. The disclosure shall be made consistent with state and federal law. Where evidence of suspected fraud is present, the requirement to disclose additional information need not be specific.

Subd. 4. **Payment of interest on late payments.** (a) If a health maintenance organization fails to pay or deny a valid home care provider claim within 30 days as specified in subdivision 3, the health maintenance organization must pay interest to the home care provider on the claim with interest accruing from the 30th day. If a negotiated contract or agreement between a home care provider and a health maintenance organization requires an audit by the health maintenance organization before acceptance and payment of the claim, interest payments do not apply until 30 days after the timely completion of the audit by the health maintenance organization. Before any interest payment is made, the home care provider must bill the health maintenance organization for the interest.

(b) The rate of interest paid by a health maintenance organization under this subdivision shall be 1.5 percent per month or any part of the month.

(c) A home care provider who prevails in a civil action to collect interest payments from a health maintenance organization shall be awarded the costs and disbursements, including attorney fees, incurred in bringing the action.

(d) The minimum monthly interest payment that a health maintenance organization must pay to a home care provider for the unpaid balance for any single overdue claim equal to or exceeding $100 is $10. For unpaid balances of less than $100, the health maintenance organization must pay the actual interest payment due to the home care provider.

(e) A health maintenance organization 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.

History: *1999 c 146 s 1*

62D.11 COMPLAINT SYSTEM.

Subdivision 1. **Enrollee complaint system.** Every health maintenance organization shall establish and maintain a complaint system, as required under sections 62Q.68 to 62Q.72 to provide reasonable procedures for the resolution of written complaints initiated by or on behalf of enrollees concerning the provision of health care services.

[For text of subds 1a to 3, see M.S.1998]

History: *1999 c 239 s 1*

NOTE: The amendment to subdivision 1 by Laws 1999, chapter 239, section 1, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

NOTE: Subdivisions 1b and 2 are repealed by Laws 1999, chapter 239, section 43, paragraph (a), effective April 1, 2000, and apply to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62D.12 PROHIBITED PRACTICES.

[For text of subds 1 and 1a, see M.S.1998]

Subd. 2. **Coverage cancellation; nonrenewal.** No health maintenance organization may cancel or fail to renew the coverage of an enrollee except for (a) failure to pay the charge for health care coverage; (b) termination of the health care plan; (c) termination of the group plan; (d) enrollee moving out of the area served, subject to section 62A.17, subdivisions 1 and 6, and section 62D.104; (e) enrollee moving out of an eligible group, subject to section 62A.17, subdivisions 1 and 6, and section 62D.104; (f) failure to make copayments required by the health care plan; (g) fraud or misrepresentation by the enrollee with respect to eligibility for coverage or any other material fact; or (h) other reasons established in rules promulgated by the commissioner of health.

[For text of subds 2a to 19, see M.S.1998]

History: *1999 c 177 s 43*

62D.124 GEOGRAPHIC ACCESSIBILITY.

Subdivision 1. **Primary care; mental health services; general hospital services.** Within the health maintenance organization's service area, the maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider of each of the following services: primary care services, mental health services, and general hospital services. The health maintenance organization must designate which method is used.

Subd. 2. **Other health services.** Within a health maintenance organization's service area, the maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider of specialty physician services, ancillary services, specialized hospital services, and all other health services not listed in subdivision 1. The health maintenance organization must designate which method is used.

Subd. 3. **Exception.** The commissioner shall grant an exception to the requirements of this section according to Minnesota Rules, part 4685.1010, subpart 4, if the health maintenance organization can demonstrate with specific data that the requirement of subdivision 1 or 2 is not feasible in a particular service area or part of a service area.

Subd. 4. **Application.** (a) Subdivisions 1 and 2 do not apply if an enrollee is referred to a referral center for health care services.

(b) Subdivision 1 does not apply:

(1) if an enrollee has chosen a health plan with full knowledge that the health plan has no participating providers within 30 miles or 30 minutes of the enrollee's place of residence; or

(2) to service areas approved before May 24, 1993.

History: *1999 c 239 s 2*