

1 SB249
2 129286-2
3 By Senator Whatley
4 RFD: Health
5 First Read: 08-FEB-12

2
3
4
5
6
7
8 SYNOPSIS: This bill would establish a program for
9 health care providers and certain health care
10 insurers, health maintenance organizations, and
11 other related entities to resolve claim disputes by
12 allowing a third-party resolution organization to
13 review and consider the claim dispute and make
14 recommendations to the Department of Public Health
15 regarding resolution of the claims.

16 This bill would also authorize the
17 department to adopt rules to administer this
18 program.

19
20 A BILL
21 TO BE ENTITLED
22 AN ACT
23

24 To provide for the establishment of a statewide
25 claim-dispute-resolution program for health care providers and
26 certain health insurers, health maintenance organizations, and

1 other related entities; and to provide rulemaking authority to
2 the State Department of Public Health.

3 BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

4 Section 1. (a) For the purposes of this section, the
5 following words shall have the following meanings:

6 (1) DEPARTMENT. The State Department of Public
7 Health.

8 (2) HEALTH BENEFIT PLAN. A health insurance policy,
9 including a self-insured health plan, that covers hospital,
10 medical, or surgical expenses, health maintenance
11 organizations, preferred provider organizations, medical
12 service organizations, physician-hospital organizations, or
13 any other person, firm, corporation, joint venture, or other
14 similar business entity that pays for, purchases, or furnishes
15 health care services to patients, insureds, or beneficiaries
16 in this state. The term includes, but is not limited to,
17 entities created pursuant to Article 6 of Chapter 20 of Title
18 10A, Code of Alabama 1975.

19 (3) PROVIDER. A medical practitioner, dental
20 practitioner, medical institution, physician, dentist,
21 hospital, or other health care provider as the terms are
22 defined in Section 6-5-481, Code of Alabama 1975.

23 (4) RESOLUTION ORGANIZATION. A qualified independent
24 third-party claim-dispute-resolution entity selected by and
25 contracted with the department.

1 (b) (1) The department shall establish a program by
2 January 1, 2013, to provide assistance to providers and health
3 benefit plans for resolution of claim disputes that are not
4 resolved by the provider and the health benefit plan. The
5 department shall contract with a resolution organization to
6 timely review and consider claim disputes submitted by
7 providers and health benefit plans and recommend to the
8 department an appropriate resolution of those disputes. The
9 department shall establish by rule jurisdictional amounts and
10 methods of aggregation for claim disputes that may be
11 considered by the resolution organization.

12 (2) The resolution organization shall review claim
13 disputes filed by providers and health benefit plans unless
14 the disputed claim:

15 a. Is related to interest payment.

16 b. Does not meet the jurisdictional amounts or the
17 methods of aggregation established by department rule, as
18 provided in subdivision (1).

19 c. Is part of an internal grievance in a Medicare
20 managed care organization or a reconsideration appeal through
21 the Medicare appeals process.

22 d. Is related to a health benefit plan that is not
23 regulated by the state.

24 e. Is part of a Medicaid fair hearing pursued under
25 42 C.F.R. §§ 431.220 et seq.

1 f. Is the basis for an action pending in state or
2 federal court.

3 g. Is subject to a binding claim-dispute-resolution
4 process provided by contract entered into prior to the
5 effective date of this act, between the provider and the
6 health benefit plan.

7 (3) Contracts entered into or renewed on or after
8 the effective date of this act may require exhaustion of an
9 internal dispute-resolution process as a prerequisite to the
10 submission of a claim by a provider or a health benefit plan
11 to the resolution organization.

12 (4) A provider or health benefit plan may not file a
13 claim dispute with the resolution organization more than 12
14 months after a final determination has been made on a claim by
15 a health benefit plan or provider.

16 (5) The resolution organization shall require the
17 health benefit plan or provider submitting the claim dispute
18 to submit any supporting documentation to the resolution
19 organization within 15 days after receipt by the health
20 benefit plan or provider of a request from the resolution
21 organization for documentation in support of the claim
22 dispute. The resolution organization may extend the time if
23 appropriate. Failure to submit the supporting documentation
24 within such time period shall result in the dismissal of the
25 submitted claim dispute.

1 (6) The resolution organization shall require the
2 respondent in the claim dispute to submit all documentation in
3 support of its position within 15 days after receiving a
4 request from the resolution organization for supporting
5 documentation. The resolution organization may extend the time
6 if appropriate. Failure to submit the supporting documentation
7 within such time period shall result in a default against the
8 health benefit plan or provider. In the event of a default,
9 the resolution organization shall issue its written
10 recommendation to the department that a default be entered
11 against the defaulting entity. The written recommendation
12 shall include a recommendation to the department that the
13 defaulting entity shall pay the entity submitting the claim
14 dispute the full amount of the claim dispute, plus all accrued
15 interest, and shall be considered a nonprevailing party for
16 the purposes of this section.

17 (7) a. If, on an ongoing basis during the preceding
18 12 months, the department has reason to believe that a pattern
19 of noncompliance with Section 27-1-17, Code of Alabama 1975,
20 exists on the part of a particular health benefit plan or
21 provider, the department shall evaluate the information
22 contained in these cases to determine whether the information
23 evidences a pattern and report its findings, together with
24 substantiating evidence, to the appropriate licensure or
25 certification entity for the health benefit plan or provider.

1 b. In addition, the department shall prepare a
2 report to the Governor and the Legislature by February 1 of
3 each year, enumerating: Claims dismissed; defaults issued; and
4 failures to comply with department final orders issued under
5 this section.

6 (c) The department shall adopt rules to establish a
7 process to be used by the resolution organization in
8 considering claim disputes submitted by a provider or health
9 benefit plan which shall include the issuance by the
10 resolution organization of a written recommendation, supported
11 by findings of fact, to the department within 60 days after
12 the requested information is received by the resolution
13 organization within the timeframes specified by the resolution
14 organization. In no event may the review time exceed 90 days
15 following receipt of the initial claim dispute submission by
16 the resolution organization.

17 (d) Within 30 days after receipt of the
18 recommendation of the resolution organization, the department
19 shall adopt the recommendation as a final order.

20 (e) The department shall notify within seven days
21 the appropriate licensure or certification entity of a
22 violation of a final order issued by the department pursuant
23 to this section.

24 (f) The entity that does not prevail in the
25 department's order shall pay a review cost to the review
26 organization, as determined by department rule. The rule shall

1 provide for an apportionment of the review fee in any case in
2 which both parties prevail in part. If the nonprevailing party
3 fails to pay the ordered review cost within 35 days after the
4 department's order, the nonpaying party is subject to a
5 penalty of not more than five hundred dollars (\$500) per day
6 until the penalty is paid.

7 (g) The department shall have the power to adopt
8 rules to administer this section.

9 Section 2. This act shall become effective on the
10 first day of the third month following its passage and
11 approval by the Governor, or its otherwise becoming law.