

Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

REVISED

*This Version Includes All Amendments Adopted
on Second Reading in the Second House*

LLS NO. 10-0264.01 Christy Chase

HOUSE BILL 10-1332

HOUSE SPONSORSHIP

Miklosi, Apuan, Gagliardi, Kefalas, Primavera, Tyler

SENATE SPONSORSHIP

Romer,

House Committees

Health and Human Services
Appropriations

Senate Committees

Health and Human Services

A BILL FOR AN ACT

101 CONCERNING THE CREATION OF THE "BARRY KEENE MEDICAL CLEAN
102 CLAIMS TRANSPARENCY AND UNIFORMITY ACT".

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at <http://www.leg.state.co.us/billsummaries>.)

The bill creates the "Medical Clean Claims Transparency and Uniformity Act" (act), which requires the executive director of the department of health care policy and financing (department) to establish a task force of industry and government representatives to develop a standardized set of payment rules and claim edits to be used by payers and

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.

Capital letters indicate new material to be added to existing statute.

Dashes through the words indicate deletions from existing statute.

SENATE
Am ended 2nd Reading
April 20, 2010

HOUSE
3rd Reading Unam ended
March 25, 2010

HOUSE
Am ended 2nd Reading
March 23, 2010

health care providers in Colorado. The task force is to track the progress of the national initiative, known as the American society for quality initiative (ASQ initiative), in the development of a national uniform, standardized set of rules and edits and avoid duplication of conflict with the ASQ initiative.

The task force is to develop a base set of rules and edits using existing national industry sources and work with the ASQ initiative to develop a complete set of uniform, standardized payment rules and claim edits applicable to all types of professional services.

The task force is required to report its recommendations by December 31, 2012, including recommendations to:

- ! Adopt any standardized rules and edits developed by the ASQ initiative if appropriate for Colorado, for implementation by commercial payers by the end of 2012, and by nonprofit payers by the end of 2013; or
- ! Adopt the rules and edits sets established by the task force if the ASQ initiative has not come to consensus.

If the task force is required to develop its own standard rules and edits, the task force is to do so by December 31, 2012, and payers are to implement the standard rules and edits by the end of 2013 for commercial payers and by the end of 2014 for nonprofit payers.

The bill precludes the use of any proprietary or other claims edits to modify the payment of the charges for covered services once the standard payment rules and claim edits are implemented.

Contractual provisions between contracting persons or entities and health care providers regarding actual contracted reimbursement rates for procedures and other contractual arrangements negotiated by the parties would be preserved under the bill.

The bill reorganizes provisions pertaining to health care contracts, without making any substantive changes to those provisions.


1 *Be it enacted by the General Assembly of the State of Colorado:*

2 **SECTION 1.** Article 37 of title 25, Colorado Revised Statutes, is
3 amended, WITH THE RELOCATION OF PROVISIONS, to read:

4 **25-37-101. [Formerly 25-37-101 (1)] Applicability of article.**
5 ~~(1) Effective January 1, 2008~~ EXCEPT AS PROVIDED IN SECTION
6 25-37-106, a person or entity that contracts with a health care provider
7 shall comply with this article and shall include the provisions required by
8 this article in the contract. ~~A contract in existence prior to January 1,~~

1 2008, that is renewed or renews by its terms shall comply with this article
2 no later than December 31, 2008.

3 **25-37-102. [Formerly 25-37-101 (2)] Definitions.** (2) As used
4 in this article, unless the context otherwise requires:

5 
6 (a) (1) "Category of coverage" means one of the following types
7 of coverage offered by a person or entity:

8 (H) (a) Health maintenance organization plans;

9 (H) (b) Any other commercial plan or contract that is not a health
10 maintenance organization plan;

11 (H) (c) Medicare;

12 (H) (d) Medicaid; or

13 (H) (e) Workers' compensation.

14 (2) "CMS" MEANS THE FEDERAL CENTERS FOR MEDICARE AND
15 MEDICAID SERVICES IN THE UNITED STATES DEPARTMENT OF HEALTH AND
16 HUMAN SERVICES.

17 (3) "CPT CODE SET" MEANS THE CURRENT PROCEDURAL
18 TERMINOLOGY CODE, OR ITS SUCCESSOR CODE, AS DEVELOPED AND
19 COPYRIGHTED BY THE AMERICAN MEDICAL ASSOCIATION, OR ITS
20 SUCCESSOR ENTITY, AND ADOPTED BY THE CMS AS A HIPAA CODE SET.

21 (b) (4) "Edit" means a practice or procedure, CONSISTENT WITH
22 THE STANDARDIZED SET OF PAYMENT RULES AND CLAIM EDITS DEVELOPED
23 PURSUANT TO SECTION 25-37-106, pursuant to which one or more
24 adjustments are made regarding procedure codes, including the ~~American~~
25 ~~medical association's current procedural terminology code, also known as~~
26 ~~a "CPT code", CPT CODE SETS and the centers for medicare and medicaid~~
27 ~~services health care common procedure coding system, also known as~~

1 ~~"HCPCS"~~ HCPCS, that results in:

2 ~~(I)~~ (a) Payment for some, but not all, of the codes;

3 ~~(II)~~ (b) Payment for a different code;

4 ~~(III)~~ (c) A reduced payment as a result of services provided to a
5 patient that are claimed under more than one code on the same service
6 date;

7 ~~(IV)~~ (d) A ~~reduced~~ MODIFIED payment related to a PERMISSIBLE
8 AND LEGITIMATE modifier used with a procedure code, AS SPECIFIED IN
9 SECTION 25-37-106 (2); or

10 ~~(V)~~ (e) A reduced payment based on multiple units of the same
11 code billed for a single date of service.

12 (5) "HCPCS" MEANS THE HEALTH CARE COMMON PROCEDURE
13 CODING SYSTEM DEVELOPED BY THE CMS FOR IDENTIFYING HEALTH CARE
14 SERVICES IN A CONSISTENT AND STANDARDIZED MANNER.

15 ~~(e)~~ (6) "Health care contract" or "contract" means a contract
16 entered into or renewed between a person or entity and a health care
17 provider for the delivery of health care services to others.

18 ~~(d)~~ (7) "Health care provider" means a person licensed or certified
19 in this state to practice medicine, pharmacy, chiropractic, nursing,
20 physical therapy, podiatry, dentistry, optometry, occupational therapy, or
21 other healing arts. "Health care provider" also means an ambulatory
22 surgical center, a licensed pharmacy or provider of pharmacy services,
23 and a professional corporation or other corporate entity consisting of
24 licensed health care providers as permitted by the laws of this state.

25

26 (8) "HIPAA CODE SET" MEANS ANY SET OF CODES USED TO
27 ENCODE ELEMENTS, SUCH AS TABLES OF TERMS, MEDICAL CONCEPTS,

1 MEDICAL DIAGNOSTIC CODES, OR MEDICAL PROCEDURE CODES, THAT HAVE
2 BEEN ADOPTED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT
3 OF HEALTH AND HUMAN SERVICES PURSUANT TO THE FEDERAL "HEALTH
4 INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996", AS
5 AMENDED. "HIPAA CODE SET" INCLUDES THE CODES AND THE
6 DESCRIPTORS OF THE CODES.

7 ~~(e)~~ ~~(f)~~ (9) (a) "Material change" means a change to a contract that
8 decreases the health care provider's payment or compensation, changes
9 the administrative procedures in a way that may reasonably be expected
10 to significantly increase the provider's administrative expense, replaces
11 the maximum allowable cost list used with a new and different maximum
12 allowable cost list by a person or entity for reimbursement of generic
13 prescription drug claims, or adds a new category of coverage. A

14 (b) "Material change" does not include:

15 ~~(A)~~ (I) A decrease in payment or compensation resulting solely
16 from a change in a published fee schedule upon which the payment or
17 compensation is based and the date of applicability is clearly identified in
18 the contract;

19 ~~(B)~~ (II) A decrease in payment or compensation resulting from a
20 change in the fee schedule specified in a contract for pharmacy services
21 such as a change in a fee schedule based on average wholesale price or
22 maximum allowable cost;

23 ~~(C)~~ (III) A decrease in payment or compensation that was
24 anticipated under the terms of the contract, if the amount and date of
25 applicability of the decrease is clearly identified in the contract;

26 ~~(D)~~ (IV) An administrative change that may significantly increase
27 the provider's administrative expense, the specific applicability of which

1 is clearly identified in the contract;

2 ~~(E)~~ (V) Changes to an existing prior authorization,
3 precertification, notification, or referral program that do not substantially
4 increase the provider's administrative expense; or

5 ~~(F)~~ (VI) Changes to an edit program or to specific edits; however,
6 THE PERSON OR ENTITY SHALL PROVIDE NOTICE OF THE CHANGES TO the
7 health care provider ~~shall be provided notice of the changes pursuant to~~
8 ~~subparagraph (H) of this paragraph (e)~~ IN ACCORDANCE WITH PARAGRAPH
9 (c) OF THIS SUBSECTION (9), and the notice shall include information
10 sufficient for the health care provider to determine the effect of the
11 change.

12 ~~(H)~~ (c) If a change to the contract is administrative only and is not
13 a material change, the change shall be effective upon at least fifteen days'
14 notice to the health care provider. All other notices shall be provided
15 pursuant to the contract.

16 (10) "NATIONAL CORRECT CODING INITIATIVE" OR "NCCI" MEANS
17 THE SYSTEM DEVELOPED BY THE CMS TO PROMOTE CONSISTENCY IN
18 NATIONAL CORRECT CODING METHODOLOGIES AND TO CONTROL IMPROPER
19 CODING LEADING TO INAPPROPRIATE PAYMENT IN MEDICARE PART B
20 CLAIMS FOR PROFESSIONAL SERVICES.

21 (11) "NATIONAL INITIATIVE" MEANS A NATIONAL INITIATIVE BY A
22 NEUTRAL PARTY IN THE INDUSTRY THAT BRINGS TOGETHER DIVERSE
23 STAKEHOLDERS TO CREATE A LEVEL OF UNDERSTANDING OF THE IMPACT
24 OF CODING EDITS ON THE INDUSTRY AND A UNIFORM, STANDARDIZED SET
25 OF CLAIM EDITS THAT MEETS THE NEEDS OF THE STAKEHOLDERS IN THE
26 INDUSTRY.

27 ~~(f)~~ (12) "Person or entity" means a person or entity that has a

1 primary business purpose of contracting with health care providers for the
2 delivery of health care services.

3 **25-37-103. [Formerly 25-37-101 (3), (4), (6), (9), and**
4 **(19)] Health care contracts - required provisions - permissible**
5 **provision.** ~~(3)~~ (1) (a) A PERSON OR ENTITY SHALL PROVIDE, WITH each
6 HEALTH CARE contract, ~~shall have provided with it~~ a summary disclosure
7 form disclosing, in plain language, the following:

8 (I) The terms governing compensation and payment;

9 (II) Any category of coverage for which the health care provider
10 is to provide service;

11 (III) The duration of the contract and how the contract may be
12 terminated;

13 (IV) The identity of the person or entity responsible for the
14 processing of the health care provider's claims for compensation or
15 payment;

16 (V) Any internal mechanism required by the person or entity to
17 resolve disputes that arise under the terms or conditions of the contract;
18 and

19 (VI) The subject and order of addenda, if any, to the contract.

20 (b) The summary disclosure form required by paragraph (a) of this
21 subsection ~~(3)~~ (1) shall be for informational purposes only and shall not
22 be a term or condition of the contract; however, such disclosure shall
23 reasonably summarize the applicable contract provisions.

24 (c) If the contract provides for termination for cause by either
25 party, the contract shall state the reasons that may be used for termination
26 for cause, which terms shall not be unreasonable, and the contract shall
27 state the time by which notice of termination for cause shall be provided

1 and to whom the notice shall be given.

2 (d) The person or entity shall identify any utilization review or
3 management, quality improvement, or similar program the person or
4 entity uses to review, monitor, evaluate, or assess the services provided
5 pursuant to a contract. The policies, procedures, or guidelines of such
6 program applicable to a provider shall be disclosed upon request of the
7 health care provider within fourteen days after the date of the request.

8 ~~(4)~~ (2) (a) The disclosure of payment and compensation terms
9 pursuant to subsection ~~(3)~~ (1) of this section shall include information
10 sufficient for the health care provider to determine the compensation or
11 payment for the health care services and shall include the following:

12 (I) The manner of payment, such as fee-for-service, capitation, or
13 risk sharing;

14 (II) (A) The methodology used to calculate any fee schedule, such
15 as relative value unit system and conversion factor, percentage of
16 medicare payment system, or percentage of billed charges. As applicable,
17 the methodology disclosure shall include the name of any relative value
18 system; its version, edition, or publication date; any applicable conversion
19 or geographic factor; and any date by which compensation or fee
20 schedules may be changed by such methodology if allowed for in the
21 contract.

22 (B) The fee schedule for codes reasonably expected to be billed
23 by the health care provider for services provided pursuant to the contract,
24 and, upon request, the fee schedule for other codes used by or which may
25 be used by the health care provider. Such fee schedule shall include,
26 as may be applicable, service or procedure codes such as current
27 procedural terminology (CPT) codes or health care common procedure

1 coding system (HCPCS) codes and the associated payment or
2 compensation for each service code.

3 (C) The fee schedule required in sub-subparagraph (B) of this
4 subparagraph (II) may be provided electronically.

5 (D) A fee schedule for the codes described by sub-subparagraph
6 (B) of this subparagraph (II) shall be provided when a material change
7 related to payment or compensation occurs. Additionally, a health care
8 provider may request that a written fee schedule be provided up to twice
9 per year, and the person or entity must provide such fee schedule
10 promptly.

11 (III) The person or entity shall state the effect of edits, if any, on
12 payment or compensation. A person or entity may satisfy this
13 requirement by providing a clearly understandable, readily available
14 mechanism, such as through a web site, that allows a health care provider
15 to determine the effect of edits on payment or compensation before
16 service is provided or a claim is submitted.

17 (b) Notwithstanding any provision of this subsection ~~(4)~~ (2) to the
18 contrary, disclosure of a fee schedule or the methodology used to
19 calculate a fee schedule is not required:

20 (I) From a person or entity if the fee schedule is for a plan for
21 dental services, its providers include licensed dentists, the fee schedule
22 is based upon fees filed with the person or entity by dental providers, and
23 the fee schedule is revised from time to time based upon such filings.
24 Specific numerical parameters are not required to be disclosed.

25 (II) If the fee schedule is for pharmacy services or drugs such as
26 a fee schedule based on use of national drug codes.

27 ~~(6)~~ (3) When a proposed contract is presented by a person or

1 entity for consideration by a health care provider, the person or entity
2 shall provide in writing or make reasonably available the information
3 required in subsections ~~(3)~~ (1) and ~~(4)~~ (2) of this section. If the
4 information is not disclosed in writing, it shall be disclosed in a manner
5 that allows the health care provider to timely evaluate the payment or
6 compensation for services under the proposed contract. The disclosure
7 obligations in this article shall not prevent a person or entity from
8 requiring a reasonable confidentiality agreement regarding the terms of
9 a proposed contract.

10 ~~(9)~~ (4) Nothing in this article shall be construed to require the
11 renegotiation of a contract in existence before the applicable compliance
12 date in this article, and any disclosure required by this article for such
13 contracts may be by notice to the health care provider.

14 ~~(19)~~ (5) A contract subject to this article may include an
15 agreement for binding arbitration.

16 **25-37-104. [Formerly 25-37-101 (7)] Material change in health**
17 **care contract - written advance notice.** ~~(7)~~ ~~(a)~~ (1) A material change
18 to a contract shall occur only if the person or entity provides in writing to
19 the health care provider the proposed change and gives ninety days' notice
20 before the effective date of the change. The writing shall be
21 conspicuously entitled "notice of material change to contract".

22 ~~(b)~~ (2) If the health care provider objects in writing to the material
23 change within fifteen days and there is no resolution of the objection,
24 either party may terminate the contract upon written notice of termination
25 provided to the other party not later than sixty days before the effective
26 date of the material change.

27 ~~(c)~~ (3) If the health care provider does not object to the material

1 change pursuant to ~~paragraph (b) of this subsection (7)~~ SUBSECTION (2)
2 OF THIS SECTION, the change shall be effective as specified in the notice
3 of material change to the contract.

4 ~~(d)~~ (4) If a material change is the addition of a new category of
5 coverage and the health care provider objects, the addition shall not be
6 effective as to the health care provider, and the objection shall not be a
7 basis upon which the person or entity may terminate the contract.

8 **25-37-105. [Formerly 25-37-101 (8)] Contract modification**
9 **by operation of law.** ~~(8)~~ Notwithstanding ~~subsection (6) of this section~~
10 SECTION 25-37-103 (3), a contract may be modified by operation of law
11 as required by any applicable state or federal law or regulation, and the
12 person or entity may disclose this change by any reasonable means.

13 **25-37-106. Clean claims - development of standardized**
14 **payment rules and code edits - task force to develop - legislative**
15 **recommendations - short title - applicability - repeal.** (1) THIS
16 SECTION SHALL BE KNOWN AND MAY BE CITED AS THE "BARRY KEENE
17 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT".

18 (2) (a) (I) FOR PURPOSES OF FACILITATING THE DEVELOPMENT OF
19 A STANDARDIZED SET OF PAYMENT RULES AND CLAIM EDITS FOR USE BY
20 HEALTH CARE PROVIDERS AND PAYERS IN THE PROCESSING OF MEDICAL
21 CLAIMS, THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE
22 POLICY AND FINANCING SHALL ESTABLISH A TASK FORCE, WITHIN
23 FORTY-FIVE BUSINESS DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION,
24 CONSISTING OF REPRESENTATIVES OF ALL INDUSTRY SEGMENTS DIRECTLY
25 AFFECTED BY THIS SECTION, INCLUDING:

26 (A) HEALTH CARE PROVIDERS OR EMPLOYEES THEREOF FROM A
27 DIVERSE GROUP OF SETTINGS, WHICH SHALL INCLUDE PROVIDERS FROM

1 HEALTH CARE COMMUNITY CLINICS, AMBULATORY SURGICAL CENTERS,
2 URGENT CARE CENTERS, AND HOSPITALS;

3 (B) PERSONS OR ENTITIES THAT PAY FOR HEALTH CARE SERVICES,
4 REFERRED TO IN THIS SECTION AS "PAYERS";

5 (C) PRACTICE MANAGEMENT SYSTEM VENDORS;

6 (D) BILLING AND REVENUE CYCLE MANAGEMENT SERVICE
7 COMPANIES; AND

8 (E) STATE AND FEDERAL GOVERNMENT ENTITIES AND AGENCIES
9 THAT PAY FOR OR ARE OTHERWISE INVOLVED IN THE PAYMENT OR
10 PROVISION OF HEALTH CARE SERVICES.

11 (II) THE TASK FORCE SHOULD BE COMPRISED OF INDIVIDUALS WITH
12 EXPERTISE IN THE AREAS OF PAYMENT RULES AND CLAIM EDITS AND THEIR
13 IMPACT ON THE SUBMISSION AND PAYMENT OF HEALTH INSURANCE
14 CLAIMS.

15 (III) THE TASK FORCE SHALL WORK TO DEVELOP A STANDARDIZED
16 SET OF PAYMENT RULES AND CLAIM EDITS AS REQUIRED BY THIS
17 SUBSECTION (2) AND, WHILE FULFILLING ITS DUTIES, SHALL MONITOR AND
18 STAY INFORMED OF THE NATIONAL INITIATIVE SO AS TO AVOID
19 DUPLICATION OR CREATION OF COMPETING OR CONFLICTING PAYMENT
20 RULES AND CLAIM EDITS.

21 (b) WITHIN ONE YEAR AFTER THE TASK FORCE IS ESTABLISHED,
22 THE TASK FORCE SHALL DEVELOP A BASE SET OF STANDARDIZED PAYMENT
23 RULES AND CLAIM EDITS TO BE USED BY PAYERS AND HEALTH CARE
24 PROVIDERS IN THE PROCESSING OF MEDICAL CLAIMS THAT CAN BE
25 IMPLEMENTED INTO COMPUTERIZED MEDICAL CLAIMS PROCESSING
26 SYSTEMS. THE BASE SET OF RULES AND EDITS SHALL BE IDENTIFIED
27 THROUGH EXISTING NATIONAL INDUSTRY SOURCES THAT ARE

1 REPRESENTED BY THE FOLLOWING:

- 2 (I) THE NCCI;
- 3 (II) CMS DIRECTIVES, MANUALS, AND TRANSMITTALS;
- 4 (III) THE MEDICARE PHYSICIAN FEE SCHEDULE;
- 5 (IV) THE CMS NATIONAL CLINICAL LABORATORY FEE SCHEDULE;
- 6 (V) THE HCPCS CODING SYSTEM AND DIRECTIVES;
- 7 (VI) THE CPT CODING GUIDELINES AND CONVENTIONS; AND
- 8 (VII) NATIONAL MEDICAL SPECIALTY SOCIETY CODING
- 9 GUIDELINES.

10 (c) (I) AS THE BASE SET OF RULES AND EDITS DEVELOPED
11 PURSUANT TO PARAGRAPH (b) OF THIS SUBSECTION (2) MAY NOT ADDRESS
12 EVERY TYPE OF HEALTH CARE SERVICE INVOLVED IN A MEDICAL CLAIM,
13 THE TASK FORCE SHALL WORK TO DEVELOP A COMPLETE SET OF UNIFORM,
14 STANDARDIZED PAYMENT RULES AND CLAIM EDITS TO COVER ALL TYPES
15 OF PROFESSIONAL SERVICES. IN WORKING TO DEVELOP A COMPLETE SET
16 OF RULES AND EDITS, THE TASK FORCE SHALL REQUEST TO PARTICIPATE IN
17 THE NATIONAL INITIATIVE OR WORK WITH NATIONAL EXPERTS TO IDENTIFY
18 ANY RULES AND EDITS THAT ARE NOT ENCOMPASSED BY THE NATIONAL
19 INDUSTRY SOURCES IDENTIFIED IN PARAGRAPH (b) OF THIS SUBSECTION (2)
20 OR THAT POTENTIALLY CONFLICT WITH EACH OTHER. ADDITIONALLY, THE
21 TASK FORCE SHALL CONSIDER THE CMS MEDICALLY UNLIKELY EDITS AND
22 COMMERCIAL CLAIMS EDITING SYSTEMS THAT SOURCE THEIR EDITS TO
23 NATIONAL INDUSTRY SOURCES ON A CODE AND CODE EDIT PAIR LEVEL IN
24 ORDER TO CREATE A COMPLETE SET OF PAYMENT RULES AND CLAIM EDITS.

25 (II) IN DEVELOPING A COMPLETE SET OF UNIFORM, STANDARDIZED
26 PAYMENT RULES AND CLAIM EDITS, THE TASK FORCE SHALL CONSIDER
27 STANDARDIZING THE FOLLOWING TYPES OF EDITS, WITHOUT LIMITATION:

- 1 (A) UNBUNDLE;
- 2 (B) MUTUALLY EXCLUSIVE;
- 3 (C) MULTIPLE PROCEDURE REDUCTION;
- 4 (D) AGE;
- 5 (E) GENDER;
- 6 (F) MAXIMUM FREQUENCY PER DAY;
- 7 (G) GLOBAL SURGERY DAYS;
- 8 (H) PLACE OF SERVICE;
- 9 (I) TYPE OF SERVICE;
- 10 (J) ASSISTANT AT SURGERY;
- 11 (K) CO-SURGEON;
- 12 (L) TEAM SURGEONS;
- 13 (M) TOTAL, PROFESSIONAL, OR TECHNICAL SPLITS;
- 14 (N) BILATERAL PROCEDURES;
- 15 (O) ANESTHESIA SERVICES; AND
- 16 (P) THE EFFECT OF CPT AND HCPCS MODIFIERS ON THESE EDITS
- 17 AS APPLICABLE.

18 (d) (I) THE TASK FORCE SHALL SUBMIT A REPORT AND
19 RECOMMENDATIONS CONCERNING THE SET OF UNIFORM, STANDARDIZED
20 PAYMENT RULES AND CLAIM EDITS TO THE EXECUTIVE DIRECTOR OF THE
21 DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND THE HEALTH
22 AND HUMAN SERVICES COMMITTEES OF THE SENATE AND HOUSE OF
23 REPRESENTATIVES, OR THEIR SUCCESSOR COMMITTEES, BY DECEMBER 31,
24 2011, AND SHALL PRESENT ITS REPORT AND RECOMMENDATIONS TO A
25 JOINT MEETING OF THE SAID HEALTH AND HUMAN SERVICES COMMITTEES
26 BY JANUARY 31, 2012.

27 (II) IF, AT THE TIME THE TASK FORCE SUBMITS ITS REPORT, THE

1 NATIONAL INITIATIVE HAS REACHED CONSENSUS ON A COMPLETE OR
2 PARTIAL SET OF STANDARDIZED PAYMENT RULES AND CLAIM EDITS THAT
3 THE TASK FORCE DETERMINES TO BE IN THE BEST INTERESTS OF
4 COLORADO, THE TASK FORCE SHALL RECOMMEND THAT STANDARDIZED
5 SET OF PAYMENT RULES AND CLAIM EDITS FOR USE BY ALL PAYERS DOING
6 BUSINESS IN COLORADO, WHICH SHALL BE IMPLEMENTED BY PAYERS AS
7 FOLLOWS:

8 (A) PAYERS THAT ARE COMMERCIAL HEALTH PLANS SHALL
9 IMPLEMENT THESE STANDARDIZED SET OF PAYMENT RULES AND CLAIM
10 EDITS WITHIN THEIR CLAIMS PROCESSING SYSTEMS ACCORDING TO A
11 SCHEDULE OUTLINED UNDER THE NATIONAL INITIATIVE OR BY JANUARY 1,
12 2014, WHICHEVER OCCURS FIRST; AND

13 (B) PAYERS THAT ARE DOMESTIC, NONPROFIT HEALTH PLANS
14 SHALL IMPLEMENT THESE STANDARDIZED SET OF PAYMENT RULES AND
15 CLAIM EDITS WITHIN THEIR CLAIMS PROCESSING SYSTEMS BY JANUARY
16 1, 2015.

17 (III) IF, AT THE TIME THE TASK FORCE SUBMITS ITS REPORT, THE
18 NATIONAL INITIATIVE WORK GROUP HAS NOT REACHED CONSENSUS ON A
19 COMPLETE OR PARTIAL SET OF STANDARDIZED PAYMENT RULES AND CLAIM
20 EDITS:

21 (A) THE BASE SET OF STANDARDIZED PAYMENT RULES AND CLAIM
22 EDITS DEVELOPED PURSUANT TO PARAGRAPH (b) OF THIS SUBSECTION (2)
23 SHALL BECOME THE STANDARDS USED IN COLORADO BY PAYERS AND
24 HEALTH CARE PROVIDERS; AND

25 (B) THE TASK FORCE SHALL CONTINUE WORKING TO DEVELOP A
26 COMPLETE SET OF UNIFORM, STANDARDIZED PAYMENT RULES AND CLAIM
27 EDITS AND, BY DECEMBER 31, 2012, SHALL SUBMIT A REPORT AND

1 RECOMMENDATIONS CONCERNING A SET OF UNIFORM, STANDARDIZED
2 PAYMENT RULES AND CLAIM EDITS TO BE USED BY PAYERS AND HEALTH
3 CARE PROVIDERS.

4 (IV) AS PART OF ITS RECOMMENDATIONS PURSUANT TO THIS
5 PARAGRAPH (d), THE TASK FORCE SHALL MAKE RECOMMENDATIONS
6 CONCERNING THE IMPLEMENTATION, UPDATING, AND DISSEMINATION OF
7 THE STANDARDIZED SET OF PAYMENT RULES AND CLAIM EDITS, INCLUDING
8 IDENTIFYING WHO IS RESPONSIBLE FOR ESTABLISHING A CENTRAL
9 REPOSITORY FOR ACCESSING THE RULES AND EDITS SET AND ENABLING
10 ELECTRONIC ACCESS, INCLUDING DOWNLOADING CAPABILITY, TO THE
11 RULES AND EDITS SET.

12 (V) THE STANDARDIZED PAYMENT RULES AND CLAIM EDITS
13 DEVELOPED PURSUANT TO SUBPARAGRAPH (III) OF THIS PARAGRAPH (d)
14 SHALL BE IMPLEMENTED BY PAYERS AS FOLLOWS:

15 (A) PAYERS THAT ARE COMMERCIAL HEALTH PLANS SHALL
16 IMPLEMENT THE STANDARDIZED SET OF PAYMENT RULES AND CLAIM EDITS
17 WITHIN THEIR CLAIMS PROCESSING SYSTEMS [REDACTED] ACCORDING TO A
18 SCHEDULE OUTLINED IN THE TASK FORCE RECOMMENDATIONS OR BY
19 JANUARY 1, 2015, WHICHEVER OCCURS FIRST; AND

20 (B) PAYERS THAT ARE DOMESTIC, NONPROFIT HEALTH PLANS
21 SHALL IMPLEMENT THE STANDARDIZED SET OF PAYMENT RULES AND
22 CLAIM EDITS WITHIN THEIR CLAIMS PROCESSING SYSTEMS BY [REDACTED] JANUARY
23 1, 2016.

24 (3) ONCE THE STANDARDIZED SET OF PAYMENT RULES AND CLAIM
25 EDITS IS ESTABLISHED AND IMPLEMENTED, NO OTHER PROPRIETARY OR
26 OTHER CLAIMS EDITS, OTHER THAN THOSE EDITS DESCRIBED IN
27 PARAGRAPH (c) OF SUBSECTION (4) OF THIS SECTION, SHALL BE APPLIED TO

1 MODIFY THE PAYMENT OF CHARGES FOR COVERED SERVICES; EXCEPT
2 THAT, IF NATIONAL STANDARDS ARE LATER IDENTIFIED FOR
3 STANDARDIZED PAYMENT RULES AND CLAIM EDITS, COLORADO PAYERS
4 SHALL COMPLY WITH THE NATIONAL STANDARDS WITHIN TWENTY-FOUR
5 MONTHS AFTER THOSE STANDARDS ARE PUBLISHED.

6 (4) NOTHING IN THIS SECTION SHALL BE CONSTRUED TO:

7 (a) INTERFERE WITH OR MODIFY THE ACTUAL CONTRACTED RATE
8 THAT IS REIMBURSED BY A CONTRACTING PERSON OR ENTITY TO A HEALTH
9 CARE PROVIDER FOR ANY PROCEDURE OR GROUPING OF PROCEDURES;

10 (b) LIMIT CONTRACTUAL ARRANGEMENTS OR TERMS NEGOTIATED
11 BETWEEN THE CONTRACTING PERSON OR ENTITY AND THE HEALTH CARE
12 PROVIDER; OR

13 (c) LIMIT THE ABILITY OF THE CONTRACTING PERSON OR ENTITY TO
14 APPLY PROPRIETARY OR OTHER CLAIMS EDITS USED TO DETERMINE
15 WHETHER OR NOT A COVERED SERVICE IS REASONABLE AND NECESSARY
16 FOR THE PATIENT'S CONDITION OR TREATMENT. THE EDITS PERMISSIBLE
17 PURSUANT TO THIS PARAGRAPH (c) ARE THOSE USED IN UTILIZATION
18 REVIEW, COST CONTAINMENT, OR MONITORING FOR SUSPECTED CASES OF
19 ABUSE OR FRAUD, AND THE EDITS MAY LIMIT COVERAGE BASED ON THE
20 DIAGNOSIS OR FREQUENCY REPORTED ON THE CLAIM. INFORMATION
21 PERTAINING TO THESE EDITS SHALL BE DISCLOSED WITHIN FOURTEEN DAYS
22 AFTER THE REQUEST OF THE HEALTH CARE PROVIDER IN ACCORDANCE
23 WITH SECTION 25-37-103 (1) (d).

24 (5) NOTHING IN THIS SECTION REQUIRES THE DEPARTMENT OF
25 HEALTH CARE POLICY AND FINANCING TO PROVIDE ADMINISTRATIVE OR
26 RESEARCH SUPPORT OR ASSISTANCE TO THE TASK FORCE IN CARRYING OUT
27 ITS DUTIES UNDER THIS SECTION.

1 (6) (a) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH
2 CARE POLICY AND FINANCING SHALL DESIGNATE A NONPROFIT OR PRIVATE
3 ORGANIZATION AS THE CUSTODIAL OF FUNDS FOR THE TASK FORCE. THE
4 DESIGNATED ORGANIZATION IS AUTHORIZED TO ACCEPT AND EXPEND
5 FUNDS AS NECESSARY FOR THE OPERATION OF THE TASK FORCE AND MAY
6 SOLICIT AND ACCEPT MONETARY AND IN-KIND GIFTS, GRANTS, AND
7 DONATIONS FOR USE IN FURTHERANCE OF THE TASK FORCE'S DUTIES AND
8 RESPONSIBILITIES. ANY MONEYS DONATED OR AWARDED TO THE
9 DESIGNATED ORGANIZATION FOR THE BENEFIT OF THE TASK FORCE ARE
10 NOT SUBJECT TO APPROPRIATION BY THE GENERAL ASSEMBLY, AND ANY
11 SUCH MONEYS THAT ARE UNEXPENDED OR UNENCUMBERED AT THE TIME
12 THE TASK FORCE IS DISSOLVED OR THIS SECTION REPEALS PURSUANT TO
13 SUBSECTION (7) OF THIS SECTION SHALL BE RETURNED TO THE DONORS OR
14 GRANTORS ON A PRO RATA BASIS, AS DETERMINED BY THE DESIGNATED
15 ORGANIZATION.

16 (b) THE DESIGNATED ORGANIZATION, ON BEHALF OF THE TASK
17 FORCE, MAY ACCEPT IN-KIND STAFF SUPPORT FROM NONPROFIT AGENCIES
18 OR PRIVATE GROUPS OR MAY CONTRACT WITH NONPROFIT AGENCIES OR
19 PRIVATE GROUPS FOR THE PURPOSE OF PROVIDING STAFF SUPPORT TO
20 ASSIST THE TASK FORCE IN CONDUCTING ITS DUTIES AND RESPONSIBILITIES
21 UNDER THIS SECTION. ANY STAFF SUPPORT PROVIDED BY A NONPROFIT
22 AGENCY OR PRIVATE GROUP, WETHER DONATED OR ENGAGED THROUGH A
23 CONTRACT, SHALL NOT BE CONSIDERED EMPLOYEES OF THE TASK FORCE
24 OR THE DESIGNATED ORGANIZATION.

25 (c) THE DESIGNATED ORGANIZATION SHALL PREPARE AN
26 OPERATING BUDGET FOR THE TASK FORCE. PRIOR TO EXPENDING ANY
27 MONEYS IT RECEIVES, THE DESIGNATED ORGANIZATION, ON BEHALF OF THE

1 TASK FORCE, SHALL TRANSMIT A COPY OF THE BUDGET TO THE EXECUTIVE
2 DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
3 AND SHALL CERTIFY TO THE EXECUTIVE DIRECTOR THAT THE DESIGNATED
4 ORGANIZATION HAS RECEIVED OR HAS AVAILABLE ADEQUATE FUNDING TO
5 COVER THE EXPENSES OF THE TASK FORCE AS IDENTIFIED IN THE BUDGET.

6 (7) THIS SECTION IS REPEALED, EFFECTIVE JUNE 30, 2012, UNLESS
7 THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY
8 AND FINANCING NOTIFIES THE REVISOR OF STATUTES, IN WRITING, THAT
9 THE ORGANIZATION DESIGNATED PURSUANT TO SUBSECTION (6) OF THIS
10 SECTION HAS CERTIFIED THAT, AS OF JUNE 30, 2012, IT HAS RECEIVED OR
11 HAS AVAILABLE SUFFICIENT MONEYS TO IMPLEMENT THIS SECTION.

12 **25-37-107. [Formerly 25-37-101 (5)] Claim adjudication**
13 **information - balance owing.** ~~(5)~~ Upon completion of processing of a
14 claim, the person or entity shall provide information to the health care
15 provider stating how the claim was adjudicated and the responsibility for
16 any outstanding balance of any party other than the person or entity.

17 **25-37-108. [Formerly 25-37-101 (10)] Assignment of rights -**
18 **requirements.** ~~(10)~~ (1) A person or entity shall not assign, allow access
19 to, sell, rent, or give the person's or entity's rights to the health care
20 provider's services pursuant to the person's or entity's contract unless ~~he~~
21 ~~or she~~ THE PERSON OR ENTITY complies with paragraph (a), (b), or (c) of
22 this subsection (10) and also complies with paragraphs (d) and (e) of this
23 subsection (10) as follows: THE REQUIREMENTS OF THIS SECTION.

24 (2) A PERSON OR ENTITY MAY ASSIGN, ALLOW ACCESS TO, SELL,
25 RENT, OR GIVE HIS, HER, OR ITS RIGHTS TO THE HEALTH CARE PROVIDER'S
26 SERVICES PURSUANT TO THE PERSON'S OR ENTITY'S CONTRACT IF ONE OF
27 THE FOLLOWING SITUATIONS EXISTS:

1 (a) The third party accessing the health care provider's services
2 under the contract is an employer or other entity providing coverage for
3 health care services to its employees or members and such employer or
4 entity has, with the person or entity contracting with the health care
5 provider, a contract for the administration or processing of claims for
6 payment or service provided pursuant to the contract with the health care
7 provider;

8 (b) The third party accessing the health care provider's services
9 under the contract is an affiliate of, subsidiary of, or is under common
10 ownership or control with the person or entity; or, is providing or
11 receiving administrative services from the person or entity or an affiliate
12 of, or subsidiary of, or is under common ownership or control with the
13 person or entity; OR

14 (c) The health care contract specifically provides that it applies to
15 network rental arrangements and states that it is for the purpose of
16 assigning, allowing access to, selling, renting, or giving the person's or
17 entity's rights to the health care provider's services.

18 (3) IN ADDITION TO SATISFYING THE REQUIREMENTS OF
19 SUBSECTION (2) OF THIS SECTION, A PERSON OR ENTITY MAY ASSIGN,
20 ALLOW ACCESS TO, SELL, RENT, OR GIVE HIS, HER, OR ITS RIGHTS UNDER
21 THE CONTRACT TO THE SERVICES OF THE HEALTH CARE PROVIDER ONLY IF:

22 ~~(d)~~ (a) The individuals receiving services under the health care
23 provider's contract are provided with appropriate identification stating
24 where claims should be sent and where inquiries should be directed; and

25 ~~(e)~~ (b) The third party accessing the health care provider's services
26 through the health care provider's contract is obligated to comply with all
27 applicable terms and conditions of the contract; except that a self-funded

1 plan receiving administrative services from the person or entity or its
2 affiliates shall be solely responsible for payment to the provider.

3 **25-37-109. [Formerly 25-37-101 (11)] Waiver of rights**
4 **prohibited.** ~~(11)~~ Except as permitted by this article, a person or entity
5 shall not require, as a condition of contracting, that a health care provider
6 waive or forego any right or benefit to which the health care provider may
7 be entitled under state or federal law, RULE, or regulation that provides
8 legal protections to a person solely based on the person's status as a health
9 care provider providing services in this state.

10 **25-37-110. [Formerly 25-37-101 (12)] Provider declining**
11 **service to new patients - notice - definition.** ~~(12)~~ (1) Upon sixty days'
12 notice, a health care provider may decline to provide service pursuant to
13 a contract to new patients covered by the person or entity. The notice
14 shall state the reason or reasons for this action.

15 ~~(2) For the purposes of this subsection (12)~~ AS USED IN THIS
16 SECTION, "new patients" means those patients who have not received
17 services from the health care provider in the immediately preceding three
18 years. A patient shall not become a "new patient" solely by changing
19 coverage from one person or entity to another person or entity.

20 **25-37-111. [Formerly 25-37-101 (13), (15), and**
21 **(17)] Termination of contract - effect on payment terms - right to**
22 **terminate - termination of pharmacy contracts.** ~~(13)~~ (1) A term for
23 compensation or payment shall not survive the termination of a contract,
24 except for a continuation of coverage required by law or with the
25 agreement of the health care provider.

26 ~~(15)~~ (2) In addition to the ~~provisions of paragraph (e) of~~
27 ~~subsection (2) of this section~~ RIGHT TO TERMINATE A CONTRACT IN

1 ACCORDANCE WITH SECTION 25-37-104 (2) BASED ON A MATERIAL
2 CHANGE TO THE CONTRACT, a contract with a duration of less than two
3 years shall provide to each party a right to terminate the contract without
4 cause, which termination shall occur with at least ninety days' written
5 notice. For contracts with a duration of two or more years, termination
6 without cause may be as specified in the contract.

7 ~~(17)~~ (3) A contract between a pharmacist or a pharmacy and a
8 pharmacy benefit manager, such as a pharmacy benefit management firm
9 as defined in section 10-16-102, C.R.S., shall be terminated if the federal
10 drug enforcement agency or other federal law enforcement agency ceases
11 the operations of the pharmacist or pharmacy due to alleged or actual
12 criminal activity.

13 **25-37-112. [Formerly 25-37-101 (14)] Disclosure to third**
14 **parties - confidentiality.** ~~(14)~~ A contract shall not preclude its use or
15 disclosure to a third party for the purpose of enforcing the provisions of
16 this article or enforcing other state or federal law. The third party shall
17 be bound by the confidentiality requirements set forth in the contract or
18 otherwise.

19 **25-37-113. [Formerly 25-37-101 (16) and (18)] Article**
20 **inapplicable - when.** ~~(16)~~ (1) This article shall not apply to:

21 (a) An exclusive contract with a single medical group in a specific
22 geographic area to provide or arrange for health care services; however,
23 this article shall apply to contracts for health care services between the
24 medical group and other medical groups;

25 (b) A contract or agreement for the employment of a health care
26 provider or a contract or agreement between health care providers;

27 (c) A contract or arrangement entered into by a hospital or health

1 care facility that is licensed or certified pursuant to section 25-3-101;

2 (d) A contract between a health care provider and the state or
3 federal government or their agencies for health care services provided
4 through a program for workers' compensation, medicaid, medicare, the
5 children's basic health plan provided for in article 8 of title 25.5, C.R.S.,
6 or the Colorado indigent care program created in part 1 of article 3 of title
7 25.5, C.R.S.;

8 (e) Contracts for pharmacy benefit management, such as with a
9 pharmacy benefit management firm as defined in section 10-16-102,
10 C.R.S.; except that this exclusion shall not apply to a contract for health
11 care services between a person or entity and a pharmacy, a pharmacist, or
12 a professional corporation or corporate entity consisting of pharmacies or
13 pharmacists as permitted by the laws of this state; or

14 (f) A contract or arrangement entered into by a hospital or health
15 care facility that is licensed or certified pursuant to section 25-3-101, or
16 any outpatient service provider that has entered into a joint venture with
17 the hospital or is owned by the hospital or health care facility.

18 ~~(18) Notwithstanding the applicable compliance date requirement~~
19 ~~in subsection (1) of this section, a domestic nonprofit health plan shall~~
20 ~~comply with this article within twelve months after the applicable~~
21 ~~compliance date.~~

22 **25-37-114. [Formerly 25-37-101 (20)] Enforcement.** ~~(20) (a)~~

23 (1) With respect to the enforcement of this article, including arbitration,
24 there shall be available:

- 25 ~~(A)~~ (a) Private rights of action at law and in equity;
- 26 ~~(B)~~ (b) Equitable relief, including injunctive relief;
- 27 ~~(C)~~ (c) Reasonable attorney fees when the health care provider

1 is the prevailing party in an action to enforce this article, except to the
2 extent that the violation of this article consisted of a mere failure to make
3 payment pursuant to a contract;

4 ~~(IV)~~ (d) The option to introduce as persuasive authority prior
5 arbitration awards regarding a violation of this article.

6 ~~(b)~~ (2) Arbitration awards related to the enforcement of this article
7 may be disclosed to those who have a bona fide interest in the arbitration.

8 **25-37-115. [Formerly 25-37-101 (21)] Providers obligated to**
9 **comply with law.** ~~(21)~~ No provision of this article shall be used to
10 justify any act or omission by a health care provider that is prohibited by
11 any applicable professional code of ethics or state or federal law
12 prohibiting discrimination against any person.

13 **25-37-116. Copyrights protected. NOTHING IN THIS ARTICLE,**
14 **INCLUDING THE DESIGNATION OF STANDARDS, CODE SETS, RULES, EDITS,**
15 **OR RELATED SPECIFICATIONS, DIVESTS COPYRIGHT HOLDERS OF THEIR**
16 **COPYRIGHTS IN ANY WORK REFERENCED IN THIS ARTICLE.**

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18 **SECTION 2. Safety clause.** The general assembly hereby finds,
19 determines, and declares that this act is necessary for the immediate
20 preservation of the public peace, health, and safety.