Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

PREAMENDED

This Unofficial Version Includes Committee Amendments Not Yet Adopted on Second Reading

LLS NO. 10-0264.01 Christy Chase

HOUSE BILL 10-1332

HOUSE SPONSORSHIP

Miklosi, Apuan, Gagliardi, Kefalas, Primavera, Tyler

SENATE SPONSORSHIP

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House Committees
Health and Human Services
Appropriations

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Health and Human Services

A BILL FOR AN ACT

CONCERNING THE CREATION OF THE "BARRY KEENE MEDICAL CLEAN 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

HOUSE
3rd Reading Unamended
March 25, 2010

HOUSE
Amended 2nd Reading
March 23, 2010

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.

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.

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

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

25-37-101. [Formerly 25-37-101 (1)] Applicability of article.

~~(1) Effective January 1, 2008~~ EXCEPT AS PROVIDED IN SECTION 25-37-106, a person or entity that contracts with a health care provider shall comply with this article and shall include the provisions required by this article in the contract. ~~A contract in existence prior to January 1,~~

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

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

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

~~(I)~~ (a) Health maintenance organization plans;

~~(II)~~ (b) Any other commercial plan or contract that is not a health maintenance organization plan;

~~(III)~~ (c) Medicare;

~~(IV)~~ (d) Medicaid; or

~~(V)~~ (e) Workers' compensation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) "Material change" does not include:

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

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

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

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

is clearly identified in the contract;

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

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

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

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

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

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

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

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

(I) The terms governing compensation and payment;

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

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

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

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

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

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

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

and to whom the notice shall be given.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) PRACTICE MANAGEMENT SYSTEM VENDORS;

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

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

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

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

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

REPRESENTED BY THE FOLLOWING:

(I) THE NCCI;

(II) CMS DIRECTIVES, MANUALS, AND TRANSMITTALS;

(III) THE MEDICARE PHYSICIAN FEE SCHEDULE;

(IV) THE CMS NATIONAL CLINICAL LABORATORY FEE SCHEDULE;

(V) THE HCPCS CODING SYSTEM AND DIRECTIVES;

(VI) THE CPT CODING GUIDELINES AND CONVENTIONS; AND

(VII) NATIONAL MEDICAL SPECIALTY SOCIETY CODING GUIDELINES.

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

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

(A) UNBUNDLE;

(B) MUTUALLY EXCLUSIVE;

(C) MULTIPLE PROCEDURE REDUCTION;

(D) AGE;

(E) GENDER;

(F) MAXIMUM FREQUENCY PER DAY;

(G) GLOBAL SURGERY DAYS;

(H) PLACE OF SERVICE;

(I) TYPE OF SERVICE;

(J) ASSISTANT AT SURGERY;

(K) CO-SURGEON;

(L) TEAM SURGEONS;

(M) TOTAL, PROFESSIONAL, OR TECHNICAL SPLITS;

(N) BILATERAL PROCEDURES;

(O) ANESTHESIA SERVICES; AND

(P) THE EFFECT OF CPT AND HCPCS MODIFIERS ON THESE EDITS AS APPLICABLE.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25-37-114. [Formerly 25-37-101 (20)] Enforcement. ~~(20) (a)~~ (1) With respect to the enforcement of this article, including arbitration, there shall be available:

~~(I)~~ (a) Private rights of action at law and in equity;

~~(II)~~ (b) Equitable relief, including injunctive relief;

~~(III)~~ (c) Reasonable attorney fees when the health care provider

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

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

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

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

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

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