## 10-16-705. Requirements for carriers and participating providers.

(1) In addition to any other applicable requirements of this part 7, a carrier offering a managed care plan shall satisfy all the requirements of this section.

(2) A carrier shall maintain a mechanism by which providers can access information on the covered health services for which the provider is responsible, including any limitations or conditions on services.

(3) Every contract between a carrier and a participating provider shall set forth a hold harmless provision specifying that covered persons shall, in no circumstances, be liable for money owed to participating providers by the plan and that in no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the carrier. Nothing in this section shall prohibit a participating provider from collecting coinsurance, deductibles, or copayments as specifically provided in the covered person's contract with the managed care plan.

(4) (a) Every contract between a carrier and a participating provider shall include provisions for continuity of care as specified in this subsection (4).

(b) Each managed care plan shall allow covered persons to continue receiving care for sixty days from the date a participating provider is terminated by the plan without cause when proper notice as specified in subsection (7) of this section has not been provided to the covered person.

(c) In the circumstance that coverage is terminated for any reason other than nonpayment of the premium, fraud, or abuse, every managed care plan shall provide for continued care for covered persons being treated at an in-patient facility until the patient is discharged.

(5) (a) Except as provided for in paragraph (b) of this subsection (5), notwithstanding any contractual provision to the contrary, a carrier that has entered into contracts with one or more contractors or subcontractors or their intermediaries to provide covered health care services to covered persons of the carrier under any managed care plan shall, in the event of nonpayment by, or insolvency of, such contractors or subcontractors or their intermediaries, remain responsible for the payment of all participating providers that have provided covered health care services to covered persons of the carrier pursuant to one or more contracts with such contractors or subcontractors or their intermediaries. Any contracting provider that provides covered health care services to covered persons of the carrier under a managed care contract shall, in the event of nonpayment for such services, have legal standing to enforce the managed care contract against the carrier and receive payment for such services. In the event of the insolvency of a carrier, participating provider claims for unpaid services shall be a class 6 claim under section 10-3-541 (1) (f).

(b) A carrier may apply to the commissioner for the use of an alternative mechanism to ensure that all participating providers that have provided covered health care services to covered persons of the carrier pursuant to one or more contracts with such contractors or subcontractors or their intermediaries receive payment due. If approval is granted, said carrier shall be exempt from the requirements of paragraph (a) of this subsection (5).

(6) A carrier shall notify participating providers of the providers' responsibilities with respect to the carrier's applicable administrative policies and programs, including but not limited to, payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or state programs.

(6.5) A carrier that has entered into a contract with one or more intermediaries to conduct utilization management, utilization review, provider credentialing, administration of health insurance benefits, setting or

negotiation of reimbursement rates, payment to providers, network development, or disease management programs shall require the intermediary to comply with the same standards, guidelines, medical policies, and benefit terms of the carrier.

(7) A carrier and participating provider shall provide at least sixty days written notice to each other before terminating the contract without cause. The carrier shall make a good faith effort to provide written notice of termination within fifteen working days after receipt of or issuance of a notice of termination to all covered persons that are patients seen on a regular basis by the provider whose contract is terminating, regardless of whether the termination was for cause or without cause. Where a contract termination involves a primary care provider, all covered persons that are patients of that primary care provider shall also be notified. Within five working days after the date that the provider either gives or receives notice of termination, the provider shall supply the carrier with a list of those patients of the provider that are covered by a plan of the carrier.

(8) The rights and responsibilities under a contract between a carrier and a participating provider shall not be assigned or delegated by the provider without the prior written consent of the carrier, and any subcontracts shall comply with the requirements of this part 7.

(9) A carrier's contract with participating providers shall include a provision that participating providers do not discriminate, with respect to the provision of medically necessary covered benefits, against covered persons that are participants in a publicly financed program.

(9.5) If the health benefit plan provides coverage for a second opinion, the carrier and any entity that contracts with the carrier shall disclose the availability of the second opinion along with the health benefit description form.

(10) A carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of coverage or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for noncovered services.

(10.5) (a) A carrier that has entered into a contract with one or more intermediaries to conduct utilization management, utilization review, provider credentialing, administration of health insurance benefits, setting or negotiation of reimbursement rates, payment to providers, network development, or disease management programs, shall require the intermediary to indicate the name of the intermediary and the name of the carrier for which it is conducting the work when making any payment to a health care provider on behalf of the carrier.

(b) (I) A violation of subsection (6.5) of this section or this subsection (10.5) is an unfair or deceptive act or practice in the business of insurance pursuant to section 10-3-1104.

(II) The commissioner may examine the actions of a carrier pursuant to subsection (6.5) of this section and this subsection (10.5) when conducting a market conduct analysis pursuant to part 2 of article 1 of this title.

(11) A carrier shall not penalize a provider because the participating provider, in good faith, reports to state or federal authorities any act or practice by the carrier that jeopardizes patient health or welfare, or because the participating provider discusses the financial incentives or financial arrangements between the provider and the managed care plan.

(11.5) A carrier or entity that contracts with the carrier shall not penalize a primary care provider who makes a standing referral of a covered person to a specialist, nor shall the specialist treating the covered person be penalized, with actions that include but are not limited to disincentives or disaffiliation, except for violations of section 10-1-128.

(12) (a) A carrier shall establish one or more mechanisms by which the participating providers may determine, at the time services are provided, whether or not a person is covered by the carrier. If a carrier maintains only one mechanism, such mechanism shall not require electronic access.

(b) (I) Each carrier, regardless of the mechanism used, shall issue a verification code that the participating provider may use as proof of verification as required by section 10-16-704 (4.5) (f).

(II) In lieu of the requirements of this paragraph (b), for the purposes of verifying the carrier's communication to the provider pursuant to section 10-16-704 (4.5) (g) or (4.5) (h), a carrier may submit written confirmation to a provider within two business days.

(III) If a carrier provides electronic access as a mechanism to verify coverage, the carrier may, in lieu of the requirement to issue a verification code through such mechanism, accept as proof of verification a dated screen print from the carrier's electronic verification mechanism demonstrating that the member is eligible pursuant to section 10-16-704 (4.5) (g) or that the carrier is not required to pay for services pursuant to section 10-16-704 (4.5) (h).

(c) In lieu of the requirements of paragraph (b) of this subsection (12), a carrier may institute a policy providing that adjustments to claims related to eligibility will be made only if the carrier can demonstrate that the member did not appear as eligible on any of the carrier's verification mechanisms on the date of service.

(d) A carrier shall notify participating providers of the mechanisms available to verify eligibility and the carrier's intent with respect to the requirements of paragraphs (a), (b), and (c) of this subsection (12).

(13) A carrier shall establish procedures for resolution of administrative, payment, or other disputes between providers and the carrier.

(14) Every contract between a carrier or entity that contracts with a carrier and a participating provider for a managed care plan that requires preauthorization for particular services, treatments, or procedures shall include:

(a) A provision that clearly states that the sole responsibility for obtaining any necessary preauthorization rests with the participating provider that recommends or orders said services, treatments, or procedures, not with the covered person; and

(b) A provision that allows a covered person to receive a standing referral, as defined in section 10-16-102 (43.5), for medically necessary treatment, to a specialist or specialized treatment center participating in the carrier's network or participating in a subdivision or subgrouping of the carrier's network if the subdivision or subgrouping demonstrates network adequacy pursuant to section 10-16-704. The primary care provider for the covered person, in consultation with the specialist and covered person, shall determine that the covered person needs ongoing care from the specialist in order to make the standing referral. A time period for the standing referral of up to one year, or a longer period of time if authorized by the carrier or any entity that contracts with the carrier, shall be determined by the primary care provider in consultation with the specialist or specialized treatment center. The specialist or specialized treatment center shall refer the covered person back to the primary care provider for primary care. To be reimbursed by the carrier or entity contracting with a carrier, treatment provided by the specialist shall be for a covered person and must comply with provisions contained in the covered person's certificate or policy. The primary care physician shall record the reason, diagnosis, or treatment plan necessitating the standing referral.

(15) A contract between a carrier and a participating provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or this part 7.

(16) A provider who is not licensed to furnish health care services in this state and who participates in a network shall be licensed in the state in which the provider practices and shall meet minimum statutory and regulatory standards for that professional practice applicable in this state.

**Source: L. 97:** Entire part added, p. 1328, § 2, effective July 1. **L. 99:** (9.5) and (11.5) added and (14) amended, p. 318, § 2, effective July 1. **L. 2002:** (12) amended, p. 886, § 2, effective January 1, 2003; (16) added, p. 1299, § 14, effective January 1, 2003. **L. 2003:** (11.5) and (12)(b)(I) amended, p. 618, § 21, effective

July 1. **L. 2009:** (6.5) and (10.5) added, (HB 09-1061), ch. 197, p. 885, § 1, effective August 5.

**Cross references:** For the legislative declaration contained in the 1999 act amending this section, see section 1 of chapter 111, Session Laws of Colorado 1999.

## ANNOTATION

**Subsection (7) of this section and § 10-16-121 are expressions of the intent of the general assembly that termination clauses should be permitted in contracts between doctors and health care providers.** Grossman v. Columbine Medical Group, Inc., 12 P.3d 269 (Colo. App. 1999).