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SENATE BILL NO. 403

Offered January 9, 2008

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A BILL to amend and reenact § 38.2-3407.15 of the Code of Virginia, relating to payment of accident and sickness insurance claims.

Patron—Puckett

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:**1. That § 38.2-3407.15 of the Code of Virginia is amended and reenacted as follows:**

§ 38.2-3407.15. Ethics and fairness in carrier business practices.

A. As used in this section:

"Carrier," "enrollee" and "provider" shall have the meanings set forth in § 38.2-3407.10; however, a "carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) of this title or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.

"Clean claim" means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with this section.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (CHAMPUS); or (ii) accident only, credit or disability insurance, long-term care insurance, CHAMPUS supplement, Medicare supplement, or workers' compensation coverages.

"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other payments currently owed to the provider, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the provider.

B. Subject to subsection H, every provider contract entered into by a carrier shall contain specific provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

b. The claim was submitted fraudulently.

Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The

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59 person submitting the claim shall be entitled to inspect such record on request and to rely on that record
60 or on any other admissible evidence as proof of the fact of receipt of the claim, including without
61 limitation electronic or facsimile confirmation of receipt of a claim.

62 2. A carrier shall, within 30 days after receipt of a claim, request electronically or in writing from
63 the person submitting the claim the information and documentation that the carrier reasonably believes
64 will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt
65 of the additional information requested under this subsection necessary to make the original claim a
66 clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier
67 may refuse to pay a claim for health care services rendered pursuant to a provider contract which are
68 covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim
69 of the matters identified above unless such failure was caused in material part by the person submitting
70 the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of
71 payment of such a claim if permitted by the provider contract unless such retroactive denial of payment
72 of the claim would violate subdivision 6 of this subsection. Nothing in this subsection shall require a
73 carrier to pay a claim which is not a clean claim.

74 3. Any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1 of this title, under
75 any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid,
76 be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.

77 4. a. Every carrier shall establish and implement reasonable policies to permit any provider with
78 which there is a provider contract (i) to confirm in advance during normal business hours by free
79 telephone or electronic means if available whether the health care services to be provided are medically
80 necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider
81 (or to the type of health care services which the provider has contracted to deliver under the provider
82 contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of
83 a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c)
84 provider-specific payment and reimbursement methodology, coding levels and methodology,
85 downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and
86 payment matters necessary to meet the terms and conditions of the provider contract, including
87 determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or
88 downcodes claims submitted by a provider, the carrier shall clearly disclose that practice in each
89 provider contract. Further, such carrier shall either (i) disclose in its provider contracts or on its website
90 the specific bundling and downcoding policies that the carrier reasonably expects to be applied to the
91 provider or provider's services on a routine basis as a matter of policy or (ii) disclose in each provider
92 contract a telephone or facsimile number or e-mail address that a provider can use to request the specific
93 bundling and downcoding policies that the carrier reasonably expects to be applied to that provider or
94 provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a
95 provider, a carrier shall provide the requesting provider with such policies within 10 business days
96 following the date the request is received.

97 b. Every carrier shall make available to such providers within 10 business days of receipt of a
98 request, copies of or reasonable electronic access to all such policies which are applicable to the
99 particular provider or to particular health care services identified by the provider. In the event the
100 provision of the entire policy would violate any applicable copyright law, the carrier may instead
101 comply with this subsection by timely delivering to the provider a clear explanation of the policy as it
102 applies to the provider and to any health care services identified by the provider.

103 5. Every carrier shall pay a claim if the carrier has previously authorized the health care service or
104 has advised the provider or enrollee in advance of the provision of health care services that the health
105 care services are medically necessary and a covered benefit, unless:

106 a. The documentation for the claim provided by the person submitting the claim clearly fails to
107 support the claim as originally authorized; or

108 b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider
109 has already been paid for the health care services identified on the claim, (iii) the claim was submitted
110 fraudulently or the authorization was based in whole or material part on erroneous information provided
111 to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person
112 receiving the health care services was not eligible to receive them on the date of service and the carrier
113 did not know, and with the exercise of reasonable care could not have known, of the person's eligibility
114 status.

115 5.1. A carrier's administrator of pharmacy benefits whose contract with a provider requires claims to
116 be submitted electronically shall make payments electronically to the participating provider or its
117 designee for clean claims submitted electronically in the form required by the payor, such as National
118 Council for Prescription Drug Programs, Inc. (NCPDP) standard format, provided such participating
119 provider or designee agrees to accept claims details for such payments electronically, in NCPDP
120 standard format, and provides accurate electronic funds transfer information to the payor.

6. No carrier may impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Effective July 1, 2000, a carrier shall notify a provider at least 30 days in advance of any retroactive denial of a claim.

7. Notwithstanding subdivision 6 of this subsection, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.

8. No provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules and exhibits thereto and any policies (including those referred to in subdivision 4 of this subsection) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

9. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

10. In the event that the carrier's provision of a policy required to be provided under subdivision 8 or 9 of this subsection would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

11. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers.

C. Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every carrier subject to regulation by this title shall adhere to and comply with the minimum fair business standards required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has violated the standards set forth in subsection B by failing to include the requisite provisions in its provider contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and B 2 in the performance of its provider contracts.

D. No carrier shall be in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the carrier's compliance is rendered impossible due to matters beyond the carrier's reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by the carrier.

E. Any provider who suffers loss as the result of a carrier's violation of this section or a carrier's breach of any provider contract provision required by this section shall be entitled to initiate an action to recover actual damages. If the trier of fact finds that the violation or breach resulted from a carrier's gross negligence and willful conduct, it may increase damages to an amount not exceeding three times the actual damages sustained. Notwithstanding any other provision of law to the contrary, in addition to any damages awarded, such provider also may be awarded reasonable attorney's fees and court costs. Each claim for payment which is paid or processed in violation of this section or with respect to which a violation of this section exists shall constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this subsection.

F. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the employment or other contractual relationship with a provider, or any provider contract, or otherwise penalize any provider, for invoking any of the provider's rights under this section or under the provider contract.

G. This section shall apply only to carriers subject to regulation under this title.

182 H. This section shall apply with respect to provider contracts entered into, amended, extended or
183 renewed on or after July 1, 1999.

184 I. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and
185 regulations as it may deem necessary to implement this section.

186 J. If any provision of this section, or the application thereof to any person or circumstance, is held
187 invalid or unenforceable, such determination shall not affect the provisions or applications of this section
188 which can be given effect without the invalid or unenforceable provision or application, and to that end
189 the provisions of this section are severable.

190 K. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of
191 this section.