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SENATE BILL NO. 765

Offered January 8, 2020
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A BILL to amend and reenact § 38.2-3407.15 of the Code of Virginia, relating to health insurance; ethics and fairness in carrier business practices; penalties.

Patron—Barker

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:

"Adverse change" means any action taken by a carrier that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a provider, an enrollee's access to covered health care services offered by the provider under the provider contract, the administrative expenses incurred by the provider in complying with the change, or the provider's inclusion in any provider networks or insurance products offered by the carrier. Examples of adverse change include a carrier's discontinuance of reimbursement for a particular health care service; a carrier's refusal to pay a reimbursement, or its payment of decreased reimbursement, on the basis of the location of service or professional designation of the provider or facility providing the service; or the imposition of a pre-certification or authorization of coverage requirement for a category of health care services performed within the provider contract. An adverse change shall not include (i) fee schedule changes attributable to a third party and over which the carrier has no control, including any Medicare or Medicaid fee schedule; (ii) changes made as a result of changes in provider billing practices, including an increase in a provider's charge master; or (iii) changes resulting from the introduction of, discontinuance of, or changed usage of a code or modifier by the American Medical Association or the federal Centers for Medicare and Medicaid Services.

"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.) 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.

"Codes" means, as applicable, Physicians' Current Procedural Terminology as published by the American Medical Association, Health Care Common Procedure Coding System codes as published by the National Uniform Billing Committee, diagnosis related group classifications, revenue codes, or other codes required or recognized by a carrier.

"Edit" means a practice or procedure pursuant to which one or more adjustments are made by a carrier to codes included in a claim that result in any one or more of the following:

1. Payment being made based on some, but not all, of the codes included in the claim;

2. Payment being made based on different codes than those included in the claim;

3. Payment for one or more of the codes included in the claim being reduced by application of multiple procedure logic; or

4. Payment for one or more of the codes being denied.

"Fee schedule" means the complete fee schedule that is applicable to and will be a part of an existing or contemplated provider contract for all health care services to be provided by a provider under a provider contract. For purposes of this definition, a summary providing fees for a list of most commonly used codes or procedures performed by the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis is not a fee schedule.

"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. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.

"Material provision" means any provider contract provision; any policy manual, coverage guideline, edit, multiple procedure logic, or audit procedure that is applicable to a provider contract; any change to provider network requirements; or the inclusion in a provider contract of any new or modified insurance product, the occurrence and timing of which is not otherwise clearly identified in the provider contract or any addendum, schedule, or exhibit thereto, that (i) decreases the provider's payment or compensation; (ii) limits an enrollee's access to covered services under his health plan; or (iii) changes the administrative procedures applicable to a provider contract in a way that may reasonably be expected to significantly increase the provider's administrative expense.

"Multiple procedure logic" means the practices or procedures used by a carrier to reduce the allowable amount for one or more of the codes included in a claim as a result of multiple surgical procedures or multiple services having been performed on the same patient on the same date of service.

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

2. A carrier shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that the carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 7. Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.

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

4. ~~a.~~ Every carrier shall establish and implement reasonable policies to permit any provider with

which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider ~~(~~or to the type of health care services which the provider has contracted to deliver under the provider contract~~)~~ for (a) pre-certification or authorization of coverage decisions~~,~~*;* (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim~~,~~*;* (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, *edits, use of multiple procedure logic,* and bundling of claims~~,~~*;* and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles ~~or~~, downcodes, *edits, or uses multiple procedure logic with respect to* claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either (1) disclose in its provider contracts or ~~on its website~~ *include in the provider contract a hyperlink for* the specific bundling ~~and~~, downcoding, *editing, or multiple procedure logic* policies that the carrier *has applied or* reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (2) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to request the specific bundling and downcoding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

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

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

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

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

c. During the post-service claims process, it is determined that the claim was submitted fraudulently.

6. In the case of an invasive or surgical procedure, if the carrier has previously authorized a health care service as medically necessary and during the procedure the health care provider discovers clinical evidence prompting the provider to perform a less or more extensive or complicated procedure than was previously authorized, then the carrier shall pay the claim, provided that the additional procedures were (i) not investigative in nature, but medically necessary as a covered service under the covered person's benefit plan; (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant with a carrier's post-service claims process, including required timing for submission to carrier.

7. 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.

8. Notwithstanding subdivision 7, 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.

9. No provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the *complete* 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~~ *for all health care services included under the provider contract with the provider* and (ii) all material *provisions,* addenda, schedules and exhibits thereto and any policies ~~(~~, including those referred to in subdivision 4~~)~~, 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. *Fee schedules shall be supplied in writing and made available in machine-readable electronic format. When the provider contract includes multiple health plans offered by the carrier and such health plans have different fee schedules, the carrier shall provide the complete fee schedule applicable to the provider for each health plan in which the provider participates or is proposed to participate.*

10. *No carrier shall unilaterally amend any provider contract or any material provision, addenda, schedule, exhibit, or policy thereto, or add any new material provision, addenda, schedule, exhibit, or policy thereto, as it relates to any material provision, addenda, schedule, exhibit, or policy thereto that was agreed to or accepted by the provider in the previous 12-month period, and no such amendment or addition shall be effective unless agreed to by the provider in a signed written amendment to the provider contract.* No amendment to any provider contract or to any *material provision,* 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)~~ *contract* 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~~)~~ *and an explanation of the adverse change* 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.

11. In the event that the carrier's provision of a policy required to be provided under subdivision 9 or 10 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.

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

13. Every carrier shall permit a provider a minimum of one year from the date a health care service is rendered to submit a claim for payment. Any provider contract mutually entered into between a carrier and provider that prohibits a provider from submitting a claim beyond the minimum time limit required under this section shall not be deemed a violation of this section.

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 2 in the performance of its provider contracts. *Pursuant to this jurisdiction, the Commission shall assist providers and examine and investigate provider complaints and inquiries relating to an alleged or suspected failure by a carrier to comply with the minimum fair business standards required under subsection B as it relates to any provider. The Commission shall provide a determination of whether a carrier has failed to comply with the minimum fair business standards required under subsection B in response to a provider complaint or inquiry within 60 days of receipt of a complaint or inquiry by a provider. The Commission is further empowered to gather information from any person subject to this chapter and determine whether the person's practices comply with the minimum fair business standards required under subsection B. Any person that refuses or fails to provide information in a timely manner to the Commission as provided in this section shall be subject to the enforcement and penalty provisions set forth in § 38.2-218. If the Commission determines that a carrier has failed to comply with the minimum fair business standards required under subsection B for which reasonable corrective action has not timely been taken by the carrier to correct such failure to comply, the Commission shall have the authority to impose penalties upon the carrier pursuant to its authority under § 38.2-218 and issue a cease and desist order upon the carrier pursuant to its authority under § 38.2-219.*

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~~, *that* 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.

H. This section shall apply with respect to provider contracts entered into, amended, extended or renewed on or after July 1, ~~1999~~ *2020*.

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

J. ~~The~~ *Except as provided in subsection C, the* Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.