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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2013

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A N A C T

RELATING TO INSURANCE - ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Representatives Marcello, Nunes, Hearn, and Corvese

Date Introduced: March 06, 2013

Referred To: House Corporations

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 27-18-61 of the General Laws in Chapter 27-18 entitled "Accident
2 and Sickness Insurance Policies" is hereby amended to read as follows:

3 **27-18-61. Prompt processing of claims.** -- (a) A health care entity or health plan
4 operating in the state shall pay all complete claims for covered health care services submitted to
5 the health care entity or health plan by a health care provider or by a policyholder within forty
6 (40) calendar days following the date of receipt of a complete written claim or within thirty (30)
7 calendar days following the date of receipt of a complete electronic claim. Each health plan shall
8 establish a written standard defining what constitutes a complete claim and shall distribute this
9 standard to all participating providers.

10 (b) If the health care entity or health plan denies or pends a claim, the health care entity
11 or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing
12 the health care provider or policyholder of any and all reasons for denying or pending the claim
13 and what, if any, additional information is required to process the claim. No health care entity or
14 health plan may limit the time period in which additional information may be submitted to
15 complete a claim.

16 (c) Any claim that is resubmitted by a health care provider or policyholder shall be
17 treated by the health care entity or health plan pursuant to the provisions of subsection (a) of this
18 section.

19 (d) A health care entity or health plan which fails to reimburse the health care provider

1 or policyholder after receipt by the health care entity or health plan of a complete claim within the
2 required timeframes shall pay to the health care provider or the policyholder who submitted the
3 claim, in addition to any reimbursement for health care services provided, interest which shall
4 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day
5 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a
6 complete written claim, and ending on the date the payment is issued to the health care provider
7 or the policyholder.

8 (e)(1) A healthcare entity or health plan shall not deny payment for a claim for medically
9 necessary inpatient services resulting from an emergency admission provided by a hospital solely
10 on the basis that the hospital did not timely notify such healthcare entity or health plan that the
11 services had been provided.

12 (2) Nothing in this subsection shall preclude a hospital and a healthcare entity or health
13 plan from agreeing to requirements for timely notification that medically necessary inpatient
14 services resulting from an emergency admission have been provided and to a reduction in
15 payment for failure to timely notify; provided, however that: (i) Any requirement for timely
16 notification must provide for a reasonable extension of timeframes for notification for emergency
17 services provided on weekends, state, or federal holidays, or during declared state or federally
18 declared states of emergency; (ii) Any agreed to reduction in payment for failure to timely notify
19 shall not exceed the lesser of two thousand dollars (\$2,000) or twelve percent (12%) of the
20 payment amount otherwise due for the services provided, and (iii) Any agreed to reduction in
21 payment for failure to timely notify shall not be imposed if the patient's insurance coverage could
22 not be determined by the hospital after reasonable efforts at the time the inpatient services were
23 provided.

24 (f) Except where the parties have developed a mutually agreed upon process for the
25 reconciliation of coding disputes that includes a review of submitted medical records to ascertain
26 the correct coding for payment, a hospital shall, upon receipt of payment of a claim for which
27 payment has been adjusted based on a particular coding to a patient including the assignment of
28 diagnosis and procedure, have the opportunity to submit the affected claim with medical records
29 supporting the hospital's initial coding of the claim within thirty (30) days of receipt of payment.
30 Upon receipt of such medical records, the healthcare entity or health plan shall review such
31 information to ascertain the correct coding for payment and process the claim in accordance with
32 the time frames set forth in subsection (a) of this section. In the event the healthcare entity or
33 health plan processes the claim consistent with its initial determination, such decision shall be
34 accompanied by a detailed statement in plain language of the healthcare entity or health plan

1 setting forth the specific reasons why the initial adjustment was appropriate. A healthcare entity
2 or health plan that increases the payment based on the information submitted by the hospital, but
3 fails to do so in accordance with the timeframes set forth in subsection (a) of this section, shall
4 pay to the hospital interest on the amount of such increase at the rate set pursuant to subsection
5 (d) of this section. Neither the initial or subsequent processing of the claim by the healthcare
6 entity or health plan shall be deemed an adverse determination if based solely on a coding
7 determination. Nothing in this subsection shall apply to those instances in which the insurer or
8 organization, or corporation has a reasonable suspicion of fraud or abuse.

9 ~~(e)~~(g) Exceptions to the requirements of this section are as follows:

10 (1) No health care entity or health plan operating in the state shall be in violation of this
11 section for a claim submitted by a health care provider or policyholder if:

12 (i) Failure to comply is caused by a directive from a court or federal or state agency;

13 (ii) The health care entity or health plan is in liquidation or rehabilitation or is operating
14 in compliance with a court-ordered plan of rehabilitation; or

15 (iii) The health care entity or health plan's compliance is rendered impossible due to
16 matters beyond its control that are not caused by it.

17 (2) No health care entity or health plan operating in the state shall be in violation of this
18 section for any claim: (i) initially submitted more than ninety (90) days after the service is
19 rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider
20 received the notice provided for in subsection (b) of this section; provided, this exception shall
21 not apply in the event compliance is rendered impossible due to matters beyond the control of the
22 health care provider and were not caused by the health care provider.

23 (3) No health care entity or health plan operating in the state shall be in violation of this
24 section while the claim is pending due to a fraud investigation by a state or federal agency.

25 (4) No health care entity or health plan operating in the state shall be obligated under this
26 section to pay interest to any health care provider or policyholder for any claim if the director of
27 business regulation finds that the entity or plan is in substantial compliance with this section. A
28 health care entity or health plan seeking such a finding from the director shall submit any
29 documentation that the director shall require. A health care entity or health plan which is found to
30 be in substantial compliance with this section shall thereafter submit any documentation that the
31 director may require on an annual basis for the director to assess ongoing compliance with this
32 section.

33 (5) A health care entity or health plan may petition the director for a waiver of the
34 provision of this section for a period not to exceed ninety (90) days in the event the health care

1 entity or health plan is converting or substantially modifying its claims processing systems.

2 ~~(h)~~(h) For purposes of this section, the following definitions apply:

3 (1) "Claim" means: (i) a bill or invoice for covered services; (ii) a line item of service; or
4 (iii) all services for one patient or subscriber within a bill or invoice.

5 (2) "Date of receipt" means the date the health care entity or health plan receives the
6 claim whether via electronic submission or as a paper claim.

7 (3) "Health care entity" means a licensed insurance company or nonprofit hospital or
8 medical or dental service corporation or plan or health maintenance organization, or a contractor
9 as described in section 23-17.13-2(2), which operates a health plan.

10 (4) "Health care provider" means an individual clinician, either in practice independently
11 or in a group, who provides health care services, and ~~otherwise referred to as a non-institutional~~
12 ~~provider~~ any healthcare facility, as defined in section 23-17-2 including any mental health and/or
13 substance abuse treatment facility, physician, or other licensed practitioners identified to the
14 review agent as having primary responsibility for the care, treatment, and services rendered to a
15 patient.

16 (5) "Health care services" include, but are not limited to, medical, mental health,
17 substance abuse, dental and any other services covered under the terms of the specific health plan.

18 (6) "Health plan" means a plan operated by a health care entity that provides for the
19 delivery of health care services to persons enrolled in those plans through:

20 (i) Arrangements with selected providers to furnish health care services; and/or

21 (ii) Financial incentive for persons enrolled in the plan to use the participating providers
22 and procedures provided for by the health plan.

23 (7) "Medically necessary" means services or supplies that are needed for the diagnosis or
24 treatment of a medical condition and meet generally accepted standards of medical practice. For
25 these purposes, "generally accepted standards of medical practice" means standards and
26 guidelines that include, but are not limited to, InterQual and other supporting information based
27 on credible scientific evidence published in peer-reviewed medical literature generally recognized
28 by the relevant medical community, physician specialty society recommendations and the views
29 of physicians practicing in relevant clinical areas, and any other relevant factors.

30 ~~(8)~~(8) "Policyholder" means a person covered under a health plan or a representative
31 designated by that person.

32 ~~(8)~~(9) "Substantial compliance" means that the health care entity or health plan is
33 processing and paying ninety-five percent (95%) or more of all claims within the time frame
34 provided for in subsections (a) and (b) of this section.

1 ~~(g)~~(i) Any provision in a contract between a health care entity or a health plan and a
2 health care provider which is inconsistent with this section shall be void and of no force and
3 effect.

4 SECTION 2. Section 27-19-52 of the General Laws in Chapter 27-19 entitled "Nonprofit
5 Hospital Service Corporations" is hereby amended to read as follows:

6 **27-19-52. Prompt processing of claims.** -- (a) A health care entity or health plan
7 operating in the state shall pay all complete claims for covered health care services submitted to
8 the health care entity or health plan by a health care provider or by a policyholder within forty
9 (40) calendar days following the date of receipt of a complete written claim or within thirty (30)
10 calendar days following the date of receipt of a complete electronic claim. Each health plan shall
11 establish a written standard defining what constitutes a complete claim and shall distribute this
12 standard to all participating providers.

13 (b) If the health care entity or health plan denies or pends a claim, the health care entity
14 or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing
15 the health care provider or policyholder of any and all reasons for denying or pending the claim
16 and what, if any, additional information is required to process the claim. No health care entity or
17 health plan may limit the time period in which additional information may be submitted to
18 complete a claim.

19 (c) Any claim that is resubmitted by a health care provider or policyholder shall be
20 treated by the health care entity or health plan pursuant to the provisions of subsection (a) of this
21 section.

22 (d) A health care entity or health plan which fails to reimburse the health care provider
23 or policyholder after receipt by the health care entity or health plan of a complete claim within the
24 required timeframes shall pay to the health care provider or the policyholder who submitted the
25 claim, in addition to any reimbursement for health care services provided, interest which shall
26 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day
27 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a
28 complete written claim, and ending on the date the payment is issued to the health care provider
29 or the policyholder.

30 (e)(1) A healthcare entity or health plan shall not deny payment for a claim for medically
31 necessary inpatient services resulting from an emergency admission provided by a hospital solely
32 on the basis that the hospital did not timely notify such healthcare entity or health plan that the
33 services had been provided.

34 (2) Nothing in this subsection shall preclude a hospital and a healthcare entity or health

1 plan from agreeing to requirements for timely notification that medically necessary inpatient
2 services resulting from an emergency admission have been provided and to a reduction in
3 payment for failure to timely notify; provided, however that: (i) Any requirement for timely
4 notification must provide for a reasonable extension of timeframes for notification for emergency
5 services provided on weekends, state, or federal holidays, or during declared state or federally
6 declared states of emergency; (ii) Any agreed to reduction in payment for failure to timely notify
7 shall not exceed the lesser of two thousand dollars (\$2,000) or twelve percent (12%) of the
8 payment amount otherwise due for the services provided, and (iii) Any agreed to reduction in
9 payment for failure to timely notify shall not be imposed if the patient's insurance coverage could
10 not be determined by the hospital after reasonable efforts at the time the inpatient services were
11 provided.

12 (f) Except where the parties have developed a mutually agreed upon process for the
13 reconciliation of coding disputes that includes a review of submitted medical records to ascertain
14 the correct coding for payment, a hospital shall, upon receipt of payment of a claim for which
15 payment has been adjusted based on a particular coding to a patient including the assignment of
16 diagnosis and procedure, have the opportunity to submit the affected claim with medical records
17 supporting the hospital's initial coding of the claim within thirty (30) days of receipt of payment.
18 Upon receipt of such medical records, the healthcare entity or health plan shall review such
19 information to ascertain the correct coding for payment and process the claim in accordance with
20 the time frames set forth in subsection (a) of this section. In the event the healthcare entity or
21 health plan processes the claim consistent with its initial determination, such decision shall be
22 accompanied by a detailed statement in plain language of the healthcare entity or health plan
23 setting forth the specific reasons why the initial adjustment was appropriate. A healthcare entity
24 or health plan that increases the payment based on the information submitted by the hospital, but
25 fails to do so in accordance with the timeframes set forth in subsection (a) of this section, shall
26 pay to the hospital interest on the amount of such increase at the rate set pursuant to subsection
27 (d) of this section. Neither the initial or subsequent processing of the claim by the healthcare
28 entity or health plan shall be deemed an adverse determination if based solely on a coding
29 determination. Nothing in this subsection shall apply to those instances in which the insurer or
30 organization, or corporation has a reasonable suspicion of fraud or abuse.

31 ~~(e)~~(g) Exceptions to the requirements of this section are as follows:

32 (1) No health care entity or health plan operating in the state shall be in violation of this
33 section for a claim submitted by a health care provider or policyholder if:

34 (i) Failure to comply is caused by a directive from a court or federal or state agency;

1 (ii) The health care provider or health plan is in liquidation or rehabilitation or is
2 operating in compliance with a court-ordered plan of rehabilitation; or

3 (iii) The health care entity or health plan's compliance is rendered impossible due to
4 matters beyond its control that are not caused by it.

5 (2) No health care entity or health plan operating in the state shall be in violation of this
6 section for any claim: (i) initially submitted more than ninety (90) days after the service is
7 rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider
8 received the notice provided for in section 27-18-61(b); provided, this exception shall not apply
9 in the event compliance is rendered impossible due to matters beyond the control of the health
10 care provider and were not caused by the health care provider.

11 (3) No health care entity or health plan operating in the state shall be in violation of this
12 section while the claim is pending due to a fraud investigation by a state or federal agency.

13 (4) No health care entity or health plan operating in the state shall be obligated under this
14 section to pay interest to any health care provider or policyholder for any claim if the director of
15 the department of business regulation finds that the entity or plan is in substantial compliance
16 with this section. A health care entity or health plan seeking such a finding from the director shall
17 submit any documentation that the director shall require. A health care entity or health plan which
18 is found to be in substantial compliance with this section shall after this submit any
19 documentation that the director may require on an annual basis for the director to assess ongoing
20 compliance with this section.

21 (5) A health care entity or health plan may petition the director for a waiver of the
22 provision of this section for a period not to exceed ninety (90) days in the event the health care
23 entity or health plan is converting or substantially modifying its claims processing systems.

24 ~~(h)~~ For purposes of this section, the following definitions apply:

25 (1) "Claim" means:

26 (i) A bill or invoice for covered services;

27 (ii) A line item of service; or

28 (iii) All services for one patient or subscriber within a bill or invoice.

29 (2) "Date of receipt" means the date the health care entity or health plan receives the
30 claim whether via electronic submission or has a paper claim.

31 (3) "Health care entity" means a licensed insurance company or nonprofit hospital or
32 medical or dental service corporation or plan or health maintenance organization, or a contractor
33 as described in section 23-17.13-2(2), that operates a health plan.

34 (4) "Health care provider" means an individual clinician, either in practice independently

1 or in a group, who provides health care services, and ~~referred to as a non-institutional provider~~
2 any healthcare facility, as defined in section 23-17-2 including any mental health and/or
3 substance abuse treatment facility, physician, or other licensed practitioners identified to the
4 review agent as having primary responsibility for the care, treatment, and services rendered to a
5 patient.

6 (5) "Health care services" include, but are not limited to, medical, mental health,
7 substance abuse, dental and any other services covered under the terms of the specific health plan.

8 (6) "Health plan" means a plan operated by a health care entity that provides for the
9 delivery of health care services to persons enrolled in those plans through:

10 (i) Arrangements with selected providers to furnish health care services; and/or

11 (ii) Financial incentive for persons enrolled in the plan to use the participating providers
12 and procedures provided for by the health plan.

13 (7) "Medically necessary" means services or supplies that are needed for the diagnosis or
14 treatment of a medical condition and meet generally accepted standards of medical practice. For
15 these purposes, "generally accepted standards of medical practice" means standards and
16 guidelines that include, but are not limited to, InterQual and other supporting information based
17 on credible scientific evidence published in peer-reviewed medical literature generally recognized
18 by the relevant medical community, physician specialty society recommendations and the views
19 of physicians practicing in relevant clinical areas, and any other relevant factors.

20 ~~(7)~~(8) "Policyholder" means a person covered under a health plan or a representative
21 designated by that person.

22 ~~(8)~~(9) "Substantial compliance" means that the health care entity or health plan is
23 processing and paying ninety-five percent (95%) or more of all claims within the time frame
24 provided for in section 27-18-61(a) and (b).

25 ~~(9)~~(i) Any provision in a contract between a health care entity or a health plan and a
26 health care provider which is inconsistent with this section shall be void and of no force and
27 effect.

28 SECTION 3. Section 27-20-47 of the General Laws in Chapter 27-20 entitled "Nonprofit
29 Medical Service Corporations" is hereby amended to read as follows:

30 **27-20-47. Prompt processing of claims.** -- (a) A health care entity or health plan
31 operating in the state shall pay all complete claims for covered health care services submitted to
32 the health care entity or health plan by a health care provider or by a policyholder within forty
33 (40) calendar days following the date of receipt of a complete written claim or within thirty (30)
34 calendar days following the date of receipt of a complete electronic claim. Each health plan shall

1 establish a written standard defining what constitutes a complete claim and shall distribute the
2 standard to all participating providers.

3 (b) If the health care entity or health plan denies or pends a claim, the health care entity
4 or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing
5 the health care provider or policyholder of any and all reasons for denying or pending the claim
6 and what, if any, additional information is required to process the claim. No health care entity or
7 health plan may limit the time period in which additional information may be submitted to
8 complete a claim.

9 (c) Any claim that is resubmitted by a health care provider or policyholder shall be
10 treated by the health care entity or health plan pursuant to the provisions of subsection (a) of this
11 section.

12 (d) A health care entity or health plan which fails to reimburse the health care provider
13 or policyholder after receipt by the health care entity or health plan of a complete claim within the
14 required timeframes shall pay to the health care provider or the policyholder who submitted the
15 claim, in addition to any reimbursement for health care services provided, interest which shall
16 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day
17 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a
18 complete written claim, and ending on the date the payment is issued to the health care provider
19 or the policyholder.

20 (e)(1) A healthcare entity or health plan shall not deny payment for a claim for medically
21 necessary inpatient services resulting from an emergency admission provided by a hospital solely
22 on the basis that the hospital did not timely notify such healthcare entity or health plan that the
23 services had been provided.

24 (2) Nothing in this subsection shall preclude a hospital and a healthcare entity or health
25 plan from agreeing to requirements for timely notification that medically necessary inpatient
26 services resulting from an emergency admission have been provided and to a reduction in
27 payment for failure to timely notify; provided, however that: (i) Any requirement for timely
28 notification must provide for a reasonable extension of timeframes for notification for emergency
29 services provided on weekends, state, or federal holidays, or during declared state or federally
30 declared states of emergency; (ii) Any agreed to reduction in payment for failure to timely notify
31 shall not exceed the lesser of two thousand dollars (\$2,000) or twelve percent (12%) of the
32 payment amount otherwise due for the services provided, and (iii) Any agreed to reduction in
33 payment for failure to timely notify shall not be imposed if the patient's insurance coverage could
34 not be determined by the hospital after reasonable efforts at the time the inpatient services were

1 provided.

2 (f) Except where the parties have developed a mutually agreed upon process for the
3 reconciliation of coding disputes that includes a review of submitted medical records to ascertain
4 the correct coding for payment, a hospital shall, upon receipt of payment of a claim for which
5 payment has been adjusted based on a particular coding to a patient including the assignment of
6 diagnosis and procedure, have the opportunity to submit the affected claim with medical records
7 supporting the hospital's initial coding of the claim within thirty (30) days of receipt of payment.
8 Upon receipt of such medical records, the healthcare entity or health plan shall review such
9 information to ascertain the correct coding for payment and process the claim in accordance with
10 the time frames set forth in subsection (a) of this section. In the event the healthcare entity or
11 health plan processes the claim consistent with its initial determination, such decision shall be
12 accompanied by a detailed statement in plain language of the healthcare entity or health plan
13 setting forth the specific reasons why the initial adjustment was appropriate. A healthcare entity
14 or health plan that increases the payment based on the information submitted by the hospital, but
15 fails to do so in accordance with the timeframes set forth in subsection (a) of this section, shall
16 pay to the hospital interest on the amount of such increase at the rate set pursuant to subsection
17 (d) of this section. Neither the initial or subsequent processing of the claim by the healthcare
18 entity or health plan shall be deemed an adverse determination if based solely on a coding
19 determination. Nothing in this subsection shall apply to those instances in which the insurer or
20 organization, or corporation has a reasonable suspicion of fraud or abuse.

21 ~~(e)~~(g) Exceptions to the requirements of this section are as follows:

22 (1) No health care entity or health plan operating in the state shall be in violation of this
23 section for a claim submitted by a health care provider or policyholder if:

24 (i) Failure to comply is caused by a directive from a court or federal or state agency;

25 (ii) The health care entity or health plan is in liquidation or rehabilitation or is operating
26 in compliance with a court-ordered plan of rehabilitation; or

27 (iii) The health care entity or health plan's compliance is rendered impossible due to
28 matters beyond its control that are not caused by it.

29 (2) No health care entity or health plan operating in the state shall be in violation of this
30 section for any claim: (i) initially submitted more than ninety (90) days after the service is
31 rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider
32 received the notice provided for in section 27-18-61(b); provided, this exception shall not apply
33 in the event compliance is rendered impossible due to matters beyond the control of the health
34 care provider and were not caused by the health care provider.

1 (3) No health care entity or health plan operating in the state shall be in violation of this
2 section while the claim is pending due to a fraud investigation by a state or federal agency.

3 (4) No health care entity or health plan operating in the state shall be obligated under this
4 section to pay interest to any health care provider or policyholder for any claim if the director of
5 the department of business regulation finds that the entity or plan is in substantial compliance
6 with this section. A health care entity or health plan seeking such a finding from the director shall
7 submit any documentation that the director shall require. A health care entity or health plan which
8 is found to be in substantial compliance with this section shall after this submit any
9 documentation that the director may require on an annual basis for the director to assess ongoing
10 compliance with this section.

11 (5) A health care entity or health plan may petition the director for a waiver of the
12 provision of this section for a period not to exceed ninety (90) days in the event the health care
13 entity or health plan is converting or substantially modifying its claims processing systems.

14 ~~(f)~~(h) For purposes of this section, the following definitions apply:

15 (1) "Claim" means: (i) a bill or invoice for covered services; (ii) a line item of service; or
16 (iii) all services for one patient or subscriber within a bill or invoice.

17 (2) "Date of receipt" means the date the health care entity or health plan receives the
18 claim whether via electronic submission or has a paper claim.

19 (3) "Health care entity" means a licensed insurance company or nonprofit hospital or
20 medical or dental service corporation or plan or health maintenance organization, or a contractor
21 as described in section 23-17.13-2(2), that operates a health plan.

22 (4) "Health care provider" means an individual clinician, either in practice independently
23 or in a group, who provides health care services, and ~~referred to as a non-institutional provider~~
24 any healthcare facility, as defined in section 23-17-2 including any mental health and/or
25 substance abuse treatment facility, physician, or other licensed practitioners identified to the
26 review agent as having primary responsibility for the care, treatment, and services rendered to a
27 patient.

28 (5) "Health care services" include, but are not limited to, medical, mental health,
29 substance abuse, dental and any other services covered under the terms of the specific health plan.

30 (6) "Health plan" means a plan operated by a health care entity that provides for the
31 delivery of health care services to persons enrolled in the plan through:

32 (i) Arrangements with selected providers to furnish health care services; and/or

33 (ii) Financial incentive for persons enrolled in the plan to use the participating providers
34 and procedures provided for by the health plan.

1 (7) "Medically necessary" means services or supplies that are needed for the diagnosis or
2 treatment of a medical condition and meet generally accepted standards of medical practice. For
3 these purposes, "generally accepted standards of medical practice" means standards and
4 guidelines that include, but are not limited to, InterQual and other supporting information based
5 on credible scientific evidence published in peer-reviewed medical literature generally recognized
6 by the relevant medical community, physician specialty society recommendations and the views
7 of physicians practicing in relevant clinical areas, and any other relevant factors.

8 ~~(7)~~(8) "Policyholder" means a person covered under a health plan or a representative
9 designated by that person.

10 ~~(8)~~(9) "Substantial compliance" means that the health care entity or health plan is
11 processing and paying ninety-five percent (95%) or more of all claims within the time frame
12 provided for in section 27-18-61(a) and (b).

13 ~~(8)~~(f) Any provision in a contract between a health care entity or a health plan and a
14 health care provider which is inconsistent with this section shall be void and of no force and
15 effect.

16 SECTION 4. Section 27-41-64 of the General Laws in Chapter 27-41 entitled "Health
17 Maintenance Organizations" is hereby amended to read as follows:

18 **27-41-64. Prompt processing of claims. --** (a) A health care entity or health plan
19 operating in the state shall pay all complete claims for covered health care services submitted to
20 the health care entity or health plan by a health care provider or by a policyholder within forty
21 (40) calendar days following the date of receipt of a complete written claim or within thirty (30)
22 calendar days following the date of receipt of a complete electronic claim. Each health plan shall
23 establish a written standard defining what constitutes a complete claim and shall distribute this
24 standard to all participating providers.

25 (b) If the health care entity or health plan denies or pends a claim, the health care entity
26 or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing
27 the health care provider or policyholder of any and all reasons for denying or pending the claim
28 and what, if any, additional information is required to process the claim. No health care entity or
29 health plan may limit the time period in which additional information may be submitted to
30 complete a claim.

31 (c) Any claim that is resubmitted by a health care provider or policyholder shall be
32 treated by the health care entity or health plan pursuant to the provisions of subsection (a) of this
33 section.

34 (d) A health care entity or health plan which fails to reimburse the health care provider

1 or policyholder after receipt by the health care entity or health plan of a complete claim within the
2 required timeframes shall pay to the health care provider or the policyholder who submitted the
3 claim, in addition to any reimbursement for health care services provided, interest which shall
4 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day
5 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a
6 complete written claim, and ending on the date the payment is issued to the health care provider
7 or the policyholder.

8 (e) (1) A healthcare entity or health plan shall not deny payment for a claim for
9 medically necessary inpatient services resulting from an emergency admission provided by a
10 hospital solely on the basis that the hospital did not timely notify such healthcare entity or health
11 plan that the services had been provided.

12 (2) Nothing in this subsection shall preclude a hospital and a healthcare entity or health
13 plan from agreeing to requirements for timely notification that medically necessary inpatient
14 services resulting from an emergency admission have been provided and to a reduction in
15 payment for failure to timely notify; provided, however that: (i) Any requirement for timely
16 notification must provide for a reasonable extension of timeframes for notification for emergency
17 services provided on weekends, state, or federal holidays, or during declared state or federally
18 declared states of emergency; (ii) Any agreed to reduction in payment for failure to timely notify
19 shall not exceed the lesser of two thousand dollars (\$2,000) or twelve percent (12%) of the
20 payment amount otherwise due for the services provided, and (iii) Any agreed to reduction in
21 payment for failure to timely notify shall not be imposed if the patient's insurance coverage could
22 not be determined by the hospital after reasonable efforts at the time the inpatient services were
23 provided.

24 (f) Except where the parties have developed a mutually agreed upon process for the
25 reconciliation of coding disputes that includes a review of submitted medical records to ascertain
26 the correct coding for payment, a hospital shall, upon receipt of payment of a claim for which
27 payment has been adjusted based on a particular coding to a patient including the assignment of
28 diagnosis and procedure, have the opportunity to submit the affected claim with medical records
29 supporting the hospital's initial coding of the claim within thirty (30) days of receipt of payment.
30 Upon receipt of such medical records, the healthcare entity or health plan shall review such
31 information to ascertain the correct coding for payment and process the claim in accordance with
32 the time frames set forth in subsection (a) of this section. In the event the healthcare entity or
33 health plan processes the claim consistent with its initial determination, such decision shall be
34 accompanied by a detailed statement in plain language of the healthcare entity or health plan

1 setting forth the specific reasons why the initial adjustment was appropriate. A healthcare entity
2 or health plan that increases the payment based on the information submitted by the hospital, but
3 fails to do so in accordance with the timeframes set forth in subsection (a) of this section, shall
4 pay to the hospital interest on the amount of such increase at the rate set pursuant to subsection
5 (d) of this section. Neither the initial or subsequent processing of the claim by the healthcare
6 entity or health plan shall be deemed an adverse determination if based solely on a coding
7 determination. Nothing in this subsection shall apply to those instances in which the insurer or
8 organization, or corporation has a reasonable suspicion of fraud or abuse.

9 ~~(e)~~(g) Exceptions to the requirements of this section are as follows:

10 (1) No health care entity or health plan operating in the state shall be in violation of this
11 section for a claim submitted by a health care provider or policyholder if:

12 (i) Failure to comply is caused by a directive from a court or federal or state agency;

13 (ii) The health care entity or health plan is in liquidation or rehabilitation or is operating
14 in compliance with a court-ordered plan of rehabilitation; or

15 (iii) The health care entity or health plan's compliance is rendered impossible due to
16 matters beyond its control, which are not caused by it.

17 (2) No health care entity or health plan operating in the state shall be in violation of this
18 section for any claim: (i) initially submitted more than ninety (90) days after the service is
19 rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider
20 received the notice provided for in section 27-18-61(b); provided, this exception shall not apply
21 in the event compliance is rendered impossible due to matters beyond the control of the health
22 care provider and were not caused by the health care provider.

23 (3) No health care entity or health plan operating in the state shall be in violation of this
24 section while the claim is pending due to a fraud investigation by a state or federal agency.

25 (4) No health care entity or health plan operating in the state shall be obligated under this
26 section to pay interest to any health care provider or policyholder for any claim if the director of
27 the department of business regulation finds that the entity or plan is in substantial compliance
28 with this section. A health care entity or health plan seeking that finding from the director shall
29 submit any documentation that the director shall require. A health care entity or health plan which
30 is found to be in substantial compliance with this section shall submit any documentation the
31 director may require on an annual basis for the director to assess ongoing compliance with this
32 section.

33 (5) A health care entity or health plan may petition the director for a waiver of the
34 provision of this section for a period not to exceed ninety (90) days in the event the health care

1 entity or health plan is converting or substantially modifying its claims processing systems.

2 ~~(h)~~(h) For purposes of this section, the following definitions apply:

3 (1) "Claim" means: (i) a bill or invoice for covered services; (ii) a line item of service; or
4 (iii) all services for one patient or subscriber within a bill or invoice.

5 (2) "Date of receipt" means the date the health care entity or health plan receives the
6 claim whether via electronic submission or as a paper claim.

7 (3) "Health care entity" means a licensed insurance company or nonprofit hospital or
8 medical or dental service corporation or plan or health maintenance organization, or a contractor
9 as described in section 23-17.13-2(2) that operates a health plan.

10 (4) "Health care provider" means an individual clinician, either in practice independently
11 or in a group, who provides health care services, and is ~~referred to as a non-institutional provider~~
12 any healthcare facility, as defined in section 23-17-2 including any mental health and/or
13 substance abuse treatment facility, physician, or other licensed practitioners identified to the
14 review agent as having primary responsibility for the care, treatment, and services rendered to a
15 patient.

16 (5) "Health care services" include, but are not limited to, medical, mental health,
17 substance abuse, dental and any other services covered under the terms of the specific health plan.

18 (6) "Health plan" means a plan operated by a health care entity that provides for the
19 delivery of health care services to persons enrolled in the plan through:

20 (i) Arrangements with selected providers to furnish health care services; and/or

21 (ii) Financial incentive for persons enrolled in the plan to use the participating providers
22 and procedures provided for by the health plan.

23 ~~(7)~~ "Medically necessary" means services or supplies that are needed for the diagnosis
24 or treatment of a medical condition and meet generally accepted standards of medical practice.
25 For these purposes, "generally accepted standards of medical practice" means standards and
26 guidelines that include, but are not limited to, InterQual and other supporting information based
27 on credible scientific evidence published in peer-reviewed medical literature generally recognized
28 by the relevant medical community, physician specialty society recommendations and the views
29 of physicians practicing in relevant clinical areas, and any other relevant factors.

30 ~~(7)~~(8) "Policyholder" means a person covered under a health plan or a representative
31 designated by that person.

32 ~~(8)~~(9) "Substantial compliance" means that the health care entity or health plan is
33 processing and paying ninety-five percent (95%) or more of all claims within the time frame
34 provided for in section 27-18-61(a) and (b).

1 ~~(g)~~(i) Any provision in a contract between a health care entity or a health plan and a
2 health care provider which is inconsistent with this section shall be void and of no force and
3 effect.

4 SECTION 5. This act shall take effect upon passage.

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LC01545
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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO INSURANCE - ACCIDENT AND SICKNESS INSURANCE POLICIES

1 This act would revise the processing of health insurance claims relating to timely
2 notification, coding disputes, mental health and/or substance abuse treatment as well as defining
3 medically necessary services.

4 This act would take effect upon passage.

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LC01545
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