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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2014

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A N A C T

RELATING TO INSURANCE

Introduced By: Senator Gayle L. Goldin

Date Introduced: February 27, 2014

Referred To: Senate Health & Human Services

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 health care 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 health care entity or health plan that the  
11 services had been provided.

12 (2) Nothing in this subsection shall preclude a hospital and a health care 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 health care 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 health care 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 health care entity or health plan

1 setting forth the specific reasons why the initial adjustment was appropriate. A health care 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 health care  
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 health care facility, as defined in § 23-18-1.1 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 ~~(9)~~ (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 health care 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 health care entity or health plan that the  
33 services had been provided.

34           (2) Nothing in this subsection shall preclude a hospital and a health care 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 health care 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 health care 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 health care entity or health plan  
23 setting forth the specific reasons why the initial adjustment was appropriate. A health care 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 health care  
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)~~ (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 health care facility, as defined in § 27-19-1 including any mental health and/or substance  
3 abuse treatment facility, physician, or other licensed practitioners identified to the review agent as  
4 having primary responsibility for the care, treatment, and services rendered to a patient.

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

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

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

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

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

19 ~~(7)~~ (8) "Policyholder" means a person covered under a health plan or a representative  
20 designated by that person.

21 ~~(8)~~ (9) "Substantial compliance" means that the health care entity or health plan is  
22 processing and paying ninety-five percent (95%) or more of all claims within the time frame  
23 provided for in section 27-18-61(a) and (b).

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

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

29 **27-20-47. Prompt processing of claims.** -- (a) A health care entity or health plan  
30 operating in the state shall pay all complete claims for covered health care services submitted to  
31 the health care entity or health plan by a health care provider or by a policyholder within forty  
32 (40) calendar days following the date of receipt of a complete written claim or within thirty (30)  
33 calendar days following the date of receipt of a complete electronic claim. Each health plan shall  
34 establish a written standard defining what constitutes a complete claim and shall distribute the



1 standard to all participating providers.

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

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

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

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

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

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

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

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

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

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

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

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

34           (3) No health care entity or health plan operating in the state shall be in violation of this

1 section while the claim is pending due to a fraud investigation by a state or federal agency.

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

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

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

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

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

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

21 (4) "Health care provider" means an individual clinician, either in practice independently  
22 or in a group, who provides health care services, and ~~referred to as a non-institutional provider~~  
23 any health care facility, as defined in § 27-20-1 including any mental health and/or substance  
24 abuse treatment facility, physician, or other licensed practitioners identified to the review agent as  
25 having primary responsibility for the care, treatment, and services rendered to a patient.

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

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

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

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

33 (7) "Medically necessary" means services or supplies that are needed for the diagnosis or  
34 treatment of a medical condition and meet generally accepted standards of medical practice. For

1 these purposes. "generally accepted standards of medical practice" means standards and  
2 guidelines that include, but are not limited to, InterQual and other supporting information based  
3 on credible scientific evidence published in peer-reviewed medical literature generally recognized  
4 by the relevant medical community, Physician Specialty Society recommendations and the views  
5 of physicians practicing in relevant clinical areas, and any other relevant factors.

6 ~~(7)~~ (8) "Policyholder" means a person covered under a health plan or a representative  
7 designated by that person.

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

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

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

16 **27-41-64. Prompt processing of claims.** -- (a) A health care entity or health plan  
17 operating in the state shall pay all complete claims for covered health care services submitted to  
18 the health care entity or health plan by a health care provider or by a policyholder within forty  
19 (40) calendar days following the date of receipt of a complete written claim or within thirty (30)  
20 calendar days following the date of receipt of a complete electronic claim. Each health plan shall  
21 establish a written standard defining what constitutes a complete claim and shall distribute this  
22 standard to all participating providers.

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

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

32 (d) A health care entity or health plan which fails to reimburse the health care provider  
33 or policyholder after receipt by the health care entity or health plan of a complete claim within the  
34 required timeframes shall pay to the health care provider or the policyholder who submitted the

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

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

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

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

1 fails to do so in accordance with the timeframes set forth in subsection (a) of this section, shall  
2 pay to the hospital interest on the amount of such increase at the rate set pursuant to subsection  
3 (d) of this section. Neither the initial or subsequent processing of the claim by the health care  
4 entity or health plan shall be deemed an adverse determination if based solely on a coding  
5 determination. Nothing in this subsection shall apply to those instances in which the insurer or  
6 organization, or corporation has a reasonable suspicion of fraud or abuse.

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (4) "Health care provider" means an individual clinician, either in practice independently  
9 or in a group, who provides health care services, and ~~is referred to as a non-institutional provider~~  
10 health care facility, as defined in § 27-41-2 including any mental health and/or substance abuse  
11 treatment facility, physician, or other licensed practitioners identified to the review agent as  
12 having primary responsibility for the care, treatment, and services rendered to a patient.

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

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

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

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

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

27 ~~(7)~~ (8) "Policyholder" means a person covered under a health plan or a representative  
28 designated by that person.

29 ~~(8)~~ (9) "Substantial compliance" means that the health care entity or health plan is  
30 processing and paying ninety-five percent (95%) or more of all claims within the time frame  
31 provided for in section 27-18-61(a) and (b).

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

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

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LC004560  
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EXPLANATION  
BY THE LEGISLATIVE COUNCIL  
OF  
A N A C T  
RELATING TO INSURANCE

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1           This act would address the resolution of disputes which occur between health care  
2 providers and health insurance companies regarding notification requirements prior to treatment  
3 and disputes regarding the nature, cost and justification for services provided, a more specific  
4 framework for dispute resolution is created.

5           This act would take effect upon passage.

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