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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 693 Session of 2015

INTRODUCED BY MICCARELLI, COHEN, HELM, BARRAR AND MURT, MARCH 3, 2015

REFERRED TO COMMITTEE ON INSURANCE, MARCH 3, 2015

AN ACT

Providing for contracts of physicians, physician groups and physician organizations with health insurers.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short title.

This act shall be known and may be cited as the Fair Health Care Provider Contracting Act.

Section 2. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Capitation." The payment by a health insurer to physicians, physician groups or physician organizations of a per-member-per-month amount, such as percentage of premium, by which a health insurer transfers to the physicians, physician groups or physician organizations the financial risk for those covered services as set forth in the contract between the health insurer and the physicians, physician groups or physician organizations.

"CCI." The Centers for Medicare and Medicaid Services' published list of edits and adjustments that are made to health care providers' claims submitted for services or supplies provided to patients insured under the Medicare program and under other Federal insurance programs.

"Clean claim." A claim for payment for a covered service that has no defect or impropriety. The term does not include a claim from a physician who is under investigation for fraud or abuse regarding that claim.

"Clinical information." Clinical, operative or other medical records and reports maintained in the ordinary course of a physician's, physician group's or physician organization's business. The term shall include, where applicable, requested statements of medical necessity.

"CMS-1500." The current health care provider claim form created by the Centers for Medicare and Medicaid Services.

"Covered services." With respect to a particular health insurer, a health care benefit that is within the coverage described in the plan documents applicable to an eligible plan member of the health insurer.

"CPT." Current Procedural Terminology.

"CPT codes." Current medical nomenclature in the publications entitled "CPT Standard Edition," "CPT Professional Edition," "CPT Assistant" and "Principles of CPT Coding" that are published by the American Medical Association and contain a systematic listing and coding of procedures and services provided to patients by physicians and certain nonphysician health professionals.

"CPT conventions." Rules for the application of codes to the entire contents of the American Medical Association CPT book.

"CPT guidelines." Guidelines set forth in the introduction, beginning of each major section, subsections and code level parenthetic statements and cross references contained in the American Medical Association publication "CPT, Professional Edition." The term shall not include any reference to a publication that is not subject to the existing CPT Editorial Panel process, such as "CPT Assistant" or "Principles of CPT Coding."

"Edit." A practice or procedure pursuant to which one or more adjustments are made to CPT codes or HCPCS Level II codes included in a claim that results in one or more of the following:

(1) Payment being made based on some, but not all, of the CPT codes or HCPCS Level II codes included in the claim.

(2) Payment being made based on different CPT codes or HCPCS Level II codes than those included in the claim.

(3) Payment for one or more of the CPT codes or HCPCS Level II codes included in the claim being reduced by application of multiple procedure logic.

(4) Payment for one or more of the CPT codes or HCPCS Level II codes being denied.

"ERISA." The Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829) and the rules and regulations promulgated thereunder.

"Fully insured plan." A plan under which a health insurer assumes all or a majority of health care cost and utilization risk.

"HCPCS Level II codes." Healthcare Common Procedure Coding System Level II Codes, which are alphanumeric codes used to identify codes not included in CPT.

"Health insurer." An entity and its health subsidiaries and affiliates licensed under:

(1) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations); or

(2) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

"HIPAA." The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 136).

"Individually negotiated contract." A contract pursuant to which the parties to the contract, as a result of negotiation, agree to one or more modifications to the terms of a health insurer's applicable standard form agreement that:

(1) Substantially modify the standard form agreement.

(2) Are made to individually suit, in whole or in part, the needs of a participating physician, participating physician group or participating physician organization, such as higher or customized rates and other customized payment methodologies.

"Most favored nation clause." A clause within a health care provider contract that places an obligation on a participating physician, participating physician group or participating physician organization to grant to a health insurer contract terms and conditions that are identical to every other contract negotiated by the participating physician, participating physician group or participating physician organization with another health insurer or third-party payor entity, including more advantageous terms for the participating physician, participating physician group or participating physician organization.

"Nonparticipating physician." A physician, physician group

or physician organization that is not a participating physician, participating physician group or participating physician organization.

"Overpayment." With respect to a claim submitted by or on behalf of a physician, physician group or physician organization, any erroneous or excess payment that a health insurer makes for any reason, including the following:

(1) Payment at an incorrect rate.

(2) Duplicate payments for the same physician service.

(3) Payment with respect to an individual who was not a plan member on the date the physician provided the physician services that are the subject of the payment.

(4) Payment for any noncovered service.

"Participating physician." A physician who has entered into a valid written contract with a health insurer, or who has agreed pursuant to an arrangement with a physician group, physician organization or other entity which has a valid written contract with a health insurer, to provide covered services to that health insurer's plan members and, where applicable, who meets the health insurer's credentialing requirements during the effective period of the contract. The term does not include a physician who has entered into an agreement with a rental network.

"Participating physician group." A physician group that has entered into a valid written contract with a health insurer to provide covered services to that health insurer's plan members.

"Participating physician organization." A physician organization that has entered into a valid written contract with a health insurer to provide covered services to the health insurer's plan members.

"Physician." As defined in 1 Pa.C.S. § 1991 (relating to definitions).

"Physician group." Two or more physicians, and those claiming by or through them, who practice under a single taxpayer identification number.

"Physician organization." An association, partnership, corporation or other form of organization, such as independent practice associations and physician hospital organizations, that arranges for care to be provided to plan members by physicians organized under multiple taxpayer identification numbers.

"Physician services." Covered services that a physician provides to a plan member, as specified in applicable agreements with a health insurer or otherwise.

"Physician specialty society." A United States medical specialty society that represents diplomats certified by a board recognized by the American Board of Medical Specialties.

"Plan." A benefit plan through which a plan member obtains health care benefits set forth in pertinent plan documents.

"Plan documents." Documents defining the health care benefits available to a plan member, including the plan member's summary plan description, certificate of coverage or other applicable coverage documents and the terms and conditions under which the benefits are available under the plan.

"Plan member." An individual enrolled in or covered by a plan offered and administered by a health insurer.

"Precertification." The prior approval by a health insurer that a service or supply is medically necessary and not experimental or investigational.

"Product network." A network of participating physicians who, pursuant to contracts with a health insurer, provide

covered services to plan members for one or more products or types of products offered by the health insurer in exchange for a specified type of compensation.

"Provider website." The secure and password-protected online resources for participating physicians to obtain information about a health insurer, its products and policies and other information.

"Public website." The online resources for the public to obtain information about a health insurer, its products and policies and other information.

"Self-insured plan." Any plan other than a fully insured plan.

"Significant edit." An edit that a health insurer reasonably believes, based on its experience with submitted claims, shall cause, on the initial review of submitted claims, the denial of or reduction in payment for a particular CPT code or HCPCS Level II code more than 250 times per year.

Section 3. Availability of fee schedules and scheduled payment dates.

The following shall apply:

(1) A health insurer shall develop and implement a plan to reasonably permit its participating physicians, participating physician groups and participating physician organizations to access complete fee information with the applicable fee schedule amounts for a particular participating physician, participating physician group or participating physician organization pursuant to the participating physician's, participating physician group's or participating physician organization's direct written agreement with the health insurer. Access must be provided on

a confidential basis.

(2) A participating physician, participating physician group or participating physician organization may elect to view the fee schedule in an electronic, printed or CD-ROM format.

(3) The fee schedule information shall be provided by the fee-for-service dollar amount allowable for each CPT code for those CPT codes that a participating physician, participating physician group or participating physician organization in the same specialty typically uses in providing covered services.

(4) A participating physician, participating physician group or participating physician organization may request and the health insurer shall provide the fee-for-service dollar amount allowable for other CPT codes that its participating physician, participating physician group or participating physician organization bills the health insurer.

(5) A health insurer may base actual compensation on the health insurer's maximum allowable amount and other contract adjustments.

(6) A health insurer, upon written request from a participating physician, participating physician group or participating physician organization that, in each case, has entered into a written contract directly with the health insurer shall provide a printed fee schedule for up to 100 CPT codes customarily and routinely used by the participating physician, participating physician group or participating physician organization, as specified by the participating physician, participating physician group or participating physician organization.

(7) A health insurer is obligated to provide no more than two requests under paragraph (6) annually.

(8) A health insurer may not require its participating physicians, participating physician groups or participating physician organizations to provide the health insurer with billing rates as a precondition to the health insurer providing fee information under this section.

Section 4. Reduced precertification requirements.

(a) Posting.--Except as provided under subsection (b), a health insurer shall post on its provider website those services or supplies for which precertification is routinely required and shall update the posting to reflect changes in precertification requirements.

(b) Specification of services.--Notwithstanding subsection (a), a health insurer's self-insured plan customers may specify services or supplies for which precertification is required that differ from or are in addition to the services or supplies for which the health insurer routinely requires precertification for its fully insured plans. A self-insured plan may contract with a different entity to provide precertification services.

(c) Utilization.--A health insurer shall propose to its self-insured plan customers that they utilize the health insurer's standard list of services and supplies for which precertification is required.

(d) Customized list.--With a self-insured plan's approval, a health insurer shall post the self-insured plan's customized list of precertification requirements on its provider website.

Section 5. Notice of policy and procedure changes.

(a) Written notice.--If a health insurer intends to make any material adverse changes to the terms of its contracts,

including policies and procedures, the health insurer shall provide at least 90 days' written notice to each affected participating physician, participating physician group or participating physician organization with whom the health insurer has directly contracted, unless a shorter notice period is required by law. The written notice shall reasonably inform its participating physician, participating physician group or participating physician organization of the changes and that the changes shall not become effective before the conclusion of the notice period.

(b) Termination.--If a participating physician, participating physician group or participating physician organization objects to the changes that are subject to the notice, the participating physician, participating physician group or participating physician organization must, within 30 days of the date of the notice, provide written notice to terminate the contract with the health insurer. The termination shall take effect at the conclusion of the notice period unless, within 65 days of the date of the original notice, the health insurer provides written notice to the objecting participating physician, participating physician group or participating physician organization that it shall not implement the changes to which the physician, physician group or physician organization objects.

(c) Notice date.--The date of notice required under subsection (b) shall be the date the notice is sent by United States mail, by facsimile, or if the health insurer offers it, electronically at the option of the physician, physician group or physician organization.

Section 6. Disclosure of claims payment practices.

(a) Payment rules.--A health insurer shall consistently apply, in all material respects, its automated bundling and other claims payment rules for claims submitted by or on behalf of the health insurer's plan members. This subsection does not apply to claims payment under Medicaid, State Children's Health Insurance Program and other similar government programs for low-income persons and for members of State-established high risk pools.

(b) Disclosure.--Within 30 days of the effective date of this section, a health insurer shall disclose its significant edits on its provider website.

(c) Update.--A health insurer shall update its disclosure of significant edits once each calendar year to reflect changes in the health insurer's significant edits and the health insurer's experience with submitted claims. The health insurer shall promptly disclose newly adopted significant edits. The following shall apply:

(1) Within 30 days of the effective date of this section, a health insurer shall publish on its provider website, for each commercially available claims editing software product being used by the health insurer, a list identifying each customized edit added to the standard claims editing software product at the health insurer's request.

(2) Within 30 days of the effective date of this section, a health insurer may not routinely require submission of clinical information, before or after payment of claims, in connection with the health insurer's adjudication of a physician's claims for payment, except for the following:

(i) Claims for unlisted codes.

(ii) Claims to which a CPT modifier 22 is appended.

(iii) Other limited categories of claims which the health insurer determines are appropriate for routine review. The health insurer shall disclose these categories on its public website and provider website.

(d) Required submission.--Notwithstanding subsection (c)(2), a health insurer may require submission of clinical information in connection with a health insurer's adjudication of a physician's claims for payment for the purpose of investigating intentional or unintentional fraudulent or abusive billing practices, but only when the health insurer has a reasonable belief that the investigation is warranted.

(e) Contest.--A participating physician may contest any requirement that the participating physician submit clinical information in connection with a health insurer's adjudication of the participating physician's claims for payment for the purpose of investigating intentional or unintentional fraudulent or abusive billing practices.

(f) Intent.--Nothing under this section shall be construed to limit a health insurer's right to require submission of clinical information when the requirement is not in connection with a health insurer's adjudication of a physician's claims for payment or is otherwise permitted by this section, such as the right to require submission of clinical information for precertification purposes as consistent with this section.

(g) Publication.--Within 30 days of the effective date of this section, a health insurer shall publish on its provider website the limited code combinations for particular services or procedures, relative to CPT modifiers 25 and 59, which it has determined are not appropriately reported together. The health

insurer shall explain how its application of the rule differs from CPT codes, except that no determination shall be inconsistent with this section.

Section 7. Dispute resolution.

(a) Establishment.--Within 30 days of the effective date of this section, a health insurer shall establish a billing dispute external review process. The billing dispute external review process shall provide for a billing dispute reviewer to resolve disputes with physicians and physician groups arising from covered services provided to the health insurer's plan members by the physicians and physician groups either of the following:

(1) The health insurer's application of the health insurer's coding and payment rules and methodologies for fee-for-service claims, including, but not limited to, any bundling, downcoding, application of a CPT modifier and other reassignment of a code by the health insurer, to patient-specific factual situations, including, but not limited to, the appropriate payment when two or more CPT codes are billed together or whether a payment-enhancing modifier is appropriate.

(2) Any retained claim, if the retained claim is submitted by the physician to the billing dispute reviewer within 90 days after the effective date of this section or 30 days after exhaustion of the health insurer's internal appeals process, whichever is later. Each matter shall be a separate billing dispute.

(b) Jurisdiction.--The billing dispute reviewer does not have jurisdiction over any other dispute that falls outside the scope of the external review process set forth under subsection (a), including compliance disputes and disputes concerning the

scope of covered services. The billing dispute reviewer does not have jurisdiction or authority to revise or establish any reimbursement policy of the health insurer.

(c) Intent.--Nothing contained under this section shall be construed to supersede, alter or limit the rights or remedies otherwise available to any plan member under section 502(a) of ERISA or to supersede in any respect the claims procedures for plan members under section 503 of ERISA, or required by applicable Federal or State law or regulation.

(d) Appeal process.--

(1) The physician or physician group must exhaust the health insurer's internal appeals process before submitting a billing dispute to the billing dispute reviewer.

(2) A physician or physician group shall be deemed to have exhausted the health insurer's internal appeals process if the health insurer does not communicate a decision on an internal appeal within 30 days of the health insurer's receipt of all documentation reasonably needed to decide the internal appeal. If the health insurer and physician or physician group disagree as to whether the requirements of this paragraph have been satisfied, the disagreement shall be resolved by the billing dispute reviewer.

(e) Time.--Billing disputes shall be submitted to the billing dispute reviewer no more than 90 days after a physician or physician group exhausts the health insurer's internal appeals process. A billing dispute reviewer shall not hear or decide any billing dispute submitted more than 90 days after the health insurer's internal appeals process has been exhausted.

(f) Documentation.--A health insurer shall supply appropriate documentation to the billing dispute reviewer no

later than 30 days after requested by the billing dispute reviewer, which request shall not be made until billing disputes have been submitted with amounts in dispute that in aggregate exceed $500.

(g) Cooperation.--A health insurer shall cooperate with organized physician organizations in this Commonwealth to select the person to serve as the billing dispute reviewer on a local or regional basis.

Section 8. All products clauses prohibition.

(a) Capitated fee arrangement.--No health insurer may require a participating physician to participate in a capitated fee arrangement in order to participate in product networks in which the participating physician is compensated on a fee-for-service basis.

(b) Product networks.--No health insurer may require a participating physician to participate in its Medicare Advantage or Medicaid product networks in order to participate in its commercial product networks.

(c) Participation.--If a participating physician, participating physician group or participating physician organization chooses not to participate in all of the health insurer's product networks or terminates participation in some of the health insurer's product networks, the reimbursement levels offered to or applied by the health insurer to the participating physician, participating physician group or participating physician organization for the product network in which the participating physician, participating physician group or participating physician organization continues to participate shall not be lower than the health insurer's standard reimbursement levels in the geographic market. This subsection

shall not apply if a participating physician, participating physician group or participating physician organization has agreed in an individually negotiated contract to participate in more than one product network for a specified period of time, in which case the terms of the individually negotiated contract shall govern.

(d) Reimbursement level or incentive.--Notwithstanding subsection (c), the health insurer may offer a higher reimbursement level or other incentive to any participating physician, participating physician group or participating physician organization that elects to participate or elects to continue participation in more than one of the health insurer's product networks.

(e) Obligation.--Nothing under this section shall obligate a health insurer to pay more than the lesser of the participating physician's billed charges or the health insurer's applicable fee-for-service amount.

Section 9. Termination without cause.

(a) Written notice.--Unless an individually negotiated contract between a health insurer and a participating physician, participating physician group or participating physician organization specifies a different period of notice, or specifies that the contract may not be terminated except for cause during a defined period of time, a party to a contract between a health insurer and a participating physician, participating physician group or participating physician organization may terminate the contract without cause upon prior written notice provided to the other party. The notice shall be a definite period set forth in the agreement, which period shall be no less than 60 days or more than 120 days.

(b) Obligations.--In the event of a contract termination by either party, the following obligations shall apply with respect to the continuation of care for those patients of a participating physician, participating physician group or participating physician organization who are entitled to continuation of care as reasonably defined under the participating physician's, participating physician group's or participating physician organization's contract with the health insurer or under applicable law:

(1) The participating physician, participating physician group or participating physician organization shall continue to render necessary care to the health insurer's plan member consistent with contractual or legal obligations. Following notice by the participating physician, participating physician group, participating physician organization or the health insurer's plan member, if the health insurer does not use due diligence to make alternative care available to the affected plan member within 90 days after receipt of the notice, the health insurer shall pay to the participating physician, participating physician group or participating physician organization the standard rates paid to nonparticipating physicians for the applicable geographical area.

(2) Notwithstanding paragraph (1), a health insurer's obligations under this section shall not apply to the extent that other participating physicians, participating physician groups or participating physician organizations are not available to replace the terminated physician, physician group or physician organization due to:

(i) geographic or travel-time barriers; or

(ii) contractual provisions between the terminating physician, physician group or physician organization and a facility at which the health insurer's plan member receives care that limits or precludes other participating physicians, participating physician groups or participating physician organizations from rendering replacement services to the health insurer's plan members.

Section 10. Clinical judgment.

(a) Adoption.--A health insurer shall adopt and apply to its agreements with participating physicians the definition of "medically necessary" or a comparable term. The term shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

(1) in accordance with generally accepted standards of medical practice;

(2) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

(3) not primarily for the convenience of the patient, physician or other health care provider and are not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results relative to the diagnosis or treatment of that patient's illness, injury or disease.

(b) Definition.--As used in this section, the term "generally accepted standards of medical practice" means standards that are based on credible scientific evidence

published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Section 11. Medical policies.

In formulating and adopting medical policies with respect to covered services, a health insurer shall rely on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and shall continue to make the policies readily available to its plan members and participating physicians via its public website or by other electronic means. In formulating and adopting the policies, a health insurer shall take into account national physician specialty society recommendations and the views of prudent physicians practicing in relevant clinical areas and any other clinically relevant factors.

Section 12. Administrative exemption program.

(a) Exemption.--A health insurer shall consider the feasibility and desirability of exempting selected participating physicians from certain administrative requirements based on criteria such as the participating physician's delivery of quality and cost-effective medical care and accuracy and appropriateness of claims submissions.

(b) Construction.--No health insurer shall be obligated to implement any exemption. This section shall not be construed to limit a health insurer's ability to:

(1) implement a program on a pilot or experimental basis;

(2) base exemptions on any health-insurer-determined

basis; or

(3) otherwise implement one or more programs in select markets.

Section 13. Clean claims.

A health insurer shall direct the issuance of a check or electronic funds transfer in payment for clean claims for covered services within 30 days of the date of service.

Section 14. Evaluation and management claims.

(a) Prohibition.--No health insurer shall automatically reassign or reduce the code level of evaluation and management codes billed for covered services, also known as downcoding, except that a health insurer may reassign a new patient visit code to an established patient visit code based solely on CPT codes, CPT guidelines and CPT conventions.

(b) Denial.--A health insurer shall:

(1) Continue to have the right to deny, pend or adjust the claims for covered services on other bases.

(2) Have the right to reassign or reduce the code level for selected claims for covered services or claims for covered services submitted by selected physicians, physician groups or physician organizations, based on:

(i) A review of the clinical information at the time the service was rendered for the particular claims.

(ii) A review of information derived from a health insurer's fraud or abuse billing detection programs that create a reasonable belief of intentional or unintentional fraudulent or abusive billing practices, provided that the decision to reassign or reduce is based primarily on a review of clinical information.

Section 15. Claim editing.

(a) Duties.--A health insurer shall do all of the following:

(1) Take actions necessary to cause claim-editing software to produce editing results consistent with the standards set forth in this section.

(2) Process and separately reimburse those codes listed in the American Medical Association CPT book as modifier 51 exempt CPT codes without reducing payment under the health insurer's multiple procedure logic if the American Medical Association CPT book provides that the services are appropriately reported together.

(3) Process and separately reimburse codes listed in the American Medical Association CPT book as add-on billing codes without reducing payment under the health insurer's multiple procedure logic, if the American Medical Association CPT book provides that the add-on CPT codes are appropriately billed with proper primary procedure codes.

(b) Clinical information.--No health insurer shall require a physician to submit clinical information of a physician's patient encounters solely because the physician seeks payment for both surgical procedures and CPT evaluation and management services for the same patient on the same date of service, if the correct CPT evaluation and management code, surgical code and modifier are included on the initial claim submission.

(c) Code recognition.--If a claim contains a CPT code for an evaluation and management service, appended with a CPT modifier 25 and a CPT code for performance of a nonevaluation and management service procedure code, both codes shall be recognized and separately eligible for payment, unless the clinical information indicates that use of the CPT modifier 25 was inappropriate, pursuant to the limited number of finite code

combinations that are not appropriately reported together.

(d) Payment.--Payment shall only be made for one evaluation and management service for any single day unless payment for more than one is appropriate pursuant to the American Medical Association CPT book and is supported by appropriate diagnoses in the clinical information.

(e) Edits.--A health insurer shall remove from its claim review and payment systems any edits that generally deny payment for CPT evaluation and management codes with a CPT modifier 25 appended when submitted with surgical or other procedure codes for the same patient on the same date of service except for a limited number of exceptions, which shall be disclosed on the health insurer's provider website.

(f) Prohibition.--Nothing in this section shall prohibit a health insurer from requiring use of the appropriate CPT code modifiers for evaluation and management billing codes on the original claim forms or preclude a health insurer from requiring a physician, physician group or physician organization to submit to an audit of claims submitted by the physician, physician group or physician organization for payment directly to the physician, physician group or physician organization, such as claims for surgical procedures and evaluation and management services on the same date of service submitted with the appropriate modifier, and to provide their clinical information in connection with an audit.

(g) Supervision code.--A CPT code for supervision and interpretation or radiologic guidance shall be separately recognized and eligible for payment to the extent that the associated procedure code is recognized and eligible for payment if:

(1) the associated procedure code does not include supervision and interpretation or radiologic guidance according to the American Medical Association CPT book; and

(2) for each procedure, no health insurer shall be required to pay for supervision or interpretation or radiologic guidance by more than one qualified health care professional.

(h) Reassignment.--No health insurer shall reassign any CPT code into any other CPT code or deem a CPT code ineligible for payment based solely on the format of the published CPT descriptions.

(i) Modifier 59 codes.--A CPT code submitted with a modifier 59 attached shall be eligible for payment if the code follows the American Medical Association CPT book and it designates a distinct or independent procedure performed on the same day by the same physician, but only if:

(1) the procedures or services are appropriately reported together under the particular presenting circumstances; and

(2) it would not be more appropriate to append any other CPT-recognized modifier to the CPT code.

(j) Global periods.--No global periods for surgical procedures shall be longer than the period designated by Centers for Medicare and Medicaid Services, except that this limitation shall not restrict a health insurer from establishing a global period for surgical procedures, unless the Centers for Medicare and Medicaid Services has determined a global period is not appropriate or has identified a global period not associated with a specific number of days.

(k) Automatic change.--No health insurer shall automatically

change a CPT code to a code reflecting a reduced intensity of the service if the CPT code is among or across a series that includes, without limitation, CPT codes that differentiate among simple, intermediate and complex, complete or limited, and size.

Section 16. Overpayment recovery procedures.

(a) Time limit.--Except as provided under subsection (b), no health insurer shall initiate overpayment recovery efforts more than 18 months after the payment was received by the physician, except that no time limit shall apply to the initiation of overpayment recovery efforts:

(1) based on a reasonable belief of fraud or other intentional misconduct;

(2) required by a self-insured plan; or

(3) required by a Federal or State program.

(b) Underpayment.--Notwithstanding subsection (a), if a physician asserts a claim of underpayment, a health insurer may defend or set off a claim based on overpayments since the claimed underpayment.

(c) Appeal.--If a physician requests an appeal within 30 days of receipt of a request for repayment of an overpayment, no health insurer shall require the physician to repay the alleged overpayment before the appeal is concluded.

(d) Limitation.--Nothing under this section shall be construed to limit a health insurer's right to pursue recovery of overpayments that occurred prior to the effective date of this section if the health insurer has provided the physician with notice of the recovery efforts prior to the effective date of this section.

Section 17. Confirmation of medical necessity.

(a) Revocation.--If the health insurer certifies or

precertifies, approves or preapproves that a proposed service is medically necessary for one of its plan members, the health insurer shall not subsequently revoke that medical necessity determination absent from evidence of fraud, evidence that the information submitted was materially erroneous or incomplete or evidence of material change in that plan member's health condition between the date that the certification or precertification was provided and the date of the service that makes the proposed service no longer medically necessary for the plan member.

(b) New request.--If a health insurer certifies or precertifies the medical necessity of a course of treatment limited by number, time period or otherwise, a request for services beyond the certified course of treatment shall be deemed to be a new request and that health insurer's denial of such request shall not be deemed to be inconsistent with this section.

Section 18. Communications with plan members.

(a) Exchange of information.--No health insurer shall include in its contracts with participating physicians, participating physician groups or participating physician organizations any provision limiting:

(1) The free, open and unrestricted exchange of information between its physicians and its plan members regarding the nature of the plan member's medical conditions or treatment and provider options and the relative risks, benefits and costs to the plan member of the options.

(2) Whether or not the treatment is covered under the plan member's plan.

(3) Any right to appeal any adverse decision by the

health insurer regarding coverage of treatment that has been recommended or rendered.

(b) Prohibition.--A health insurer may not penalize or sanction participating physicians for engaging in any free, open and unrestricted communication with a plan member with respect to the subjects under subsection (a) or for advocating for any service on behalf of a plan member.

Section 19. Arbitration.

(a) Refund.--With respect to any arbitration proceeding between a health insurer and its participating physician who practices individually or in a participating physician group of fewer than six physicians, the health insurer shall refund any applicable filing fees and arbitrator's fees paid by the physician if the physician is the prevailing party with respect to the arbitration proceeding. This subsection shall not apply to any arbitration proceeding in which the participating physician purports to represent any physician outside of the physician group of the physician.

(b) Prohibited language.--A health insurer may not include in any agreement with a physician, physician group or physician organization a provision:

(1) requiring that any arbitration panel have multiple members;

(2) preventing the recovery of any statutory or otherwise legally available damages or other relief in an arbitration proceeding;

(3) restricting the statutory or otherwise legally available scope or standard of review;

(4) completely prohibiting discovery;

(5) shortening any statute of limitations; or

(6) requiring that any arbitration proceeding occur more than 50 miles from the principal office of the physician, physician group or physician organization.

Section 20. Most favored nation clause.

A health insurer may not include a most favored nation clause in its contracts with participating physicians, participating physician groups and participating physician organizations, except for individually negotiated contracts.

Section 21. Enforcement.

A physician may initiate a claim in a court of competent jurisdiction following exhaustion of the internal and external review processes.

Section 22. Effective date.

This act shall take effect immediately.