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THE GENERAL ASSEMBLY OF PENNSYLVANIA

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SENATE BILL

No. 554 Session of  
2015

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INTRODUCED BY ARGALL, ALLOWAY, GORDNER, WARD, MENSCH,  
McILHINNEY, SCHWANK, TARTAGLIONE, RAFFERTY, AUMENT, BLAKE,  
WOZNIAK AND MCGARRIGLE, FEBRUARY 25, 2015

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REFERRED TO BANKING AND INSURANCE, FEBRUARY 25, 2015

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AN ACT

1 Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An  
2 act relating to insurance; amending, revising, and  
3 consolidating the law providing for the incorporation of  
4 insurance companies, and the regulation, supervision, and  
5 protection of home and foreign insurance companies, Lloyds  
6 associations, reciprocal and inter-insurance exchanges, and  
7 fire insurance rating bureaus, and the regulation and  
8 supervision of insurance carried by such companies,  
9 associations, and exchanges, including insurance carried by  
10 the State Workmen's Insurance Fund; providing penalties; and  
11 repealing existing laws," providing for retroactive denial of  
12 reimbursement of payments to health care providers by  
13 insurers.

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

16 Section 1. The act of May 17, 1921 (P.L.682, No.284), known  
17 as The Insurance Company Law of 1921, is amended by adding an  
18 article to read:

19 ARTICLE VI-C

20 RETROACTIVE DENIAL OF REIMBURSEMENTS

21 Section 601-C. Scope of article.

22 This article shall not apply to reimbursements made as part  
23 of an annual contracted reconciliation of a risk-sharing

1 arrangement under an administrative service provider contract.

2 Section 602-C. Definitions.

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

6 "Code." Any of the following codes:

7 (1) The applicable Current Procedural Terminology (CPT)  
8 code, as adopted by the American Medical Association.

9 (2) If for dental service, the applicable code adopted  
10 by the American Dental Association.

11 (3) Another applicable code under an appropriate uniform  
12 coding scheme used by an insurer in accordance with this  
13 article.

14 "Coding guidelines." Those standards or procedures used or  
15 applied by a payor to determine the most accurate and  
16 appropriate code or codes for payment by the payor for a service  
17 or services.

18 "Fraud." The intentional misrepresentation or concealment of  
19 information in order to deceive or mislead.

20 "Health care provider." A person, corporation, facility,  
21 institution or other entity licensed, certified or approved by  
22 the Commonwealth to provide health care or professional medical  
23 services. The term includes, but is not limited to, a physician,  
24 chiropractor, optometrist, professional nurse, certified nurse-  
25 midwife, podiatrist, hospital, nursing home, ambulatory surgical  
26 center or birth center.

27 "Insurer." An entity subject to any of the following:

28 (1) 40 Pa.C.S. Ch. 61 (relating to hospital plan  
29 corporations) or 63 (relating to professional health services  
30 plan corporations).

1           (2) This act.

2           (3) The act of December 29, 1972 (P.L.1701, No.364),  
3           known as the Health Maintenance Organization Act.

4           "Medical assistance program." The program established under  
5           the act of June 13, 1967 (P.L.31, No.21), known as the Public  
6           Welfare Code.

7           "Medicare." The Federal program established under Title  
8           XVIII of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301  
9           et seq. or 1395 et seq.).

10          "Reimbursement." Payments made to a health care provider by  
11          an insurer on either a fee-for-service, capitated or premium  
12          basis.

13          Section 603-C. Retroactive denial of reimbursement.

14          (a) General rule.--If an insurer retroactively denies  
15          reimbursement to a health care provider, the insurer may only:

16                 (1) retroactively deny reimbursement for services  
17                 subject to coordination of benefits with another insurer, the  
18                 medical assistance program or the Medicare program during the  
19                 12-month period after the date that the insurer paid the  
20                 health care provider; and

21                 (2) except as provided in paragraph (1), retroactively  
22                 deny reimbursement during a 12-month period after the date  
23                 that the insurer paid the health care provider.

24          (b) Written notice.--An insurer that retroactively denies  
25          reimbursement to a health care provider under subsection (a)  
26          shall provide the health care provider with a written statement  
27          specifying the basis for the retroactive denial. If the  
28          retroactive denial of reimbursement results from coordination of  
29          benefits, the written statement shall provide the name and  
30          address of the entity acknowledging responsibility for payment

1 of the denied claim.

2 Section 604-C. Effect of noncompliance.

3 Except as provided in section 605-C, an insurer that does not  
4 comply with the provisions of section 603-C may not  
5 retroactively deny reimbursement or attempt in any manner to  
6 retroactively collect reimbursement already paid to a health  
7 care provider.

8 Section 605-C. Fraudulent or improperly coded information.

9 (a) Reasons for denial.--The provisions of section 603-B do  
10 not apply if an insurer retroactively denies reimbursement to a  
11 health care provider because:

12 (1) the information submitted to the insurer was  
13 fraudulent;

14 (2) the information submitted to the insurer was  
15 improperly coded and the insurer has provided to the health  
16 care provider sufficient information regarding the coding  
17 guidelines used by the insurer at least 30 days prior to the  
18 date the services subject to the retroactive denial were  
19 rendered; or

20 (3) the claim submitted to the insurer was a duplicate  
21 claim.

22 (b) Improper coding.--Information submitted to the insurer  
23 may be considered to be improperly coded under subsection (a) (2)  
24 if the information submitted to the insurer by the health care  
25 provider:

26 (1) uses codes that do not conform with the coding  
27 guidelines used by the carrier applicable as of the date the  
28 service or services were rendered; or

29 (2) does not otherwise conform with the contractual  
30 obligations of the health care provider to the insurer

1 applicable as of the date the service or services were  
2 rendered.

3 Section 606-C. Coordination of benefits.

4 If an insurer retroactively denies reimbursement for services  
5 as a result of coordination of benefits under provisions of  
6 section 605-C(a), the health care provider shall have six months  
7 from the date of the denial, unless an insurer permits a longer  
8 time period, to submit a claim for reimbursement for the service  
9 to the insurer, the medical assistance program or Medicare  
10 program responsible for payment.

11 Section 2. This act shall take effect in 60 days.