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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2012

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A N A C T

RELATING TO INSURANCE - NONPROFIT HOSPITAL SERVICE CORPORATIONS

Introduced By: Representatives Naughton, E Coderre, and Ferri

Date Introduced: February 15, 2012

Referred To: House Corporations

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 27-19-52 of the General Laws in Chapter 27-19 entitled "Nonprofit
2 Hospital Service Corporations" is hereby amended to read as follows:

3 **27-19-52. 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) A health care entity or health plan shall be required to pay for health care services
9 ordered by a health care provider if: (1) The services are a covered benefit under the insured's
10 health benefit plan; and (2) The services are medically necessary. A claim for treatment for
11 medically necessary services may not be denied if a health care provider follows the health care
12 insurer's authorization procedures and receives authorization for a covered service for the
13 policyholder or subscriber, unless the provider submitted information to the insurer with the
14 willful intention to misinform the insurer.

15 (f) A health care entity or health plan shall not deny payment for a claim for medically
16 necessary covered services on the basis of an administrative or technical defect in the claim
17 except in the case where the insurer has a reasonable basis, supported by specific information
18 available for review, that the claim for health care services rendered was submitted fraudulently.

19 (g) A health care entity or health plan shall have no more than twelve (12) months after
20 the original payment was received by the health care provider to recoup a full or partial payment
21 for a claim for services rendered, or to adjust a subsequent payment to reflect a recoupment of a
22 full or partial payment.

23 (h) A health care entity or health plan shall not recoup payments received by a health care
24 provider for services provided to a policy holder or subscriber that the insurer deems ineligible
25 for coverage because the policyholder or subscriber was retroactively terminated or retroactively
26 disenrolled for services, provided that the health care provider can document that it received
27 verification of an individual's eligibility status following the administrative requirements of the
28 insurer at the time service was provided. Claims may also not be recouped for utilization review
29 purposes if the services were already deemed medically necessary or the manner in which the
30 services were accessed or provided were previously approved by the health care entity or health
31 plan.

32 (e) (i) Exceptions to the requirements of this section are as follows:

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

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

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

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

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

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

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

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

25 (j) For purposes of this section, the following definitions apply:

26 (1) "Claim" means:

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

28 (ii) A line item of service; or

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

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

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

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

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

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

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

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

14 (7) "Policyholder" means a person covered under a health plan or a representative
15 designated by that person.

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

19 (k) Any provision in a contract between a health care entity or a health plan and a health
20 care provider which is inconsistent with this section shall be void and of no force and effect.

21 SECTION 2. This act shall take effect upon passage.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

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RELATING TO INSURANCE - NONPROFIT HOSPITAL SERVICE CORPORATIONS

1 This act would set forth the circumstances and procedures whereby all health care entities
2 and health plans would be required to pay for health care services if the services are covered
3 under the insurance plan or the services are medically necessary.

4 This act would take effect upon passage.

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