PRINTER'S NO. 3392

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2190 Session of 2014

INTRODUCED BY MICCARELLI, BARRAR, CUTLER, SWANGER, DeLUCA, COHEN AND MURT, APRIL 17, 2014

REFERRED TO COMMITTEE ON INSURANCE, APRIL 17, 2014

AN ACT

Providing for physician contracts 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 Federal 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 kept 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 number 1500 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," "CPT codes" or "AMA CPT book." Current medical nomenclature in the publication entitled "CPT Standard Edition," "CPT Professional Edition," "CPT Assistant" and "Principles of CPT Coding" published by the American Medical Association containing 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 that go across all sections and subsections of the American Medical

Association CPT book.

"CPT guidelines." Guidelines set out in the introduction, in the beginning to each of the six major sections, in the subsections and in the 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 another 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:

(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; or

(5) any combination of the above.

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

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

"HCPCS Level II codes." Alphanumeric codes used to identify those codes not included in CPT and that are commonly referred

to as Healthcare Common Procedure Coding System Level II codes.

"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, agreed 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." 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." 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 such as:

(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; and

(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 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 that health

insurer's plan members.

"Physician." The term shall have have the same meaning as given to it in section 2 of the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act and section 2 of the act of December 20, 1985 (P.L.417, No.112), known as the Medical Practice Act of 1985.

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

"Physician organization." Any 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, such as the plan member's summary plan description, certificate of coverage or other applicable coverage document 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," "precertify" or "precertifies." The

prior approval by a health insurer that the 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 on the effective date of this section to reasonably permit its participating physician, participating physician group or participating physician organization to view, by CDROM or electronically, at the health insurer's option, on a confidential basis, complete fee information showing the

applicable fee schedule amounts for the participating physician, participating physician group or participating physician organization pursuant to that participating physician's, participating physician group's or participating physician organization's direct written agreement with the health insurer.

(2) A participating physician, participating physician group or participating physician organization may elect to receive a hard copy of the fee schedule in lieu of the foregoing.

(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 actually 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) Each 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 that health insurer shall provide, by hard copy, the 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) Each health insurer shall be obligated to honor only two requests under paragraph (6) made annually by the participating physician, participating physician group or participating physician organization.

(8) Each health insurer shall attempt to include provisions in its agreements with delegated entities that require comparable disclosure.

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

Section 4. Reduced precertification requirements.

(a) Posting.--Except as provided under subsection (b), each health insurer shall post to its provider website, on the effective date of this section, those services or supplies for which precertification is routinely required for its products, and shall update the posting to the extent the services or supplies for which precertification is routinely required changes.

(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 that health insurer routinely requires precertification

for its fully insured plans, and the self-insured plans may contract with a different entity to provide precertification services.

(c) Utilization.--Each 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, each health insurer shall post the self-insured plan's customized list of precertification requirements to the health insurer's provider website.

Section 5. Notice of policy and procedure changes.

(a) Written notice.--Each health insurer shall, if it intends to make any material adverse changes in the terms of its contracts, including policies and procedures, with its participating physicians, participating physician groups or participating physician organizations give at least 90 days' written notice to each participating physician, participating physician group or participating physician organization affected thereby with whom the health insurer has directly contracted, except to the extent that a shorter notice period is required to comply with changes in applicable law. The written notice shall reasonably apprise its participating physician, participating physician group or participating physician organization of the changes and 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, which 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, give written notice to terminate his contract with the health insurer, which shall take effect at the end of the notice period of the material adverse change unless, within 65 days of the date of the original notice of changes, the health insurer gives written notice to the objecting participating physician, participating physician group or participating physician organization that it shall not implement, as to the objecting participating physician, participating physician group or participating physician organization, the material adverse changes to which the participating physician, participating physician group or participating physician organization objected.

Section 6. Disclosure of and commitments concerning claims payment practices.

(a) Payment rules.--Each health insurer agrees that, except for Medicaid, State children's health insurance programs and other similar government programs for low-income persons and for members of State established high risk pools, its automated "bundling" and other claims payment rules shall be consistent in all material respects, for claims submitted by or on behalf of the health insurer's plan members.

(b) Disclosure.--Each health insurer agrees to disclose its significant edits on its provider website on the effective date of this section, or as soon thereafter as practicable.

(c) Update.--Each health insurer shall update its disclosure

of significant edits once per 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) On the effective date of this section, or as soon thereafter as practicable, each health insurer shall publish on its provider website, for each commercially available claims editing software product then in use 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) On the effective date of this section, a health insurer shall not routinely require submission of clinical information, before or after payment of claims, in connection with that health insurer's adjudication of a physician's claims for payment, except as to claims for unlisted codes, claims to which a modifier 22 is appended, and other limited categories of claims as to which the health insurer determines that routine review of clinical information is appropriate, except that the health insurer shall disclose any of its categories of the nature on its public website and its 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 fraudulent or abusive, whether intentional or unintentional, billing practices, but only so long as, and only during the times as, the health insurer has a reasonable basis for

believing 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 fraudulent or abusive, whether intentional or unintentional, billing practices.

(f) Intent.--Nothing under this section is intended or 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.--On the effective date of this section, each health insurer shall publish on its provider website those limited code combinations as to which it has determined that particular services or procedures, relative to modifiers 25 and 59, are not appropriately reported together with those modifiers and the health insurer's application of the rule differs from CPT codes, except that no determination shall be inconsistent with the undertakings set forth under this section.

Section 7. Dispute resolution process for physician billing disputes.

(a) Establishment.--On the effective date of this section, each of the health insurers shall take actions necessary to 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 concerning:

(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; or

(2) any retained claims, if the retained claims are submitted by the physician to the billing dispute reviewer prior to the later to occur of 90 days after the effective date of this section or 30 days after exhaustion of the health insurer's internal appeals process. Each matter shall be a billing dispute.

(b) Jurisdiction.--The billing dispute reviewer shall not have jurisdiction over any other disputes, such as those disputes that fall within the scope of the external review process set forth under subsection (a), compliance disputes and disputes concerning the scope of covered services, nor shall any billing dispute reviewer have jurisdiction or authority to revise or establish any reimbursement policy of the health insurer.

(c) Intent.--Nothing contained under this section shall be intended, or 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 of 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. The 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.--The 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.--Each health insurer shall cooperate with organized State physician organizations in order to select the persons or organizations that shall 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 such participating physician is compensated on a fee-for-service basis.

(b) Product networks.--No health insurer shall 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 or participating physician group comprised of participating physicians 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 or participating physician group or participating physician organization for the product network in which the participating physician or 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 or participating physician group comprised of participating physicians 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 who 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, either party to a contract between a health insurer and a participating physician, participating physician group or participating physician organization shall have the right to terminate the contract without cause upon prior written notice provided to the other party which notice shall be a definite period set forth in the agreement, which period shall be no less than 60 or more than 120 calendar 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) In the case of a continuation of care situation as described in the introductory paragraph, 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. If, on notice from the participating physician, participating physician group, participating physician organization or the health insurer's plan member that a plan member is in a continuation of care situation, the health insurer does not use due diligence to make alternative care available to the plan member within 90 days after receipt of the notice for continuation of care services provided after termination, the health insurer shall pay to the participating physician, participating physician group or participating physician organization the standard rates paid to nonparticipating physicians for that 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 termination 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. Patient-specific issues involving clinical judgment, and medical necessity definition.

(a) Adoption.--Each health insurer shall adopt and apply as to its current agreements and include in its future agreements with participating physicians the definition of "medically necessary" or a comparable term in each agreement. 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 not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

(b) Definition.--As used in this section, the term shall have the meaning given to it in this subsection unless the context clearly indicates otherwise:

"Generally accepted standards of medical practice." 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. Policy issues involving clinical judgment.

In formulating and adopting medical policies with respect to covered services, each 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, each 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. Future consideration by health insurers of an administrative exemption program.

(a) Exemption.--Each health insurer shall consider the feasibility and desirability of exempting certain 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 obliged to implement any exemption process, and this section shall not be construed to limit a health insurer's ability to implement any

program on a pilot or experimental basis, base exemptions on any health insurer determined basis or otherwise to implement one or more programs in only some markets.

Section 13. Timelines for processing and payment of clean claims.

Beginning on the effective date of this section, each health insurer shall direct the issuance of a check or an electronic funds transfer in payment for clean claims for covered services within 30 calendar days.

Section 14. No automatic downcoding of evaluation and management claims.

(a) Prohibition.--On the effective date of this section, no health insurer shall automatically reassign or reduce the code level of evaluation and management codes billed for covered services, 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.--Health insurers shall continue to have the right to deny, pend or adjust the claims for covered services on other bases and shall 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 a review of the information in the clinical information at the time the service was rendered for the particular claims or a review of information derived from a health insurer's fraud or abuse billing detection programs that create a reasonable belief of fraudulent or abusive, whether intentional or unintentional, billing practices, provided that the decision to reassign or reduce is based primarily on a review of clinical information.

Section 15. Bundling and other computerized claim editing.

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

(1) Take actions necessary on the health insurer's part to cause the claim-editing software program it uses to continue 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 physicians to submit clinical information of their patient encounters solely because the physicians seek 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 or the health insurer has disclosed, 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.--Each 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.--CPT codes submitted with a modifier 59 attached shall be eligible for payment to the extent they follow the American Medical Association CPT book and they designate a distinct or independent procedure performed on the same day by the same physician, but only to the extent that:

(1) although the procedures or services are not normally reported together they 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 such CPT codes.

(j) Global periods.--No global periods for surgical procedures shall be longer than the period then 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, except where 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 one reflecting a reduced intensity of the service when the CPT code is one 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 going back in time as far as 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 such appeal is concluded.

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

notice of the recovery efforts prior to the effective date of this section.

Section 17. Effect of health insurer confirmation of patient procedure 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 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. Gag clauses.

(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 and 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) Penalty.--A health insurer shall not penalize or sanction participating physicians in any way for engaging in any free, open and unrestricted communication with a plan member with respect to the foregoing subjects 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 agrees that it shall refund any applicable filing fees and arbitrators' 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 his or her physician group.

(b) Prohibited language.--No health insurer shall include any of the following language in any agreement with a physician, physician group or physician organization:

(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 nations clauses.

A health insurer shall not include any "most favored nations" clauses in its contracts with participating physicians, participating physician groups and participating physician organizations, except for individually negotiated contracts.

Section 21. Enforcement by the court.

Upon adjudication of both internal and external review processes, if a health insurer has not complied with this section, a physician may challenge this assertion by initiating a claim in a court of competent jurisdiction.

Section 40. Effective date.

This act shall take effect immediately.