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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2025

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A N A C T

RELATING TO BUSINESSES AND PROFESSIONS -- BOARD OF MEDICAL LICENSURE
AND DISCIPLINE -- PROMPT PROCESSING OF INSURANCE CLAIMS

Introduced By: Representatives Corvese, Azzinaro, Solomon, O'Brien, Slater, Noret,
Kennedy, Hull, and Phillips

Date Introduced: January 16, 2025

Referred To: House Corporations

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 5-37-5.1 of the General Laws in Chapter 5-37 entitled "Board of
2 Medical Licensure and Discipline" is hereby amended to read as follows:

3 **5-37-5.1. Unprofessional conduct.**

4 The term "unprofessional conduct" as used in this chapter includes, but is not limited to,
5 the following items or any combination of these items and may be further defined by regulations
6 established by the board with the prior approval of the director:

- 7 (1) Fraudulent or deceptive procuring or use of a license or limited registration;
- 8 (2) All advertising of medical business that is intended or has a tendency to deceive the
9 public;
- 10 (3) Conviction of a felony; conviction of a crime arising out of the practice of medicine;
- 11 (4) Abandoning a patient;
- 12 (5) Dependence upon controlled substances, habitual drunkenness, or rendering
13 professional services to a patient while the physician or limited registrant is intoxicated or
14 incapacitated by the use of drugs;
- 15 (6) Promotion by a physician or limited registrant of the sale of drugs, devices, appliances,
16 or goods or services provided for a patient in a manner as to exploit the patient for the financial
17 gain of the physician or limited registrant;
- 18 (7) Immoral conduct of a physician or limited registrant in the practice of medicine;

- 1 (8) Willfully making and filing false reports or records in the practice of medicine;
- 2 (9) Willfully omitting to file or record, or willfully impeding or obstructing a filing or
3 recording, or inducing another person to omit to file or record, medical or other reports as required
4 by law;
- 5 (10) Failing to furnish details of a patient's medical record to succeeding physicians,
6 healthcare facility, or other healthcare providers upon proper request pursuant to § 5-37.3-4;
- 7 (11) Soliciting professional patronage by agents or persons or profiting from acts of those
8 representing themselves to be agents of the licensed physician or limited registrants;
- 9 (12) Dividing fees or agreeing to split or divide the fees received for professional services
10 for any person for bringing to or referring a patient;
- 11 (13) Agreeing with clinical or bioanalytical laboratories to accept payments from these
12 laboratories for individual tests or test series for patients;
- 13 (14) Making willful misrepresentations in treatments;
- 14 (15) Practicing medicine with an unlicensed physician except in an accredited
15 preceptorship or residency training program, or aiding or abetting unlicensed persons in the practice
16 of medicine;
- 17 (16) Gross and willful overcharging for professional services; including filing of false
18 statements for collection of fees for which services are not rendered, or willfully making or assisting
19 in making a false claim or deceptive claim or misrepresenting a material fact for use in determining
20 rights to health care or other benefits;
- 21 (17) Offering, undertaking, or agreeing to cure or treat disease by a secret method,
22 procedure, treatment, or medicine;
- 23 (18) Professional or mental incompetency;
- 24 (19) Incompetent, negligent, or willful misconduct in the practice of medicine, which
25 includes the rendering of medically unnecessary services, and any departure from, or the failure to
26 conform to, the minimal standards of acceptable and prevailing medical practice in his or her area
27 of expertise as is determined by the board. The board does not need to establish actual injury to the
28 patient in order to adjudge a physician or limited registrant guilty of the unacceptable medical
29 practice in this subsection;
- 30 (20) Failing to comply with the provisions of chapter 4.7 of title 23;
- 31 (21) Surrender, revocation, suspension, limitation of privilege based on quality of care
32 provided, or any other disciplinary action against a license or authorization to practice medicine in
33 another state or jurisdiction; or surrender, revocation, suspension, or any other disciplinary action
34 relating to a membership on any medical staff or in any medical or professional association or

1 society while under disciplinary investigation by any of those authorities or bodies for acts or
2 conduct similar to acts or conduct that would constitute grounds for action as described in this
3 chapter;

4 (22) Multiple adverse judgments, settlements, or awards arising from medical liability
5 claims related to acts or conduct that would constitute grounds for action as described in this
6 chapter;

7 (23) Failing to furnish the board, its chief administrative officer, investigator, or
8 representatives, information legally requested by the board;

9 (24) Violating any provision or provisions of this chapter or the rules and regulations of
10 the board or any rules or regulations promulgated by the director or of an action, stipulation, or
11 agreement of the board;

12 (25) Cheating on or attempting to subvert the licensing examination;

13 (26) Violating any state or federal law or regulation relating to controlled substances;

14 (27) Failing to maintain standards established by peer-review boards, including, but not
15 limited to: standards related to proper utilization of services, use of nonaccepted procedure, and/or
16 quality of care;

17 (28) A pattern of medical malpractice, or willful or gross malpractice on a particular
18 occasion;

19 (29) Agreeing to treat a beneficiary of health insurance under title XVIII of the Social
20 Security Act, 42 U.S.C. § 1395 et seq., “Medicare Act,” and then charging or collecting from this
21 beneficiary any amount in excess of the amount or amounts permitted pursuant to the Medicare
22 Act;

23 (30) Sexual contact between a physician and patient during the existence of the
24 physician/patient relationship;

25 (31) Knowingly violating the provisions of § 23-4.13-2(d); or

26 (32) Performing a pelvic examination or supervising a pelvic examination performed by
27 an individual practicing under the supervision of a physician on an anesthetized or unconscious
28 female patient without first obtaining the patient’s informed consent to pelvic examination, unless
29 the performance of a pelvic examination is within the scope of the surgical procedure or diagnostic
30 examination to be performed on the patient for which informed consent has otherwise been
31 obtained or in the case of an unconscious patient, the pelvic examination is required for diagnostic
32 purposes and is medically necessary;

33 [\(33\) Refusing to submit medical bills to a health insurer solely based on the reason that a](#)
34 [bill may arise from a motor vehicle accident or third-party claim; or](#)

1 [\(34\) Failure to process any request for medical records or medical bills within fourteen \(14\)](#)
2 [days of a written request, which shall be a violation subject to the penalties set forth in § 5-37-25.](#)

3 SECTION 2. Section 23-17-19.1 of the General Laws in Chapter 23-17 entitled "Licensing
4 of Healthcare Facilities" is hereby amended to read as follows:

5 **23-17-19.1. Rights of patients.**

6 Every healthcare facility licensed under this chapter shall observe the following standards
7 and any other standards that may be prescribed in rules and regulations promulgated by the
8 licensing agency with respect to each patient who utilizes the facility:

9 (1) The patient shall be afforded considerate and respectful care.

10 (2) Upon request, the patient shall be furnished with the name of the physician responsible
11 for coordinating the patient's care.

12 (3) Upon request, the patient shall be furnished with the name of the physician or other
13 person responsible for conducting any specific test or other medical procedure performed by the
14 healthcare facility in connection with the patient's treatment.

15 (4) The patient shall have the right to refuse any treatment by the healthcare facility to the
16 extent permitted by law.

17 (5) The patient's right to privacy shall be respected to the extent consistent with providing
18 adequate medical care to the patient and with the efficient administration of the healthcare facility.
19 Nothing in this section shall be construed to preclude discreet discussion of a patient's case or
20 examination by appropriate medical personnel.

21 (6) The patient's right to privacy and confidentiality shall extend to all records pertaining
22 to the patient's treatment except as otherwise provided by law.

23 (7) The healthcare facility shall respond in a reasonable manner to the request of a patient's
24 physician, certified nurse practitioner, and/or a physician's assistant for medical services to the
25 patient. The healthcare facility shall also respond in a reasonable manner to the patient's request
26 for other services customarily rendered by the healthcare facility to the extent the services do not
27 require the approval of the patient's physician, certified nurse practitioner, and/or a physician's
28 assistant or are not inconsistent with the patient's treatment.

29 (8) Before transferring a patient to another facility, the healthcare facility must first inform
30 the patient of the need for, and alternatives to, a transfer.

31 (9) Upon request, the patient shall be furnished with the identities of all other healthcare
32 and educational institutions that the healthcare facility has authorized to participate in the patient's
33 treatment and the nature of the relationship between the institutions and the healthcare facility.

34 (10)(i) Except as otherwise provided in this subparagraph, if the healthcare facility

1 proposes to use the patient in any human-subjects research, it shall first thoroughly inform the
2 patient of the proposal and offer the patient the right to refuse to participate in the project.

3 (ii) No facility shall be required to inform prospectively the patient of the proposal and the
4 patient's right to refuse to participate when an institutional review board approves the human-
5 subjects research pursuant to the patient consent and/or de-identification requirements of 21 C.F.R.
6 Pt. 50 and/or 45 C.F.R. Pt. 46 (relating to the informed consent of human subjects).

7 (11) Upon request, the patient shall be allowed to examine and shall be given an
8 explanation of the bill rendered by the healthcare facility irrespective of the source of payment of
9 the bill.

10 (12) Upon request, the patient shall be permitted to examine any pertinent healthcare
11 facility rules and regulations that specifically govern the patient's treatment.

12 (13) The patient shall not be denied appropriate care on the basis of age, sex, gender identity
13 or expression, sexual orientation, race, color, marital status, familial status, disability, religion,
14 national origin, source of income, source of payment, or profession.

15 (14) Patients shall be provided with a summarized medical bill within thirty (30) days of
16 discharge from a healthcare facility. Upon request, the patient shall be furnished with an itemized
17 copy of the patient's bill within fourteen (14) days of receipt of a written request. When patients
18 are residents of state-operated institutions and facilities, the provisions of this subsection shall not
19 apply. Violation of this right shall be subject to the penalties set forth in § 5-37-25.

20 (15) Upon request, the patient shall be allowed the use of a personal television set provided
21 that the television complies with underwriters' laboratory standards and O.S.H.A. standards, and
22 so long as the television set is classified as a portable television.

23 (16) No charge of any kind, including, but not limited to, copying, postage, retrieval, or
24 processing fees, shall be made for furnishing a health record or part of a health record to a patient,
25 the patient's attorney, or authorized representative if the record, or part of the record, is necessary
26 for the purpose of supporting an appeal under any provision of the Social Security Act, 42 U.S.C.
27 § 301 et seq., and the request is accompanied by documentation of the appeal or a claim under the
28 provisions of the Workers' Compensation Act, chapters 29 — 38 of title 28, or for any patient who
29 is a veteran and the medical record is necessary for any application for benefits of any kind. A
30 provider shall furnish a health record requested pursuant to this section by mail, electronically, or
31 otherwise, within ~~thirty (30)~~ fourteen (14) days of the receipt of the written request. For the
32 purposes of this section, "provider" shall include any out-of-state entity that handles medical
33 records for in-state providers. Further, for patients of school-based health centers, the director is
34 authorized to specify by regulation an alternative list of age appropriate rights commensurate with

1 this section.

2 (17) The patient shall have the right to have his or her pain assessed on a regular basis.

3 (18) Notwithstanding any other provisions of this section, upon request, patients receiving
4 care through hospitals, nursing homes, assisted-living residences and home healthcare providers,
5 shall have the right to receive information concerning hospice care, including the benefits of
6 hospice care, the cost, and how to enroll in hospice care.

7 SECTION 3. Section 27-18-61 of the General Laws in Chapter 27-18 entitled "Accident
8 and Sickness Insurance Policies" is hereby amended to read as follows:

9 **27-18-61. Prompt processing of claims.**

10 (a)(1) A health care entity or health plan operating in the state shall pay all complete claims
11 for covered health care services submitted to the health care entity or health plan by a health care
12 provider or by a policyholder within forty (40) calendar days following the date of receipt of a
13 complete written claim or within thirty (30) calendar days following the date of receipt of a
14 complete electronic claim. Each health plan shall establish a written standard defining what
15 constitutes a complete claim and shall distribute this standard to all participating providers.

16 (2) No health care entity or health plan shall deny a claim for any medical bill based solely
17 on the reason such bill may arise from a motor vehicle accident or other third-party claim. This
18 subsection shall not apply to any medical bills arising from a worker's compensation claim pursuant
19 to chapter 33 of title 28.

20 (3) No health care entity of a health plan shall make payment under a policyholder's first
21 party coverage without the express written consent of the policyholder.

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

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

30 (d) A health care entity or health plan which fails to reimburse the health care provider or
31 policyholder after receipt by the health care entity or health plan of a complete claim within the
32 required timeframes shall pay to the health care provider or the policyholder who submitted the
33 claim, in addition to any reimbursement for health care services provided, interest which shall
34 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day

1 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a complete
2 written claim, and ending on the date the payment is issued to the health care provider or the
3 policyholder.

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

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

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

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

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

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

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

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

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

31 (f) For purposes of this section, the following definitions apply:

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

34 (2) "Date of receipt" means the date the health care entity or health plan receives the claim

1 whether via electronic submission or as a paper claim.

2 (3) "Health care entity" means a licensed insurance company or nonprofit hospital or
3 medical or dental service corporation or plan or health maintenance organization, or a contractor
4 as described in § 23-17.13-2(2) [repealed], which operates a health plan.

5 (4) "Health care provider" means an individual clinician, either in practice independently
6 or in a group, who provides health care services, and otherwise referred to as a non-institutional
7 provider.

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

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

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

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

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

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

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

22 SECTION 4. Section 27-19-52 of the General Laws in Chapter 27-19 entitled "Nonprofit
23 Hospital Service Corporations" is hereby amended to read as follows:

24 **27-19-52. Prompt processing of claims.**

25 (a)(1) A healthcare entity or health plan operating in the state shall pay all complete claims
26 for covered healthcare services submitted to the healthcare entity or health plan by a healthcare
27 provider or by a policyholder within forty (40) calendar days following the date of receipt of a
28 complete written claim or within thirty (30) calendar days following the date of receipt of a
29 complete electronic claim. Each health plan shall establish a written standard defining what
30 constitutes a complete claim and shall distribute this standard to all participating providers.

31 [\(2\) No health care entity or health plan shall deny a claim for any medical bill based solely](#)
32 [on the reason such bill may arise from a motor vehicle accident or other third-party claim. This](#)
33 [subsection shall not apply to any medical bills arising from a worker's compensation claim pursuant](#)
34 [to chapter 33 of title 28.](#)

1 (3) No health care entity of a health plan shall make payment under a policyholder's first
2 party coverage without the express written consent of the policyholder.

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

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

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

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

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

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

22 (ii) The healthcare provider or health plan is in liquidation or rehabilitation or is operating
23 in compliance with a court-ordered plan of rehabilitation; or

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

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

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

34 (4) No healthcare entity or health plan operating in the state shall be obligated under this

1 section to pay interest to any healthcare provider or policyholder for any claim if the director of the
2 department of business regulation finds that the entity or plan is in substantial compliance with this
3 section. A healthcare entity or health plan seeking such a finding from the director shall submit any
4 documentation that the director shall require. A healthcare entity or health plan that is found to be
5 in substantial compliance with this section shall after this submit any documentation that the
6 director may require on an annual basis for the director to assess ongoing compliance with this
7 section.

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

11 (f) For purposes of this section, the following definitions apply:

12 (1) "Claim" means:

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

14 (ii) A line item of service; or

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

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

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

21 (4) "Healthcare provider" means an individual clinician, either in practice independently
22 or in a group, who provides healthcare services, and referred to as a non-institutional provider.

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

25 (6) "Health plan" means a plan operated by a healthcare entity that provides for the delivery
26 of healthcare services to persons enrolled in those plans through:

27 (i) Arrangements with selected providers to furnish healthcare services; and/or

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

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

32 (8) "Substantial compliance" means that the healthcare entity or health plan is processing
33 and paying ninety-five percent (95%) or more of all claims within the time frame provided for in §
34 27-18-61(a) and (b).

1 (g) Any provision in a contract between a healthcare entity or a health plan and a healthcare
2 provider that is inconsistent with this section shall be void and of no force and effect.

3 SECTION 5. Section 27-20-47 of the General Laws in Chapter 27-20 entitled "Nonprofit
4 Medical Service Corporations" is hereby amended to read as follows:

5 **27-20-47. Prompt processing of claims.**

6 (a)(1) A healthcare entity or health plan operating in the state shall pay all complete claims
7 for covered healthcare services submitted to the healthcare entity or health plan by a healthcare
8 provider or by a policyholder within forty (40) calendar days following the date of receipt of a
9 complete written claim or within thirty (30) calendar days following the date of receipt of a
10 complete electronic claim. Each health plan shall establish a written standard defining what
11 constitutes a complete claim and shall distribute the standard to all participating providers.

12 (2) No health care entity or health plan shall deny a claim for any medical bill based solely
13 on the reason such bill may arise from a motor vehicle accident or other third-party claim. This
14 subsection shall not apply to any medical bills arising from a worker's compensation claim pursuant
15 to chapter 33 of title 28.

16 (3) No health care entity of a health plan shall make payment under a policyholder's first
17 party coverage without the express written consent of the policyholder.

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

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

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

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

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

1 section for a claim submitted by a healthcare provider or policyholder if:

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

3 (ii) The healthcare entity or health plan is in liquidation or rehabilitation or is operating in
4 compliance with a court-ordered plan of rehabilitation; or

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

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

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

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

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

26 (f) For purposes of this section, the following definitions apply:

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

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

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

34 (4) "Healthcare provider" means an individual clinician, either in practice independently

1 or in a group, who provides healthcare services, and referred to as a non-institutional provider.

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

4 (6) "Health plan" means a plan operated by a healthcare entity that provides for the delivery
5 of healthcare services to persons enrolled in the plan through:

6 (i) Arrangements with selected providers to furnish healthcare services; and/or

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

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

11 (8) "Substantial compliance" means that the healthcare entity or health plan is processing
12 and paying ninety-five percent (95%) or more of all claims within the time frame provided for in §
13 27-18-61(a) and (b).

14 (g) Any provision in a contract between a healthcare entity or a health plan and a healthcare
15 provider that is inconsistent with this section shall be void and of no force and effect.

16 SECTION 6. Section 27-41-64 of the General Laws in Chapter 27-41 entitled "Health
17 Maintenance Organizations" is hereby amended to read as follows:

18 **27-41-64. Prompt processing of claims.**

19 (a)(1) A healthcare entity or health plan operating in the state shall pay all complete claims
20 for covered healthcare services submitted to the healthcare entity or health plan by a healthcare
21 provider or by a policyholder within forty (40) calendar days following the date of receipt of a
22 complete written claim or within thirty (30) calendar days following the date of receipt of a
23 complete electronic claim. Each health plan shall establish a written standard defining what
24 constitutes a complete claim and shall distribute this standard to all participating providers.

25 (2) No health care entity or health plan shall deny a claim for any medical bill based solely
26 on the reason such bill may arise from a motor vehicle accident or other third-party claim. This
27 subsection shall not apply to any medical bills arising from a worker's compensation claim pursuant
28 to chapter 33 of title 28.

29 (3) No health care entity of a health plan shall make payment under a policyholder's first
30 party coverage without the express written consent of the policyholder.

31 (b) If the healthcare entity or health plan denies or pends a claim, the healthcare entity or
32 health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing the
33 healthcare provider or policyholder of any and all reasons for denying or pending the claim and
34 what, if any, additional information is required to process the claim. No healthcare entity or health

1 plan may limit the time period in which additional information may be submitted to complete a
2 claim.

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

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

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

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

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

16 (ii) The healthcare entity or health plan is in liquidation or rehabilitation or is operating in
17 compliance with a court-ordered plan of rehabilitation; or

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

20 (2) No healthcare entity or health plan operating in the state shall be in violation of this
21 section for any claim: (i) Initially submitted more than ninety (90) days after the service is rendered,
22 or (ii) Resubmitted more than ninety (90) days after the date the healthcare provider received the
23 notice provided for in § 27-18-61(b); provided, this exception shall not apply in the event
24 compliance is rendered impossible due to matters beyond the control of the healthcare provider and
25 were not caused by the healthcare provider.

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

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

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

4 (f) For purposes of this section, the following definitions apply:

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

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

9 (3) "Healthcare entity" means a licensed insurance company or nonprofit hospital or
10 medical or dental service corporation or plan or health maintenance organization, or a contractor
11 as described in § 23-17.13-2(2) [repealed] that operates a health plan.

12 (4) "Healthcare provider" means an individual clinician, either in practice independently
13 or in a group, who provides healthcare services, and is referred to as a non-institutional provider.

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

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

18 (i) Arrangements with selected providers to furnish healthcare services; and/or

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

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

23 (8) "Substantial compliance" means that the healthcare entity or health plan is processing
24 and paying ninety-five percent (95%) or more of all claims within the time frame provided for in §
25 27-18-61(a) and (b).

26 (g) Any provision in a contract between a healthcare entity or a health plan and a healthcare
27 provider that is inconsistent with this section shall be void and of no force and effect.

28 SECTION 7. This act shall take effect upon passage.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

RELATING TO BUSINESSES AND PROFESSIONS -- BOARD OF MEDICAL LICENSURE
AND DISCIPLINE -- PROMPT PROCESSING OF INSURANCE CLAIMS

1 This act would prohibit a health insurer from denying a claim and a medical provider from
2 refusing to submit a claim to a health insurer based on the services arising from a motor vehicle
3 accident or other third-party claim. This act further prohibits charges to first-party coverage
4 without an insured's written consent and requires medical providers to fulfill record requests within
5 fourteen (14) days.

6 This act would take effect upon passage.

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