# 2012 -- S 2479

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# S T A T E  O F  R H O D E  I S L A N D

**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: Senators Nesselbush, Miller, Crowley, DeVall, and Gallo

Date Introduced: February 16, 2012

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

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

**27-19-52. Prompt processing of claims. --** (a) A health care entity or health plan operating in the state shall pay all complete claims for covered health care services submitted to the health care entity or health plan by a health care provider or by a policyholder within forty (40) calendar days following the date of receipt of a complete written claim or within thirty (30) calendar days following the date of receipt of a complete electronic claim. Each health plan shall establish a written standard defining what constitutes a complete claim and shall distribute this standard to all participating providers.

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

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

(d) A health care entity or health plan which fails to reimburse the health care provider

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) "Claim" means:

(i) A bill or invoice for covered services;

(ii) A line item of service; or

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

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

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

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

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

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

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

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

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

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

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

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

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

This act would take effect upon passage.

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