HOUSE BILL 556

By Watson

AN ACT to amend Tennessee Code Annotated, Title 56, relative to radiology services.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding the following as a new section:

56-7-1018.

(a) As used in this section:

(1) The term "health insurer" includes a health insurance entity as that term is defined in § 56-7-109, a managed health insurance issuer as defined in § 56-32-128(a), a health coverage plan, health maintenance organization licensed to practice pursuant to this title, a health program administered by the state or its political subdivisions, including the TennCare programs administered pursuant to the waivers approved by the United States department of health and human services, nonprofit insurance companies, prepaid plans, self-insured entities, and all other corporations, entities, or persons, or an employer, labor union, or other group of persons organized in the state that provides health coverage to covered individuals who are employed or reside in the state. "Health insurer" does not include a health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, or other long-term care;

(2) "Radiology Benefits Manager" means a person, business, or other entity, and any wholly or partially owned subsidiary of the entity, that administers

diagnostic radiology and imaging benefits in any health plan or policy of insurance that provides coverage for diagnostic radiology testing; and

(3) “Diagnostic radiology test” includes the following diagnostic tests: X-ray, computerized tomography, magnetic resonance imaging, positron emission tomography, fluoroscopy, ultrasound, and nuclear imaging studies including cardiac nuclear imaging.

(b) In every case in which authorization to perform a diagnostic radiology test is given by a health insurer or by a radiology benefits manager which is contracted to provide utilization review services for the health insurer, that authorization shall be conclusive to satisfy any requirement of medical necessity in a health insurer’s policy, plan or schedule of benefits, and the provider’s subsequently filed claim for payment for such services shall not be denied but shall be timely paid, unless there was fraud on the part of the provider in procuring the authorization.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.