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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1285 Session of 1995

INTRODUCED BY COLAFELLA, DEMPSEY, NICKOL, DeLUCA, WOZNIAK, ITKIN, KUKOVICH, STABACK, DALEY, TRELLO, JOSEPHS, M. COHEN, BELARDI, LAUGHLIN, PRESTON, BELFANTI, TRICH AND CAPPABIANCA, MARCH 22, 1995

REFERRED TO COMMITTEE ON INSURANCE, MARCH 22, 1995

AN ACT

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," providing for health insurance claims processing, for uniform claim data elements, electronic billing formats and coding systems, for timely payment of claims, for penalties for untimely payment, for notice of noncovered service, for coding changes, for uniform explanations of payment and for rights of assignees; providing for permitted requests for, relevance of requests for, payment of costs for providing, and time frame to respond to requests for additional information; and providing for consent to release information, for complaints, for regulations and for communications.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Section 1202(c) of the act, known as The Insurance Company Law of 1921, added December 15, 1992 (P.L.1129, No.48), is amended to read:

Section 1202. Forms for Health Insurance Claims.--(a) [Each] Except as provided in Article XIX, each health insurance claim form processed or otherwise used by an insurer, including those used by the Department of Public Welfare for public health care coverage, shall be the uniform claim form developed by the department. The claim form shall be identical in form and content except as provided in subsection (c). [The] Except as provided in Article XIX, the department shall, in consultation with the Department of Public Welfare, insurers and health care providers or their representatives, first consider the feasibility of utilizing the UB-82/HCFA-1450 and HCFA-1500 forms, or their successors, as a uniform claim form. If these forms are deemed to be unsatisfactory, the department shall, in consultation with the Department of Public Welfare, insurers and health care providers or their representatives, develop a uniform claim form for use by all insurers, the Department of Public Welfare's public health care coverage program and health care providers. The uniform claim form shall contain blank spaces at appropriate places in the document for approved additional information requests under subsection (c).

(b) [The] Except as provided in Article XIX, the feasibility study and subsequent development of the uniform claim form shall be complete within one hundred eighty (180) days of the effective date of this article. All insurers, the Department of Public Welfare's public health care coverage program and health care providers shall be required to use the uniform claim form within one hundred twenty (120) days after the uniform claim form is developed. The department may consider a request from the Department of Public Welfare for an extension in meeting the implementation schedule of this section.

(c) (1) Subject to Article XIX and to the procedure contained in clause (2), an insurer may request that a claimant provide departmentally approved additional information which is not requested on the uniform claim form.

(2) An insurer may request departmental approval of additional information requests to be printed in the blank spaces on the uniform claim form, and on subsequent pages if necessary, by submitting a written request to the department. Such a request shall be deemed approved by the department if not disapproved within sixty (60) days after receipt of the request. A disapproval shall be subject to the procedures under 2 Pa.C.S. (relating to administrative law and procedure).

(d) In the case of vision and dental claim forms and in the case of supplemental major medical claim forms, except as provided in Article XIX, utilization of the uniform claim form shall be at the discretion of the individual insurer.

Section 2. The act is amended by adding an article to read:

ARTICLE XIX.

HEALTH INSURANCE CLAIMS PROCESSING.

Section 1901. Definitions.--As used in this article the following words and phrases shall have the meanings given to them in this section:

"Assignee." An individual or entity to whom a patient or participating provider has assigned the right to be reimbursed for a health care service by a health care payer, or to whom the right to reimbursement has been reassigned by an assignee.

"Clean claim." A claim containing the information requested by the payer in accordance with sections 1902 and 1911 through 1915.

"Covered service." A health care service that must be

provided or paid for, in whole or in part, under the terms of a health care benefit plan for an enrollee in the plan. "Covered service" in the context of a motor vehicle insurance policy means a health care service for which a motor vehicle insurer is required to pay, in whole or part, under the first party, uninsured, underinsured or liability benefits of the policy. "Covered service" in the context of medical assistance means a health care service covered by the medical assistance program. "Covered service" in the context of PACE means a prescription medicine. "Covered service" in the context of workers' compensation means a health care service covered under the act of June 2, 1915 (P.L.736, No.338), known as the "Workers' Compensation Act," or a successor act.

"CPT procedure codes." The codes listed and described in the current printing of Common Procedure Technology, Fourth Edition (CPT), published by the American Medical Association, or a successor publication.

"Department." The Insurance Department of the Commonwealth.

"Enrollee." An individual who is entitled under the terms of a health care benefit plan to be provided or to have paid all or part of the cost of a health care service covered by the plan. "Enrollee" in the context of a motor vehicle insurance policy means an individual whose health care is covered, in whole or in part, directly or indirectly, under the terms of the policy. "Enrollee" in the context of medical assistance means an individual who is eligible for health care benefits under the medical assistance program. "Enrollee" in the context of PACE means an individual who is eligible for benefits under the PACE Program. "Enrollee" in the context of workers' compensation means an individual who is eligible for health care benefits

under the act of June 2, 1915 (P.L.736, No.338), known as the "Workers' Compensation Act," or a successor act.

"Health care benefit plan" or "plan." An insurance policy, contract or plan that provides health care to participants or beneficiaries directly or through insurance, reimbursement or otherwise.

"Health care claim" or "claim." A request for reimbursement for a health care service from a health care payer.

"Health care payer" or "payer." A third party payer, a motor vehicle insurer, the medical assistance program, the Pharmaceutical Assistance Contract for the Elderly, a workers' compensation payer or a third party administrator.

"Health care services." Acts of diagnosis, treatment, medical evaluation or advice or such other acts as may be permissible under the health care licensing statutes of this Commonwealth, medical supplies, durable medical equipment, prosthetics and prescription pharmaceuticals.

"ICD-9-CM diagnosis codes." The codes listed and described in International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), published by the United States Department of Health and Human Services, Public Health Services, Health Care Financing Administration or a successor publication.

"Medical assistance program." The State program of medical assistance established under the act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code," or a successor act.

"Medical doctor." A person licensed to practice medicine and surgery in all of its branches within the scope of the act of December 20, 1985 (P.L.457, No.112), known as the "Medical Practice Act of 1985," or a successor act.

"Motor Vehicle Financial Responsibility Law." 75 Pa.C.S. Ch.

17 (relating to financial responsibility) or a successor act.

"Motor vehicle insurance." Insurance subject to 75 Pa.C.S. Ch.17 (relating to financial responsibility).

"Motor vehicle insurer." A person or entity licensed to underwrite motor vehicle insurance in this Commonwealth.

"Osteopathic physician." A person licensed to practice osteopathic medicine and surgery within the scope of the act of October 5, 1978 (P.L.1109, No.261), known as the "Osteopathic Medical Practice Act," or a successor act.

"Pharmaceutical Assistance Contract for the Elderly" or "PACE." The State program for providing prescription reimbursement assistance for elderly persons established under Chapter 3 of the act of August 14, 1991 (P.L.342, No.36), known as the "Lottery Fund Preservation Act," or a successor act.

"Participating provider." A provider who has contracted to render services to enrollees in a health care benefit plan in accordance with predetermined payment and other terms. "Participating provider" in the context of a motor vehicle insurance policy means any health care provider who renders a covered health care service to a motor vehicle accident victim. "Participating provider" in the context of medical assistance means any provider who has contracted to render services to enrollees in the medical assistance program. "Participating provider" in the context of PACE means any provider who has contracted to render services to enrollees in the PACE Program. "Participating provider" in the context of workers' compensation means a provider who renders a covered service under the act of June 2, 1915 (P.L.736, No.338), known as the "Workers' Compensation Act," or a successor act.

"Physician." A medical doctor or an osteopathic physician.

"Third party administrator." An individual or entity that contracts to administer the health care claims processing or other administrative services for a health care benefit plan or a motor vehicle insurer.

"Third party payer." an individual or entity that is responsible for providing or paying for all or part of the cost of health care services covered by a health care benefit plan. A third party payer includes, but is not limited to, an entity subject to: 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health service corporations); this act, including any preferred provider organization subject to section 630; the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act," or the act of December 14, 1992 (P.L.835, No.134), known as the "Fraternal Benefit Societies Code"; or an agreement by a self-insured employer or self-insured multiple employer trust to provide health care benefits to employes and their dependents.

"Uniform health insurance claim form" or "uniform claim form." The uniform claim form adopted by the Insurance Department under Article XII or a successor form.

"Workers' Compensation Act." The act of June 2, 1915 (P.L.736, No.338), known as the "Workers' Compensation Act."

"Workers' compensation payer." An employer, self-insured employer or insurer obligated to provide health care benefits under the act of June 2, 1915 (P.L.736, No.338), known as the "Workers' Compensation Act," or a successor act.

Section 1902. Uniform Claim Data Elements.--(a) The department, by regulation, shall adopt uniform data elements for inclusion on the uniform health insurance claim form.

(b) To the extent feasible, uniform health insurance claim forms shall include the uniform data elements requested by the health care payer.

(c) A health care payer may request departmental approval of unique data elements for inclusion on the payer's claim form by submitting a written request to the department. The department shall approve or disapprove a request filed under this subsection within sixty (60) days after receipt of the request. The request shall not be considered approved due to the department's failure to act within the required time frame.

(d) Health care payers shall not require the submission of information other than the uniform data elements as a condition of payment of a health care claim, except as authorized by regulations adopted by the department pursuant to section 1911 and in accordance with sections 1912 through 1915.

Section 1903. Uniform Electronic Billing Formats.--(a) The department, by regulation, shall adopt uniform electronic billing formats for electronic health care claims.

(b) Electronic health care claims shall be submitted in the applicable uniform electronic billing format.

(c) Health care payers shall not require an electronic health care claim to be transmitted in any format other than the applicable uniform electronic billing format.

Section 1904. Uniform Coding Systems.--(a) The department, by regulation, shall adopt uniform coding systems for health care services. In the case of physician services, the department shall allow use of the CPT procedure codes and the ICD-9-CM diagnosis codes in effect at the time the service was rendered.

(b) To the extent possible, health care claims shall identify the health care services that are the subject of the

claim and, when applicable, the diagnoses, by using the uniform coding systems adopted by the department.

(c) Upon the request of a patient, a health care provider shall assist the patient in completing a claim regarding a service rendered by the provider by identifying the appropriate codes.

Section 1905. Timely Payment of Claims.--(a) A health care payer shall pay the full amount due for a covered service within thirty (30) days of submission of a clean claim, except as provided in subsection (b).

(b) In the event a participating provider has contractually agreed to a longer time frame for payment, the payer may pay the provider in accordance with the contractual time frame.

Section 1906. Penalties for Untimely Payment.--(a) An enrollee, a participating provider or an assignee who has not been paid the full amount due for a health care service from a health care payer within the time frame required by section 1905 may file a complaint with the department pursuant to section 1916.

(b) In the event a health care payer is determined to have failed to pay the full amount due for a health care service within the required time frame, the following penalties shall be imposed on the payer:

(1) The payer shall be required to pay interest at the higher of six per centum (6%) per annum, or the rate established by the department in accordance with the regulations of the United States Secretary of the Treasury that are applicable to charges for late payments. Interest shall begin to accrue on the day after the required payment date and end on the date on which payment is made; and

(2) If the payer is determined to have acted unreasonably, the payer shall be required to pay the reasonable attorney fees and costs of the enrollee, participating provider or assignee who filed the complaint.

Section 1907. Notice of Noncovered Service.--(a) In the event a health care payer determines that a service for which a claim has been submitted is not covered by the plan, the payer shall notify the individual or entity who submitted the claim within the time frame that payment would otherwise be due under section 1905 if the claim had been for a covered service. The notice shall state the basis for the determination.

(b) In the event it is subsequently determined that the service is a covered service, the payer shall immediately pay the amount due for the service, plus interest on the amount due at the rate specified in section 1906 from the date payment was due under section 1905.

Section 1908. Coding Changes.--(a) A health care payer shall pay a claim based upon the coding stated on the uniform claim form unless the payer has a reasonable basis to conclude that the coding is incorrect.

(b) In the event a coding change made by a health care payer is incorrect, the payer shall pay interest on any resulting underpayment as provided in section 1906.

(c) An enrollee, a participating provider or an assignee may challenge a coding change by a health care payer in a complaint filed pursuant to section 1916.

Section 1909. Uniform Explanations of Payment.--(a) The department, by regulation, shall adopt uniform explanation of payment forms and uniform electronic explanation of payment formats for health care services.

(b) When making payment for a health care service, a health care payer shall include an explanation of the payment. The explanation shall provide the following information for each service listed on the claim:

(1) the code billed;

(2) the code paid (if different from the billed code);

(3) the provider's billed charge;

(4) the amount paid; and

(5) any copayment or deductible due from the enrollee.

(c) Health care payers shall make paper explanations of payment on the applicable uniform explanation of payment form and electronic explanations of payment in the applicable uniform electronic explanation of payment format.

(d) In the event a health care payer changes the coding of the claim, the payer shall also include with the explanation of payment both the basis for the change and the information relied upon by the payer in making the change.

(e) In the event a health care payer denies payment or does not pay the full amount billed, the payer shall also include with the explanation of payment a clear and complete statement of the reason for the denial or reduction.

Section 1910. Rights of Assignees.--(a) In the event an enrollee or a participating provider assigns the right to be reimbursed for a health care service by a health care payer, the assignee shall have the same rights as the enrollee or participating provider with respect to payment of the claim, including, but not limited to, timely payment of the claim as provided in section 1905 and penalties for late payment as provided in section 1906.

(b) An assignee who believes his or her rights have been

violated may file a complaint with the department under section 1916.

Section 1911. Permitted Requests for Additional Information.--The department, by regulation, shall specify circumstances under which a health care payer may, on a case by case basis and as a condition of paying a claim, require the submission of additional information beyond the data elements permitted under section 1902. The department's regulations shall also specify the types of additional information the payer may require under those circumstances.

Section 1912. Relevance of Requests for Additional Information.--(a) A health care payer's request for additional information under section 1911 shall be case specific, that is, based upon an individual assessment of the information needed to properly evaluate the specific claim.

(b) A health care payer shall not request additional information as a delay tactic to extend the time period for payment.

Section 1913. Payment of Costs for Providing Additional Information.--(a) A health care provider shall be entitled to charge a health care payer a reasonable fee for copying medical records and otherwise providing additional information requested by the payer.

(b) The department, by regulation, shall establish reasonable fees for copying, which shall apply absent unique circumstances that warrant a higher or additional charge. The fees established by the department shall be sufficient to cover all expenses incurred by the health care provider, including, but not limited to, the costs of duplication, administrative expenses and postage and shall not be less than the fees the

department charges for copying.

Section 1914. Time Frame to Respond to Requests for Additional Information.--Whenever a health care payer requests a health care provider to provide copies of medical records, the payer shall allow the provider a reasonable time to respond prior to taking adverse action on the claim. An allowance of forty-five (45) days from the receipt of the request is a reasonable time absent unique circumstances that warrant an extension.

Section 1915. Consent to Release Information.--A health care payer shall not require a health care provider to release confidential patient information unless the patient, or an authorized representative of the patient, has consented to the release.

Section 1916. Complaints.--(a) The department, by regulation, shall establish procedures for the filing and adjudication of complaints permitted by sections 1906, 1908 and 1910.

(b) If the department fails to render a decision within sixty (60) days on a complaint filed pursuant to this section, the complainant shall have the right to judicial review. The court shall conduct a de novo review and may take any action against a health care payer that the department is authorized to take under this act.

Section 1917. Regulations.--(a) The department shall adopt the regulations required by this article within ninety (90) days of the effective date of this act.

(b) The department shall have the power to adopt such other rules and regulations as are reasonably necessary to administer and enforce this article.

(c) The regulations shall be adopted in conformity with the provisions of the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law, and the act of June 25, 1982 (P.L.633, No.181), known as the "Regulatory Review Act," or their successors.

Section 1918. Communications.--Any notice, request or other communication required or permitted by this article or regulations adopted under this article shall be deemed properly transmitted when set forth in a writing that is personally delivered or deposited in the United States mail with first class postage prepaid. In the case of a mailed communication, the postmark appearing on the envelope shall be considered to be the date of mailing.

Section 3. Provisions of the Employee Retirement Income Security Act of 1974 (ERISA) (Public Law 93-406, 88 Stat. 829) currently prohibit the application of this act to certain types of health care benefit plans and third party payers. It is the intent of the General Assembly that this act be given the broadest possible application and that its scope include applications permitted by future legislative amendments and judicial interpretations of ERISA.

Section 4. The provisions of this act are severable. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application.

Section 5. (a) The following acts and parts of acts are repealed insofar as they are in conflict with this act:

75 Pa.C.S. Ch. 17.

Act of June 2, 1915 (P.L.736, No.338), known as the Workers'

Compensation Act.

(b) All other acts and parts of acts in conflict with this act are repealed.

Section 6. This act shall take effect in 60 days.