
THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 230 Session of
2005

INTRODUCED BY TOMLINSON, RHOADES, SCARNATI, MUSTO, RAFFERTY,
KASUNIC, KITCHEN, BOSCOLA AND LOGAN, FEBRUARY 9, 2005

REFERRED TO BANKING AND INSURANCE, FEBRUARY 9, 2005

AN ACT

1 Requiring health insurers to disclose fee schedules and all
2 rules and algorithms relating thereto; requiring health
3 insurers to provide full payment to physicians when more than
4 one surgical procedure is performed on the patient by the
5 same physician during one continuous operating procedure; and
6 providing for causes of action and for penalties.

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

9 Section 1. Short title.

10 This act shall be known and may be cited as the Fee Schedule
11 Disclosure and Multiple Surgical Procedures Policy Act.

12 Section 2. Legislative findings.

13 The General Assembly finds that:

14 (1) A majority of physicians in this Commonwealth are
15 reimbursed for their services to patients by third-party
16 payors. In some cases, this contractual relationship between
17 physician and insurer has existed for years without the
18 physician receiving from the insurer a formal contract or an
19 accurate or complete fee schedule detailing fees or the rules

1 or algorithms that actually define the rates at which
2 physicians are compensated for the services they render to
3 the payors' insureds.

4 (2) Most health care insurers in this Commonwealth
5 refuse to fully and accurately disclose their fee schedules
6 to participating physicians; therefore, doctors do not know
7 and cannot find out what they will receive in compensation
8 prior to performing a service.

9 (3) This insurer policy is manifestly unfair to
10 physicians; it is a breach of the physicians' contracts; and
11 it facilitates further breaches of such contracts by making
12 it impossible for physicians to enforce their right to full
13 payment for services rendered.

14 (4) During the course of a single operative session, a
15 surgeon may perform multiple surgical procedures on the
16 patient. These multiple surgical procedures are separate and
17 distinct operations in layman's terms and as defined by the
18 Current Procedure Terminology Coding System created by the
19 American Medical Association and other professional medical
20 societies.

21 (5) The Current Procedural Terminology (CPT) Coding
22 System is utilized by all physicians to identify to payors
23 the services rendered by physicians and that payors purport
24 to adopt the same CPT Coding System in defining the services
25 for which they compensate such physicians.

26 (6) However, contrary to the dictates of the CPT Coding
27 System and without disclosing any such deviation to the
28 physicians with whom they contract, a number of health care
29 insurers in this Commonwealth compensate physicians as if the
30 procedures performed in addition to the primary procedure

1 were merely incidental to the primary procedure and therefore
2 such payors will compensate the surgeon for only one
3 procedure.

4 (7) This insurer policy is inconsistent with the medical
5 judgments upon which the CPT Coding System is based, it is
6 not accurately disclosed to physicians, it is manifestly
7 unfair to surgeons, it leads to a lack of access to quality
8 health care services for patients, and it adds to the excess
9 profits insurers take from the health care delivery system.

10 Section 3. Declaration of intent.

11 The General Assembly hereby declares that it is the policy of
12 this Commonwealth that:

13 (1) Physicians should receive from health care insurers
14 a complete and accurate schedule of the reimbursement fees,
15 including any rules or algorithms utilized by the payors to
16 determine the amount physicians will be compensated if more
17 than one procedure is performed during a single treatment
18 session.

19 (2) Insurers must comply with their contractual
20 obligations and that surgeons should be fairly and justly
21 compensated for all surgical procedures they perform in a
22 single operative session.

23 Section 4. Definitions.

24 The following words and phrases when used in this act shall
25 have the meanings given to them in this section unless the
26 context clearly indicates otherwise:

27 "CPT." Current Procedural Terminology used by physicians as
28 developed by the American Medical Association.

29 "Fee schedule." The generally applicable monetary allowance
30 payable to a participating physician for services rendered as

1 provided for by agreement between the participating physician
2 and the insurer, including, but not limited to, a list of HCPCS
3 Level I Codes, HCPCS Level II National Codes and HCPCS Level III
4 Local Codes and the fees associated therein; and a delineation
5 of the precise methodology used for determining the generally
6 applicable monetary allowances, including, but not limited to,
7 footnotes describing formulas, algorithms, rules and
8 calculations associated with determination of the individual
9 allowances.

10 "HCPCS." The Healthcare Common Procedural Coding System of
11 the Health Care Financing Administration that provides a uniform
12 method for health care providers and medical suppliers to report
13 professional services, procedures, pharmaceuticals and supplies.

14 "HCPCS Level I CPT Codes." The descriptive terms and
15 identifying codes used in reporting supplies and pharmaceuticals
16 used by and services and procedures performed by participating
17 physicians as listed in the CPT.

18 "HCPCS Level II National Codes." Descriptive terms and
19 identifying codes used in reporting supplies and pharmaceuticals
20 used by and services and procedures performed by participating
21 physicians.

22 "HCPCS Level III Local Codes." Descriptive terms and
23 identifying codes used in reporting supplies and pharmaceuticals
24 used by and services and procedures performed by participating
25 physicians which are assigned and maintained by Pennsylvania's
26 Centers for Medicare and Medicaid Services carrier.

27 "Insurer." Any insurance company, association or exchange
28 authorized to transact the business of insurance in this
29 Commonwealth. This shall also include any entity operating under
30 any of the following:

1 (1) Section 630 of the act of May 17, 1921 (P.L.682,
2 No.284), known as The Insurance Company Law of 1921.

3 (2) Article XXIV of the act of May 17, 1921 (P.L.682,
4 No.284), known as The Insurance Company Law of 1921.

5 (3) The act of December 29, 1972 (P.L.1701, No.364),
6 known as the Health Maintenance Organization Act.

7 (4) 40 Pa.C.S. Ch. 61 (relating to hospital plan
8 corporations).

9 (5) 40 Pa.C.S. Ch. 63 (relating to professional health
10 services plan corporations).

11 (6) 40 Pa.C.S. Ch. 67 (relating to beneficial
12 societies).

13 "Participating physician." An individual licensed under the
14 laws of this Commonwealth to engage in the practice of medicine
15 and surgery in all its branches within the scope of the act of
16 December 20, 1985 (P.L.457, No.112), known as the Medical
17 Practice Act of 1985, or in the practice of osteopathic medicine
18 within the scope of the act of October 5, 1978 (P.L.1109,
19 No.261), known as the Osteopathic Medical Practice Act, who by
20 agreement provides services to an insurer's subscribers.

21 Section 5. Disclosure of fee schedules.

22 Within 30 days of the effective date of this section,
23 insurers shall provide their participating physicians with a
24 copy of their fee schedule, including all applicable rules and
25 algorithms utilized by the insurer to determine the amount any
26 such physician will be compensated for performing any single
27 procedure and any group of procedures during a single treatment
28 session, which are applicable on July 1, 2004, and annually
29 thereafter. Insurers shall also provide participating physicians
30 with updates to the fee schedule as modifications occur.

1 Section 6. Procedure for payment of multiple surgical
2 procedures.

3 When a participating physician performs more than one
4 surgical procedure on the same patient and at the same operative
5 session, insurers shall pay the participating physician the
6 greater of the amount calculated on the basis of the applicable
7 insurer fee schedule and:

8 (1) any rules, algorithms, codes, or modifiers included
9 therein, governing reimbursement for multiple surgical
10 procedures; or

11 (2) the principles governing reimbursement for multiple
12 surgical procedures set forth and established by the Centers
13 for Medicare and Medicaid Services within the United States
14 Department of Health and Human Services, including the rule
15 mandating payment to the physician of:

16 (i) 100% of the generally applicable maximum
17 monetary allowance for the procedure which has the
18 highest monetary allowance.

19 (ii) 50% of the generally applicable maximum
20 monetary allowance for the second through fifth
21 procedures with the next highest values.

22 (iii) Such payment amount as is determined following
23 submission of documentation and individual review for
24 more than five surgical procedures.

25 Section 7. Contract provisions.

26 Any provision in any contract, insurer policy or fee schedule
27 that is inconsistent with any provision of this act is hereby
28 declared to be contrary to the public policy of the Commonwealth
29 and is void and unenforceable.

30 Section 8. Violations.

1 An insurer violates:

2 (1) Section 5 (relating to disclosure of fee schedules)
3 if the insurer fails to provide a participating physician
4 with a copy of the fee schedule and updates to the fee
5 schedule in the time frame provided in section 5.

6 (2) Section 6 (relating to procedure for payment of
7 multiple surgical procedures) if the insurer fails to adhere
8 to the policy for payment of multiple surgeries as set forth
9 and established by the Centers for Medicare and Medicaid
10 Services within the Department of Health and Human Services.

11 Section 9. Cause of action.

12 In addition to all statutory, common law and equitable causes
13 of action which already exist, a participating physician shall
14 have a private cause of action for any violation of any
15 provision of this act to enforce the provisions of this act. A
16 participating physician shall be entitled to recover from an
17 insurer any legal fees and costs associated with any suit
18 brought under this section.

19 Section 10. Termination of agreement.

20 In addition to other remedies provided in this act, a
21 participating physician may terminate the physician's agreement
22 with an insurer if the insurer violates the provisions of this
23 act. The physician may continue to provide services to the
24 insurer's insureds and shall receive compensation as an out-of-
25 network provider.

26 Section 11. Penalties.

27 Violations of this act shall be considered violations of the
28 act of May 17, 1921 (P.L.682, No.284), known as The Insurance
29 Company Law of 1921, and are subject to the penalties and
30 sanctions of section 2182 of The Insurance Company Law of 1921.

1 Section 12. Effective date.

2 This act shall take effect immediately.