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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 849 Session of 2007

INTRODUCED BY RHOADES, BROWNE, ORIE, COSTA, MUSTO, ERICKSON, RAFFERTY, EARLL, REGOLA, WOZNIAK, GORDNER, McILHINNEY, KASUNIC, MELLOW AND LAVALLE, MAY 9, 2007

REFERRED TO BANKING AND INSURANCE, MAY 9, 2007

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 retroactive denial of reimbursement of payments to health care providers by insurers.

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

Section 1. The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended by adding an article to read:

ARTICLE VI-B

RETROACTIVE DENIAL OF REIMBURSEMENTS

§ 601-B. Scope of article.

This article shall not apply to reimbursements made as part of an annual contracted reconciliation of a risk-sharing

arrangement under an administrative service provider contract.

§ 602-B. Definitions.

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

"Code." Any of the following codes:

(1) The applicable Current Procedural Terminology (CPT) code, as adopted by the American Medical Association.

(2) If for dental service, the applicable code adopted by the American Dental Association.

(3) Another applicable code under an appropriate uniform coding scheme used by an insurer in accordance with this article.

"Coding guidelines." Those standards or procedures used or applied by a payor to determine the most accurate and appropriate code or codes for payment by the payor for a service or services.

"Fraud." The intentional misrepresentation or concealment of information in order to deceive or mislead.

"Health care provider." A person, corporation, facility, institution or other entity licensed, certified or approved by the Commonwealth to provide health care or professional medical services. The term includes, but is not limited to, a physician, chiropractor, optometrist, professional nurse, certified nurse-midwife, podiatrist, hospital, nursing home, ambulatory surgical center or birth center.

"Insurer." An entity subject to any of the following:

(1) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

(2) This act.

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

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

"Medicare." The Federal program established under Title XVIII of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq. or 1395 et seq.).

"Reimbursement." Payments made to a health care provider by an insurer on:

(1) a fee-for-service;

(2) capitated; or

(3) premium basis.

§ 603-B. Retroactive denial of reimbursement.

(a) General rule.--If an insurer retroactively denies reimbursement to a health care provider, the insurer may only:

(1) retroactively deny reimbursement for services subject to coordination of benefits with another insurer, the medical assistance program or the Medicare program during the 12-month period after the date that the insurer paid the health care provider; and

(2) except as provided in paragraph (1), retroactively deny reimbursement during a 12-month period after the date that the insurer paid the health care provider.

(b) Written notice.--An insurer that retroactively denies reimbursement to a health care provider under subsection (a) shall provide the health care provider with a written statement specifying the basis for the retroactive denial. If the retroactive denial of reimbursement results from coordination of

benefits, the written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denied claim.

§ 604-B. Effect of noncompliance.

Except as provided in section 605-B, an insurer that does not comply with the provisions of section 603-B may not retroactively deny reimbursement or attempt in any manner to retroactively collect reimbursement already paid to a health care provider.

§ 605-B. Fraudulent or improperly coded information.

(a) Reasons for denial.--The provisions of section 603-B do not apply if an insurer retroactively denies reimbursement to a health care provider because:

(1) the information submitted to the insurer was fraudulent;

(2) the information submitted to the insurer was improperly coded and the insurer has provided to the health care provider sufficient information regarding the coding guidelines used by the insurer at least 30 days prior to the date the services subject to the retroactive denial were rendered; or

(3) the claim submitted to the insurer was a duplicate claim.

(b) Improper coding.--Information submitted to the insurer may be considered to be improperly coded under subsection (a)(2) if the information submitted to the insurer by the health care provider:

(1) uses codes that do not conform with the coding guidelines used by the carrier applicable as of the date the service or services were rendered; or

(2) does not otherwise conform with the contractual obligations of the health care provider to the insurer applicable as of the date the service or services were rendered.

§ 606-B. Coordination of benefits.

If an insurer retroactively denies reimbursement for services as a result of coordination of benefits under provisions of section 605-B(a), the health care provider shall have six months from the date of the denial, unless an insurer permits a longer time period, to submit a claim for reimbursement for the service to the insurer, the medical assistance program or Medicare program responsible for payment.

Section 2. This act shall take effect in 60 days.