

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 337 Session of  
2007

INTRODUCED BY BARRAR, BENNINGHOFF, CALTAGIRONE, COHEN, CURRY,  
DALEY, FABRIZIO, FAIRCHILD, FREEMAN, GEIST, GEORGE, GRUCELA,  
HALUSKA, KAUFFMAN, PICKETT, REED, ROEBUCK, SCAVELLO, SONNEY  
AND VEREB, FEBRUARY 9, 2007

REFERRED TO COMMITTEE ON INSURANCE, FEBRUARY 9, 2007

AN ACT

1 Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An  
2 act relating to insurance; amending, revising, and  
3 consolidating the law providing for the incorporation of  
4 insurance companies, and the regulation, supervision, and  
5 protection of home and foreign insurance companies, Lloyds  
6 associations, reciprocal and inter-insurance exchanges, and  
7 fire insurance rating bureaus, and the regulation and  
8 supervision of insurance carried by such companies,  
9 associations, and exchanges, including insurance carried by  
10 the State Workmen's Insurance Fund; providing penalties; and  
11 repealing existing laws," providing for retroactive denial of  
12 reimbursement of payments to health care providers by  
13 insurers.

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

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

19 ARTICLE VI-B

20 RETROACTIVE DENIAL OF REIMBURSEMENTS

21 § 601-B. Scope of article.

22 This article shall not apply to reimbursements made as part

1 of an annual contracted reconciliation of a risk-sharing  
2 arrangement under an administrative service provider contract.

3 § 602-B. Definitions.

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

7 "Code." Any of the following codes:

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

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

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

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

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

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

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

29 (1) 40 Pa.C.S. Ch. 61 (relating to hospital plan  
30 corporations) or 63 (relating to professional health services

1 plan corporations).

2 (2) This act.

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

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

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

11 "Reimbursement." Payments made to a health care provider by  
12 an insurer on either a fee-for-service, capitated or premium  
13 basis.

14 § 603-B. Retroactive denial of reimbursement.

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

17 (1) retroactively deny reimbursement for services  
18 subject to coordination of benefits with another insurer, the  
19 medical assistance program or the Medicare program during the  
20 12-month period after the date that the insurer paid the  
21 health care provider; and

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

25 (b) Written notice.--An insurer that retroactively denies  
26 reimbursement to a health care provider under subsection (a)  
27 shall provide the health care provider with a written statement  
28 specifying the basis for the retroactive denial. If the  
29 retroactive denial of reimbursement results from coordination of  
30 benefits, the written statement shall provide the name and

1 address of the entity acknowledging responsibility for payment  
2 of the denied claim.

3 § 604-B. Effect of noncompliance.

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

9 § 605-B. Fraudulent or improperly coded information.

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

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

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

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

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

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

30 (2) does not otherwise conform with the contractual

1 obligations of the health care provider to the insurer  
2 applicable as of the date the service or services were  
3 rendered.

4 § 606-B. Coordination of benefits.

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

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