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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 663 Session of 2011

INTRODUCED BY BARRAR, B. BOYLE, CALTAGIRONE, D. COSTA, GEIST, GEORGE, HUTCHINSON, MUNDY, MURT, ROAE, SCHRODER, SWANGER AND TRUITT, FEBRUARY 14, 2011

REFERRED TO COMMITTEE ON INSURANCE, FEBRUARY 14, 2011

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-C

RETROACTIVE DENIAL OF REIMBURSEMENTS

§ 601-C. 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-C. 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.

"Department." The Insurance Department of the Commonwealth.

"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.).

"Patterns of inappropriate billing." Claims submitted by a provider to an insurer, either electronically or by paper, where the provider seeks reimbursement for services rendered and the claim submission, when compared to the provider's own claims or those of a peer provider, exhibits a unique pattern that is improper or inappropriate, predictable and not supported by the services rendered.

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

§ 603-C. 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 18-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 the 18-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-C. Effect of noncompliance.

Except as provided in sections 605-C and 607-C, an insurer that does not comply with the provisions of section 603-C may not retroactively deny reimbursement or attempt in any manner to retroactively collect reimbursement already paid to a health care provider.

§ 605-C. Fraudulent or improperly coded information.

(a) Reasons for denial.--The provisions of section 603-C 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 health care provider has engaged in patterns of inappropriate billing;

(3) 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

(4) 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-C. Coordination of benefits.

If an insurer retroactively denies reimbursement for services as a result of coordination of benefits under provisions of section 605-C(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.

§ 607-C. Tolling.

An insurer may request medical or billing records in writing from a provider. The provider shall produce the records to the insurer. The period of time in which the provider is gathering the requested documentation shall be added to the 18-month period to permit the insurer adequate time to determine if the claim submitted is supported by the records. For each subsequent request for records resulting from the initial audit findings, the time to furnish the subsequent records will be added to the original 18-month period.

§ 608-C. Enforcement.

(a) Enforcement.--The department shall ensure compliance with this article and shall investigate potential violations of the article based upon information received from health care providers and other sources.

(b) Remedies.--The enforcement remedies imposed under this section shall be in addition to any other remedies or penalties that may be imposed by any other statute, including the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act. A violation by any person of this article is deemed an unfair method of competition and an unfair or deceptive act or practice pursuant to the Unfair Insurance Practices Act.

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