PRINTER'S NO. 3704

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2241 Session of 2015

INTRODUCED BY BOBACK, PICKETT, DeLUCA AND D. COSTA, JULY 1, 2016

REFERRED TO COMMITTEE ON INSURANCE, JULY 1, 2016

AN ACT

Amending Title 40 (Insurance) of the Pennsylvania Consolidated Statutes, in regulation of insurers and related persons generally, providing for retroactive denial of reimbursements.

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

Section 1. Title 40 of the Pennsylvania Consolidated Statutes is amended by adding a chapter to read:

CHAPTER 37

RETROACTIVE DENIAL OF REIMBURSEMENTS

Sec.

§ 3701. Scope of chapter.

This chapter shall not apply to reimbursements made as part

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

§ 3702. Definitions.

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

"Abuse." Incidents or practices of providers, physicians or suppliers of services and equipment which are inconsistent with accepted sound medical, business or fiscal practices.

"Fraud." Any activity defined as an offense under 18 Pa.C.S. § 4117 (relating to insurance fraud).

"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." A health insurance entity licensed in this Commonwealth to issue any individual or group health, sickness or accident policy or subscriber contract or certificate that provides medical or health care coverage by a health care facility or licensed health care provider that is offered or governed under any of the following:

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

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

(3) The act of May 18, 1976 (P.L.123, No.54), known as the Individual Accident and Sickness Insurance Minimum

Standards Act.

(4) Chapter 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

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

"Waste." The overutilization of professional medical services or the misuse of resources by a health care provider.

§ 3703. Retroactive denial of reimbursement.

(a) General rule.--Except as provided in section 3704 (relating to exceptions to retroactive denial of reimbursement), an insurer may not retroactively deny reimbursement as a result of an overpayment determination more than 24 months after the date the insurer initially paid the health care provider. An insurer that retroactively denies reimbursement to a health care provider under this chapter shall do so based upon coding guidelines and policies in effect at the time the service subject to the retroactive denial was rendered.

(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 responsible for payment of the denied claim.

§ 3704. Exceptions to retroactive denial of reimbursement.

The provisions of section 3703 (relating to retroactive denial of reimbursement) do not apply if an insurer retroactively denies reimbursement to a health care provider

because any of the following apply:

(1) The information submitted to the insurer constitutes fraud, waste or abuse as defined in this chapter.

(2) The claim submitted to the insurer was a duplicate claim.

(3) Denial was required by a Federal or State government plan.

(4) Services were subject to coordination of benefits with another insurer, the medical assistance program or the Medicare program.

§ 3705. Coordination of benefits.

If an insurer retroactively denies reimbursement for services as a result of coordination of benefits under the provisions of section 3704(4) (relating to exceptions to retroactive denial of reimbursement), the health care provider shall have 12 months from the date of the denial, unless the entity responsible for payment permits a longer time period to submit a claim for reimbursement for the service to such entities.

§ 3706. Tolling.

An insurer may request medical or billing records in writing from a health care provider under section 3703 (relating to retroactive denial of reimbursement). The health care provider shall provide the necessary records to the insurer within 60 days of the request. The period of time in which the health care provider is gathering the requested documentation shall be added to the 24-month period.

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