

STATE OF OKLAHOMA

2nd Session of the 49th Legislature (2004)

HOUSE BILL HB2378:

Stanley

AS INTRODUCED

An Act relating to insurance; creating the Timely Reimbursement of Medical Claims Act; stating findings; defining terms; requiring payment of claims within certain time frame; providing procedures for filing certain claims; providing guidelines for denial of claim; establishing procedures for verifying claim; allowing preauthorization process; requiring contracts between entities contain certain provisions; prohibiting waiver or voiding of certain provisions; setting fines and penalties for violations; allowing for other claims of action; allowing for attorney fees; requiring covered entity to comply with certain audit procedures; prohibiting retaliation for claims filed; amending 36 O.S. 2001, Section 1250.5, which relates to unfair claims and practices; deleting certain act as being an unfair claim settlement practice; repealing 36 O.S. 2001, Section 1219, as amended by Section 52, Chapter 197, O.S.L. 2003 (36 O.S. Supp. 2003, Section 1219), which relates to reimbursement for claims; providing for codification; and declaring an emergency.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1270.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

Sections 1 through 15 of this act shall be known and may be cited as the "Timely Reimbursement of Medical Claims Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1270.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Oklahoma Legislature finds:

1. Patients and health care providers often do not receive the reimbursements to which they are entitled from covered entities in a timely manner, even when the claim is submitted on a completed

standard claim form and does not contain attachments or does not require additional information for processing;

2. Covered entities often try to recoup or retroactively deny claims for arbitrary reasons and this practice is extremely detrimental to the business operations of health care providers;

3. Delays in payment and unfair recoupment and denial processes are unnecessary and costly, often causing patients and physicians to spend considerable time and resources attempting to secure reimbursement; and

4. This state has a strong public interest in ensuring that health care claims are paid on a timely basis. This practice adds to the efficient functioning of the health care system of the state and assures continued protection of the health and welfare of the citizens in this state.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1270.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Timely Reimbursement of Medical Claims Act:

1. "Claim submission" means the date a claim is deemed to have been received by a covered entity. If a claim for health care services provided to a patient is mailed, the claim is presumed to have been received by the covered entity on the fifth day after the date the claim is mailed, or, if the claim is mailed using overnight service or return receipt requested, on the date the delivery receipt is signed. If the claim is submitted electronically, the claim is presumed to have been received on the date of the electronic verification of receipt by the covered entity or the clearinghouse of the covered entity. If the claim is faxed, the claim is presumed to have been received on the date of the transmission acknowledgement. If the claim is hand delivered, the claim is presumed to have been received on the date the delivery receipt is signed;

2. "Complete claim" means a timely claim for payment of covered health care expenses that:

- a. if submitted nonelectronically is submitted using the Centers for Medicare and Medicaid Services Form 1500 or Form UB-92, whichever is applicable, or successor forms, and
- b. if submitted electronically is submitted using the Professional or Institutional 837 (ASC X12N 837) format, whichever is applicable, or a successor format.

An otherwise complete claim submitted by a health care provider that includes additional fields, data elements, attachments, or other information not required under this section is considered to be a complete claim for purposes of the Timely Reimbursement of Medical Claims Act;

3. "Contested claim" means a claim that is denied during the benefit determination process;

4. "Covered entity" includes, but is not limited to, any entity responsible for payment of health care services, including but not limited to all entities that pay or administer claims on behalf of other entities;

5. "Health care provider" means any person or other entity who is licensed, certified or otherwise authorized by the provisions of Title 59 or Title 63 of the Oklahoma Statutes to render health care services in the practice of a profession or in the ordinary course of business;

6. "Health care services" mean any services provided by a health care provider, or by an individual working for or under the supervision of a health care provider, that relate to the diagnosis, assessment, prevention, treatment, or care of any human illness, disease, injury, or condition;

7. "Incomplete claim" means a claim that cannot be adjudicated because it fails to include all of the required data elements necessary for adjudication;

8. "Recoupment" means the action by a health insurance entity to recover amounts previously paid to a health care provider by withholding or setting off such amounts against current payments to the health care provider; and

9. "Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a covered entity retroactively to collect payments already made to a health care provider with respect to a claim by reducing other payments currently owed to the health care provider, by withholding or setting off against future payments, by demanding payment back from a health care provider for a claim already paid or in any other manner reducing or affecting the future claim payments to the health care provider.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1270.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. All covered entities shall pay all complete and uncontested claims within fourteen (14) days of claim submission when the claim is filed electronically, and within thirty (30) days when the claim is submitted on paper.

B. 1. A covered entity, within twenty-four (24) hours after beginning of the next business day after claim submission, shall provide electronic acknowledgement of the receipt of the claim to the claimant.

2. A covered entity shall notify the claimant, in writing, that the claim is incomplete within ten (10) days of claim submission. Notice of the action of the covered entity on the claim is considered made on the date the notice was mailed or electronically transferred.

3. Notification of the determination of the covered entity of an incomplete claim shall specify all deficiencies and shall list, in writing, all additional information or documents needed for proper processing and payment of the claim. Any request for additional information must relate only to information the covered entity can demonstrate is specific to the claim or the related episode of care of the claim. A health care provider is not required to provide additional information that is not contained in, or is not in the process of being incorporated into, the medical or billing record of the patient maintained by the health care provider. A covered entity may not make more than one request for additional information in connection with a claim.

4. A claim is deemed to be complete if a covered entity does not provide notification to the claimant of any deficiency in the claim within ten (10) days of the date of its submission.

5. Any uncontested portion of the claim shall be paid in accordance with subsection A of this section.

6. If the covered entity notifies the claimant that additional information or documents are required, the covered entity has ten (10) days following the receipt of the information to pay or deny the claim.

7. If a claim is not paid or contested within the timeframe set forth in this subsection, the covered entity is under an uncontestable obligation to pay the claim.

C. 1. A covered entity, within ten (10) days after claim submission, shall provide acknowledgement of receipt of claim to the claimant.

2. A covered entity shall notify the claimant, in writing, that the claim is incomplete within ten (10) days of claim submission. Notice of the action of the covered entity on the claim is considered made on the date the notice was mailed or electronically transferred.

3. Notification of the determination of the covered entity of an incomplete claim shall specify all deficiencies and shall list, in writing, all additional information or documents needed for proper processing and payment of the claim. Any request for additional information must relate only to information the covered entity can demonstrate is specific to the claim or the related episode of care of the claim. A health care provider is not required to provide additional information that is not contained in, or is not in the process of being incorporated into, the medical or billing record of the patient maintained by the health care provider. A covered entity may not make more than one request for additional information in connection with a claim.

4. A claim is deemed to be complete if a covered entity does not provide notification to the claimant of any deficiency in the claim within ten (10) days of the date of its submission.

5. Any uncontested portion of the claim shall be paid in accordance with subsection A of this section.

6. If the covered entity notifies the claimant that additional information or documents are required, the covered entity has ten (10) days following the receipt of such information to pay or deny the claim.

7. If a claim not paid or contested within the timeframes set forth in this subsection, the covered entity is under an uncontestable obligation to pay the claim.

D. Payment of claim is considered made on the date the payment was received by the health care provider.

E. 1. For electronically submitted claims, any covered entity that does not comply with subsection A of this section shall pay the health care provider that submitted the claim as follows:

- a. one and one-half percent (1 1/2%) from the 15th day through the 45th day,

- b. two percent (2%) per month from the 46th day through the 90th day, and
- c. two and one-half percent (2 1/2%) per month after the 90th day.

2. For nonelectronically submitted claims, any covered entity that does not comply with subsection A of this section shall pay the claimant as follows:

- a. one and one-half percent (1 1/2%) from the 31st day through the 60th day,
- b. two percent (2%) per month from the 61st day through the 120th day, and
- c. two and one-half percent (2 1/2%) per month after the 120th day.

3. For contested claims, once deemed complete, the interest schedule for noncompliance shall attach to timeframes consistent with paragraphs 1 and 2 of this subsection.

4. A health care provider may recover reasonable attorney's fees and court costs in an action to recover payment under the Timely Reimbursement of Medical Claims Act.

F. Within twenty-four (24) hours after the date of acknowledgement of receipt of claim, consistent with timeframes set forth in this section, a covered entity shall provide the health care provider who submitted the claim with electronic access to the status of a submitted claim.

G. If a covered entity intends to audit the health care provider claim, the covered entity shall pay the charges submitted at one hundred percent (100%) of the contracted rate on the claim not later than the dates specified in subsection A of this section. The covered entity shall clearly indicate on the explanation of payment statement in the manner prescribed by the Insurance Commissioner by rule that the complete claim is being paid at one hundred percent (100%) of the contracted rate, subject to completion

of the audit. If the covered entity requests additional information to complete the audit, the request must describe with specificity the clinical information requested and relate only to information the covered entity in good faith can demonstrate is specific to the claim or episode of care. The covered entity may not request as a part of the audit information that is not contained in, or is not in the process of being incorporated into, the medical or billing record of the patient maintained by a preferred provider. The covered entity must complete the audit on or before the 60th day after the date the complete claim is received by the covered entity.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1270.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except in cases of fraud committed by the health care provider, a covered entity may only retroactively deny reimbursements to the provider during the six-month period after the date that the covered entity paid the claim submitted by the health care provider.

B. A covered entity that retroactively denies reimbursement to a health care provider under this section shall give the health care provider a written or electronic statement specifying the basis for the retroactive denial and the statement shall contain, at a minimum, the information required by subsection E of this section.

C. If a covered entity determines that payment was made for services not covered under the health insurance coverage of the covered person, the covered entity shall give written notice to the health care provider of its intent to retroactively deny a previously paid claim and may:

1. Request a refund from the health care provider; or
2. Make a recoupment of the payment from the health care provider in accordance with subsection E of this section.

D. Notwithstanding subsection A of this section, if a covered entity contracted to provide eligibility verification, verifies that an individual is a covered person and if the health care provider provides services to the individual in reliance on the verification, the covered entity may not thereafter retroactively deny a claim on the basis that the individual is not a covered person unless the retroactive denial occurs within three (3) months of the date that the covered entity paid the claim; otherwise, the covered entity is barred from making the recoupment unless there was fraud by the health care provider.

E. If a covered entity chooses to recoup from a health care provider amounts previously paid under a retroactively denied claim pursuant to subsections A and C of this section, the covered entity shall provide the health care provider written documentation that specifies:

1. The amount of the recoupment;
2. The name of the covered person to whom the recoupment applies;
3. Patient identification number;
4. Date of service;
5. The service or services on which the recoupment is based;

and

6. The pending claims being recouped or that future claims will be recouped.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1270.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As used in this section, "verification" means preauthorization only when preauthorization is a condition for the verification.

B. On the request of a health care provider for verification of a particular health care service the health care provider proposes

to provide to a particular patient, the covered entity shall inform the health care provider without delay whether the service, if provided to that patient, will be paid by the insurer and shall specify any deductibles, copayments, or coinsurance for which the insured is responsible.

C. A covered entity shall have appropriate personnel reasonably available at a toll-free telephone number to provide a verification under this section between 6 a.m. and 6 p.m. Central Standard Time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and 12 noon Central Standard Time on Saturday, Sunday, and legal holidays. A covered entity must have a telephone system capable of accepting or recording incoming phone calls for verification after 6 p.m. Central Standard Time Monday through Friday and after 12 noon Central Standard Time on Saturday, Sunday, and legal holidays and responding to each of those calls within twenty-four (24) hours from the time the call is received.

D. A covered entity may establish a specific period during which the verification is valid of not less than thirty (30) days.

E. If a covered entity has provided a verification for proposed health care service, the covered entity may not deny or reduce payment to the health care provider for those health care services if provided to the patient on or before the 30th day after the date the verification was provided.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1270.7 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A covered entity that uses a preauthorization process for health care services shall provide to each health care provider, not later than the 5th business day after the date a request is made, a list of health care services that require preauthorization and information concerning the preauthorization process.

B. If proposed health care services require preauthorization as a condition of payment by the insurer to a preferred provider under a health insurance policy, the insurer shall determine whether the health care services proposed to be provided to the patient are medically necessary and appropriate.

C. On receipt of a request from a health care provider for preauthorization, the covered entity shall review and issue a determination indicating whether the proposed health care services are preauthorized. The determination must be issued and transmitted not later than the third calendar day after the date the request is received by the covered entity.

D. If the proposed health care services involve inpatient care and the covered entity requires preauthorization as a condition of payment, the covered entity shall review the request and issue a length of stay for the admission into a health care facility based on the recommendation of the physician or other health care provider of the patient and the written medically accepted screening criteria and review procedures of the covered entity. If the proposed health care services are to be provided to a patient who is an inpatient in a health care facility at the time the services are proposed, the covered entity shall review the request and issue a determination indicating whether proposed services are preauthorized within twenty-four (24) hours of the request by the health care provider.

E. A covered entity shall have appropriate personnel reasonably available at a toll-free telephone number to provide a preauthorization under this section between 6 a.m. and 6 p.m. Central Standard Time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and 12 noon Central Standard Time on Saturday, Sunday, and legal holidays. A covered entity must have a telephone system capable of accepting or recording incoming phone calls for preauthorization after 6 p.m. Central Standard Time Monday through Friday and after 12 noon Central Standard Time on Saturday,

Sunday, and legal holidays and responding to each of those calls within twenty-four (24) hours from the time the call is received.

F. If a covered entity has preauthorized health care services, the covered entity may not deny or reduce payment to the health care provider for those health care services based on medical necessity or appropriateness of care.

G. This section applies to an agent or other person with whom a covered entity contracts to perform, or to whom the covered entity delegates the performance of, preauthorization of proposed health care services.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1270.8 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A contract between a covered entity and a health care provider pertaining to the provision of health care services must provide that:

1. The health care provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the health care provider will receive under the contract;

2. The covered entity or the agent of the covered entity provide the coding guidelines and fee schedules not later than the 15th day after the date the covered entity receives the request;

3. The covered entity or the agent of the covered entity provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to the health care provider not later than the 90th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules; and

4. The contract may be terminated by the health care provider on or before the 30th day after the date the health care provider

receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans.

B. The covered entity, on request of the health care provider, shall provide the name, edition, and model version of the software that the insurer uses to determine bundling and unbundling of claims.

C. The provisions of this section may not be waived, voided, or nullified by contract.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1270.9 of Title 36, unless there is created a duplication in numbering, reads as follows:

The payment processes of a covered entity shall:

1. Use nationally recognized, generally accepted Current Procedural Terminology codes, notes, and guidelines, including all relevant modifiers; and
2. Be consistent with nationally recognized, generally accepted bundling edits and logics.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1270.10 of Title 36, unless there is created a duplication in numbering, reads as follows:

The provisions of the Timely Reimbursement of Medical Claims Act shall not be waived, voided, or nullified by contract.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1270.11 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Where it is established that the covered entity willfully and knowingly violated the Timely Reimbursement of Medical Claims Act or has a pattern of repeated violations of the Timely Reimbursement of Medical Claims Act, the Insurance Commissioner shall impose a fine not to exceed One Thousand Dollars (\$1,000.00) per day per claim for each day beyond the date specified for

response. If three separate fines are levied within five (5) years for failure to comply with this section, the Insurance Commissioner may levy a penalty in an amount not to exceed Ten Thousand Dollars (\$10,000.00) per claim.

B. Where it is established that the covered entity willfully and knowingly violated the Timely Reimbursement of Medical Claims Act or has a pattern of repeated violations, the Insurance Commissioner shall require the covered entity to submit a remedial action plan and contact claimants regarding the delays in their processing of claims and inform claimants of steps being taken to improve the delays.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1270.12 of Title 36, unless there is created a duplication in numbering, reads as follows:

Nothing in the Timely Reimbursement of Medical Claims Act prohibits or limits any claim or action for a claim that the claimant has against the covered entity.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1270.13 of Title 36, unless there is created a duplication in numbering, reads as follows:

Reasonable attorney's fees for advising and representing a claimant on an overdue claim or action for an overdue claim must be paid by the covered entity if overdue benefits are recovered in an action against the covered entity or if overdue benefits are paid after receipt of notice of the attorney's representation.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1270.14 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Within sixty (60) days of the end of each fiscal year the covered entity shall contract with a qualified independent third party auditor to conduct an annual audit of claims to determine the

degree to which the covered entity is in compliance with the Timely Reimbursement of Medical Claims Act.

B. The audit required by subsection A of this section shall include:

1. The average number of days in which the covered entity processed and paid complete claims;

2. The percent of complete claims processed and paid within the time specified in subsection A of Section 4 of this act;

3. The percent of claims processed and unprocessed, in part, within the times specified in subsection A of Section 4 of this act; and

4. The percent of claims denied and denied in part.

C. Each audit shall be certified by the auditor and submitted to the Insurance Commissioner within thirty (30) days of completion.

D. The covered entity shall make available to the public without charge a copy of the results of the certified audit.

E. On an annual basis, the Insurance Commissioner shall publish a list reflecting the average payment per claim, payment delays, timelines of payments, total interest paid on late claims, total fines paid, contested claim percentages, denied claims, and partially paid claims of each covered entity.

F. The cost of the audit required by subsection A of this section shall be paid by the covered entity.

SECTION 15. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1270.15 of Title 36, unless there is created a duplication in numbering, reads as follows:

No covered entity may retaliate against a claimant for exercising the right of action provided under the Timely Reimbursement of Medical Claims Act.

SECTION 16. AMENDATORY 36 O.S. 2001, Section 1250.5, is amended to read as follows:

Section 1250.5 Any of the following acts by an insurer, if committed in violation of Section 1250.3 of this title, constitutes an unfair claim settlement practice:

1. Failing to fully disclose to first party claimants, benefits, coverages, or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim;
2. Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;
3. Failing to adopt and implement reasonable standards for prompt investigations of claims arising under its insurance policies or insurance contracts;
4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;
5. Failing to comply with the provisions of Section 1219 of this title;
6. Denying a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so;
7. Except where there is a time limit specified in the policy, making statements, written or otherwise, which require a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices an insurer's rights;
8. Requesting a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment;
9. Issuing checks or drafts in partial settlement of a loss or claim under a specified coverage which contain language which releases an insurer or its insured from its total liability;
10. Denying payment to a claimant on the grounds that services, procedures, or supplies provided by a treating physician or a

hospital were not medically necessary unless the health insurer or administrator, as defined in Section 1442 of this title, first obtains an opinion from any provider of health care licensed by law and preceded by a medical examination or claim review, to the effect that the services, procedures or supplies for which payment is being denied were not medically necessary. Upon written request of a claimant, treating physician, or hospital, such opinion shall be set forth in a written report, prepared and signed by the reviewing physician. The report shall detail which specific services, procedures, or supplies were not medically necessary, in the opinion of the reviewing physician, and an explanation of that conclusion. A copy of each report of a reviewing physician shall be mailed by the health insurer, or administrator, postage prepaid, to the claimant, treating physician or hospital requesting same within fifteen (15) days after receipt of such written request. As used in this paragraph, "physician" means a person holding a valid license to practice medicine and surgery, osteopathic medicine, podiatric medicine, dentistry, chiropractic, or optometry, pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes;

11. Compensating a reviewing physician, as defined in paragraph 10 of this ~~subsection~~ section, on the basis of a percentage of the amount by which a claim is reduced for payment;

12. Violating the provisions of the Health Care Fraud Prevention Act;

13. Compelling, without just cause, policyholders to institute suits to recover amounts due under its insurance policies or insurance contracts by offering substantially less than the amounts ultimately recovered in suits brought by them, when such policyholders have made claims for amounts reasonably similar to the amounts ultimately recovered; or

14. Failing to maintain a complete record of all complaints which it has received during the preceding three (3) years or since

the date of its last financial examination conducted or accepted by the Commissioner, whichever time is longer. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For the purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance; ~~or~~

~~15. Requesting a refund of all or a portion of a payment of a claim made to a claimant or health care provider more than twenty-four (24) months after the payment is made. This paragraph shall not apply:~~

- ~~a. if the payment was made because of fraud committed by the claimant or health care provider, or~~
- ~~b. if the claimant or health care provider has otherwise agreed to make a refund to the insurer for overpayment of a claim.~~

SECTION 17. REPEALER 36 O.S. 2001, Section 1219, as amended by Section 52, Chapter 197, O.S.L. 2003 (36 O.S. Supp. 2003, Section 1219), is hereby repealed.

SECTION 18. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

49-2-7756 DLW 01/18/04