

1 STATE OF OKLAHOMA

2 2nd Session of the 51st Legislature (2008)

3 HOUSE BILL 2759

By: Cox

4
5 AS INTRODUCED

6 An Act relating to insurance; amending 36 O.S. 2001,
7 Section 1219, as last amended by Section 2, Chapter
8 338, O.S.L. 2007 (36 O.S. Supp. 2007, Section 1219),
9 which relates to time for processing claims;
10 eliminating certain time for reimbursement of clean
11 claims covered by other laws; providing certain time
12 period for notification of certain defects or
13 improprieties; providing that certain claims are
14 clean claims; providing for adoption of rules;
15 prohibiting the requirement of certain data elements;
16 authorizing modification of number of data element by
17 contract; providing effect of inclusion of additional
18 information; prohibiting waiver, voidance, or
19 nullification; providing time limit for payment of
20 claim; providing for payment of entire claim;
21 providing payment requirements when entire claim is
22 not determined payable; providing for payment of
23 claim under audit; providing time limit of payment of
24 claim; providing requirements for requests for
additional information; providing limitation of
request for additional information; providing remedy
for noncompliance with request for information;
providing for recovery of overpayment of claim;
providing for appeal of overpayment of claim;
defining term; providing for specifications contained
in verification; requiring toll-free telephone
number; providing hours of operation; requiring
answering and recording services for after hours;
allowing declination of eligibility; providing time
period for valid verification; requiring reason for
declination of verification; prohibiting waiver,
voidance, or nullification; providing for
preauthorization; providing time limit for submission
of list of services requiring preauthorization;
providing for determination of necessary services;
requiring review and determination of preauthorized

1 services; providing for issuance of length of stay in
2 facility if preauthorization required; requiring
3 toll-free telephone number; providing hours of
4 operation; requiring answering and recording services
5 for after hours; prohibiting denial of services if
6 preauthorization occurs; allowing denial of service
7 if certain conditions occur; applying provisions to
8 agents or other persons; prohibiting waiver,
9 avoidance, or nullification; providing for payment and
10 amount if insurer fails to timely pay claim;
11 providing penalty for late payment; providing for
12 accrual of interest on late payment; prohibiting
13 liability under certain circumstances; requiring
14 disclosure of payment of penalty; providing for
15 additional administrative penalties; providing for
16 codification; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 2001, Section 1219, as
last amended by Section 2, Chapter 338, O.S.L. 2007 (36 O.S. Supp.
2007, Section 1219), is amended to read as follows:

Section 1219. A. ~~In the administration, servicing, or
processing of any accident and health insurance policy, every
insurer shall reimburse all clean claims of an insured, an assignee
of the insured, or a health care provider within forty five (45)
calendar days after receipt of the claim by the insurer.~~

~~B.~~ As used in this section:

1. "Accident and health insurance policy" or "policy" means any
policy, certificate, contract, agreement or other instrument that
provides accident and health insurance, as defined in Section 703 of
this title, to any person in this state, and any subscriber

1 certificate or any evidence of coverage issued by a health
2 maintenance organization to any person in this state;

3 2. "Clean claim" means a claim that has no defect or
4 impropriety, including a lack of any required substantiating
5 documentation, or particular circumstance requiring special
6 treatment that impedes prompt payment; and

7 3. "Insurer" means any entity that provides an accident and
8 health insurance policy in this state, including, but not limited
9 to, a licensed insurance company, a not-for-profit hospital service
10 and medical indemnity corporation, a health maintenance
11 organization, a fraternal benefit society, a multiple employer
12 welfare arrangement, or any other entity subject to regulation by
13 the Insurance Commissioner.

14 ~~C.~~ B. If a claim or any portion of a claim is determined to
15 have defects or improprieties, including a lack of any required
16 substantiating documentation, or particular circumstance requiring
17 special treatment, the insured, enrollee or subscriber, assignee of
18 the insured, enrollee or subscriber, and health care provider shall
19 be notified in writing within forty-five (45) calendar days after
20 receipt of a clean claim by the insurer from a preferred provider in
21 a nonelectronic format or thirty (30) calendar days after receipt of
22 the claim by the insurer from a preferred provider in an electronic
23 format. The written notice shall specify the portion of the claim
24 that is causing a delay in processing and explain any additional

1 information or corrections needed. Failure of an insurer to provide
2 the insured, enrollee or subscriber, assignee of the insured,
3 enrollee or subscriber, and health care provider with the notice
4 shall constitute prima facie evidence that the claim will be paid in
5 accordance with the terms of the policy. Provided, if a claim is
6 not submitted into the system due to a failure to meet basic
7 Electronic Data Interchange (EDI) and/or Health Insurance
8 Portability and Accountability Act (HIPAA) edits, electronic
9 notification of the failure to the submitter shall be deemed
10 compliance with this subsection. Provided further, health
11 maintenance organizations shall not be required to notify the
12 insured, enrollee or subscriber, or assignee of the insured,
13 enrollee or subscriber of any claim defect or impropriety.

14 ~~D.~~ C. Upon receipt of the additional information or corrections
15 which led to the claim's being delayed and a determination that the
16 information is accurate, an insurer shall either pay or deny the
17 claim or a portion of the claim within forty-five (45) calendar
18 days.

19 ~~E.~~ D. Payment shall be considered made on:

20 1. The date a draft or other valid instrument which is
21 equivalent to the amount of the payment is placed in the United
22 States mail in a properly addressed, postpaid envelope; or

23 2. If not so posted, the date of delivery.
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1 ~~F.~~ E. An overdue payment shall bear simple interest at the rate
2 of ten percent (10%) per year.

3 ~~G.~~ F. In the event litigation should ensue based upon such a
4 claim, the prevailing party shall be entitled to recover a
5 reasonable attorney fee to be set by the court and taxed as costs
6 against the party or parties who do not prevail.

7 ~~H.~~ G. The Insurance Commissioner shall develop a standardized
8 prompt pay form for use by providers in reporting violations of
9 prompt pay requirements. The form shall include a requirement that
10 documentation of the reason for the delay in payment or
11 documentation of proof of payment must be provided within ten (10)
12 days of the filing of the form. The Commissioner shall provide the
13 form to health maintenance organizations and providers.

14 ~~I.~~ H. The provisions of this section shall not apply to the
15 Oklahoma Life and Health Insurance Guaranty Association or to the
16 Oklahoma Property and Casualty Insurance Guaranty Association.

17 SECTION 2. NEW LAW A new section of law to be codified
18 in the Oklahoma Statutes as Section 1219A of Title 36, unless there
19 is created a duplication in numbering, reads as follows:

20 A. As used in this act, a nonelectronic claim by a physician or
21 health care provider, other than an institutional provider, is a
22 clean claim, as defined by Section 1219 of Title 36 of the Oklahoma
23 Statutes, if the claim is submitted using the Centers for Medicare
24 and Medicaid Services Form 1500 or, if adopted by the Insurance

1 Commissioner by rule, a successor to that form developed by the
2 National Uniform Claim Committee or the successor of the committee.
3 An electronic claim by a physician or provider, other than an
4 institutional provider, is a clean claim if the claim is submitted
5 using the Professional 837 (ASC X12N 837) format or, if adopted by
6 the Insurance Commissioner by rule, a successor to that format
7 adopted by the Centers for Medicare and Medicaid Services or the
8 successor of the centers.

9 B. A nonelectronic claim by an institutional provider is a
10 clean claim if the claim is submitted using the Centers for
11 Medicare and Medicaid Services Form UB-04 or, if adopted by the
12 Insurance Commissioner by rule, a successor to that form developed
13 by the National Uniform Billing Committee or the successor of the
14 committee. An electronic claim by an institutional provider is a
15 clean claim if the claim is submitted using the Institutional 837
16 (ASC X12N 837) format or, if adopted by the Insurance Commissioner
17 by rule, a successor to that format adopted by the Centers for
18 Medicare and Medicaid Services or the successor of the centers.

19 C. The Insurance Commissioner may adopt rules that specify the
20 information that shall be entered into the appropriate fields on the
21 applicable claim form for a claim to be a clean claim.

22 D. The Insurance Commissioner shall not require any data
23 element for an electronic claim that is not required in an
24 electronic transaction set needed to comply with federal law.

1 E. An insurer and a preferred provider shall agree by contract
2 to use fewer data elements than are required in an electronic
3 transaction set needed to comply with federal law.

4 F. An otherwise clean claim submitted by a physician or health
5 care provider that includes additional fields, data elements,
6 attachments, or other information not required pursuant to this
7 section is considered to be a clean claim for the purposes of this
8 act.

9 G. Except as provided by subsection E of this section, the
10 provisions of this section shall not be waived, voided, or nullified
11 by contract.

12 SECTION 3. NEW LAW A new section of law to be codified
13 in the Oklahoma Statutes as Section 1219B of Title 36, unless there
14 is created a duplication in numbering, reads as follows:

15 Unless an insurer has requested additional information from a
16 treating preferred provider to determine payment, the insurer, not
17 later than the forty-fifth day after the date an insurer receives a
18 clean claim from a preferred provider in a nonelectronic format or
19 the thirtieth day after the date an insurer receives a clean claim
20 from a preferred provider that is electronically submitted, the
21 insurer shall make a determination of whether the claim is payable
22 and:
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1 1. If the insurer determines the entire claim is payable, pay
2 the total amount of the claim in accordance with the contract
3 between the preferred provider and the insurer;

4 2. If the insurer determines a portion of the claim is payable,
5 pay the portion of the claim that is not in dispute and notify the
6 preferred provider in writing why the remaining portion of the claim
7 will not be paid; or

8 3. If the insurer determines that the claim is not payable,
9 notify the preferred provider in writing why the claim will not be
10 paid.

11 SECTION 4. NEW LAW A new section of law to be codified
12 in the Oklahoma Statutes as Section 1219C of Title 36, unless there
13 is created a duplication in numbering, reads as follows:

14 A. Unless an insurer has requested additional information from
15 a treating preferred provider to determine payment, an insurer that
16 intends to audit a claim submitted by a preferred provider shall pay
17 the charges submitted at one hundred percent (100%) of the
18 contracted rate on the claim not later than:

19 1. The thirtieth day after the date the insurer receives the
20 clean claim from the preferred provider if the claim is submitted
21 electronically; or

22 2. The forty-fifth day after the date the insurer receives the
23 clean claim from the preferred provider if the claim is submitted
24 nonelectronically.

1 B. The insurer shall clearly indicate on the explanation of
2 payment statement in the manner prescribed by the Insurance
3 Commissioner by rule that the clean claim is being paid at one
4 hundred percent (100%) of the contracted rate, subject to completion
5 of the audit.

6 C. If the insurer requests additional information to complete
7 the audit, the request shall describe with specificity the clinical
8 information requested and relate only the information the insurer in
9 good faith can demonstrate is specific to the claim or episode of
10 care. The insurer shall not request as a part of the audit
11 information that is not contained, or is not in the process of being
12 incorporated into, the medical or billing record of the patient
13 maintained by the preferred provider.

14 D. If the preferred provider does not supply information
15 reasonably requested by the insurer in connection with the audit,
16 the insurer may:

17 1. Notify the provider in writing that the provider must
18 provide the information not later than the forty-fifth day after the
19 date of the notice or forfeit the amount of the claim; and

20 2. If the provider does not provide the information required by
21 this section, recover the amount of the claim.

22 SECTION 5. NEW LAW A new section of law to be codified
23 in the Oklahoma Statutes as Section 1219D of Title 36, unless there
24 is created a duplication in numbering, reads as follows:

1 A. An insurer may recover an overpayment to a physician or
2 health care provider if:

3 1. Not later than the one-hundred-eightieth day after the date
4 the physician or provider receives the payment, the insurer provides
5 written notice of the overpayment to the physician or provider that
6 includes the basis and specific reasons for the request for recovery
7 of funds; and

8 2. The physician or provider does not make arrangements for
9 repayment of the requested funds on or before the forty-fifth day
10 after the date the physician or provider receives the notice.

11 B. If a physician or health care provider disagrees with a
12 request for recovery of an overpayment, the insurer shall provide
13 the physician or provider with an opportunity to appeal, and the
14 insurer shall not attempt to recover the overpayment until all
15 appeal rights are exhausted.

16 SECTION 6. NEW LAW A new section of law to be codified
17 in the Oklahoma Statutes as Section 1219E of Title 36, unless there
18 is created a duplication in numbering, reads as follows:

19 A. As used in this section, "verification" includes
20 preauthorization only if preauthorization is a condition for the
21 verification.

22 B. On the request of a preferred provider for verification of a
23 particular medical care or health care service the preferred
24 provider proposes to provide to a particular patient, the insurer

1 shall inform the preferred provider without delay whether the
2 service, if provided to that patient, will be paid by the insurer
3 and shall specify any deductibles, copayments, or coinsurance for
4 which the insured is responsible.

5 C. An insurer shall have appropriate personnel reasonably
6 available at a toll-free telephone number to provide a verification
7 under this section between 6 a.m. and 6 p.m. central time Monday
8 through Friday on each day that is not a legal holiday and between 9
9 a.m. and noon central time on Saturday, Sunday and legal holidays.
10 An insurer shall have a telephone system capable of accepting or
11 recording incoming phone calls for verifications after 6 p.m.
12 central time Monday through Friday and after noon central time on
13 Saturday, Sunday and legal holidays and responding to each of those
14 calls on or before the second calendar day after the date the call
15 is received.

16 D. An insurer may decline to determine eligibility for payment
17 if the insurer notifies the physician or preferred provider that
18 requested the verification of the specific reason the determination
19 was not made.

20 E. An insurer may establish a specific period during which the
21 verification is valid of not less than thirty (30) days.

22 F. An insurer that declines to provide a verification shall
23 notify the physician or provider that requested the verification of
24 the specific reason the verification was not provided.

1 G. If an insurer has provided a verification for proposed
2 medical care or health care services, the insurer shall not deny or
3 reduce payment to the physician or provider for those medical care
4 or health care services if provided to the insured on or before the
5 thirtieth day after the date the verification was provided unless
6 the physician or provider has materially misrepresented the proposed
7 medical care or health care services or has substantially failed to
8 perform the proposed medical care or health care services.

9 H. The provisions of this section shall not be waived, voided
10 or nullified by contract.

11 SECTION 7. NEW LAW A new section of law to be codified
12 in the Oklahoma Statutes as Section 1219F of Title 36, unless there
13 is created a duplication in numbering, reads as follows:

14 A. An insurer that uses a preauthorization process for medical
15 care and health care services shall provide to each preferred
16 provider, not later than the tenth business day after the date a
17 request is made, a list of medical care and health care services
18 that require preauthorization and information concerning the
19 preauthorization process.

20 B. If proposed medical care or health care services require
21 preauthorization as a condition of the payment by the insurer to a
22 preferred provider under a health insurance policy, the insurer
23 shall determine whether the medical care or health care services
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1 proposed to be provided to the insured are medically necessary and
2 appropriate.

3 C. On receipt of a request from a preferred provider for
4 preauthorization, the insurer shall review and issue a determination
5 indicating whether the proposed medical care or health care services
6 are preauthorized. The determination shall be issued and
7 transmitted not later than the third calendar day after the date the
8 request is received by the insurer.

9 D. If the proposed medical care or health care services involve
10 inpatient care and the insurer requires preauthorization as a
11 condition of payment, the insurer shall review the request and issue
12 a length of stay for the admission into a health care facility based
13 on the recommendation of the physician of the patient or health care
14 provider and the written medically accepted screening criteria and
15 review procedures of the insurer. If the proposed medical or health
16 care services are to be provided to a patient who is an inpatient in
17 a health care facility at the time the services are proposed, the
18 insurer shall review the request and issue a determination
19 indicating whether proposed services are preauthorized within
20 twenty-four (24) hours of the request by the physician or provider.

21 E. An insurer shall have appropriate personnel reasonably
22 available at a toll-free telephone number to respond to requests for
23 a preauthorization between 6 a.m. and 6 p.m. central time Monday
24 through Friday on each day that is not a legal holiday and between 9

1 a.m. and noon central time on Saturday, Sunday and legal holidays.

2 An insurer shall have a telephone system capable of accepting or

3 recording incoming phone calls for preauthorizations after 6 p.m.

4 central time Monday through Friday and after noon central time on

5 Saturday, Sunday and legal holidays and responding to each of those

6 calls not later than twenty-four (24) hours after the call is

7 received.

8 F. If an insurer has preauthorized medical care or health care

9 services, the insurer shall not deny or reduce payment to the

10 physician or health care provider for those services based on

11 medical necessity or appropriateness of care unless the physician or

12 provider has materially misrepresented the proposed medical or

13 health care services or has substantially failed to perform the

14 proposed medical or health care services.

15 G. This section applies to an agent or other person with whom

16 an insurer contracts to perform, or to whom the insurer delegates

17 the performance of, preauthorization of proposed medical or health

18 care services.

19 H. The provisions of this section shall not be waived, voided

20 or nullified by contract.

21 SECTION 8. NEW LAW A new section of law to be codified

22 in the Oklahoma Statutes as Section 1219G of Title 36, unless there

23 is created a duplication in numbering, reads as follows:

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1 A. Except as provided by this section, if a clean claim
2 submitted to an insurer is payable and the insurer does not
3 determine that the claim is payable and pay the claim on or before
4 the date the insurer is required to make determination or
5 adjudication of the claim, the insurer shall pay the preferred
6 provider making the claim the contracted rate owed on the claim plus
7 a penalty in the amount of the lesser of:

- 8 1. Fifty percent (50%) of the difference between the billed
9 charges, as submitted on the claim, and the contracted rate; or
- 10 2. One Hundred Thousand Dollars (\$100,000.00).

11 B. If the claim is paid on or after the forty-sixth day and
12 before the ninety-first day after the date the insurer is required
13 to make a determination or adjudication of the claim, the insurer
14 shall pay a penalty in the amount of the lesser of:

- 15 1. One hundred percent (100%) of the difference between the
16 billed charges, as submitted on the claim, and the contracted rate;
17 or
- 18 2. Two Hundred Thousand Dollars (\$200,000.00).

19 C. If the claim is paid on or after the ninety-first day after
20 the date the insurer is required to make a determination or
21 adjudication of the claim, the insurer shall pay a penalty computed
22 under subsection B of this section plus eighteen percent (18%)
23 annual interest on that amount. Interest pursuant to this
24 subsection accrues beginning on the date the insurer was required to

1 pay the claim and ending on the date the claim and the penalty are
2 paid in full.

3 D. Except as provided by this section, an insurer that
4 determines that a claim is payable, that pays only a portion of the
5 amount of the claim on or before the date the insurer is required to
6 make a determination or adjudication of the claim, and pays the
7 balance of the contracted rate owed for the claim after that date,
8 shall pay to the preferred provider, in addition to the contracted
9 amount owed, a penalty on the amount not timely paid in the amount
10 of the lesser of:

- 11 1. Fifty percent (50%) of the underpaid amount; or
- 12 2. One Hundred Thousand Dollars (\$100,000.00).

13 E. If the balance of the claim is paid on or after the forty-
14 sixth day and before the ninety-first day after the date the insurer
15 is required to make a determination or adjudication of the claim,
16 the insurer shall pay a penalty on the balance of the claim in the
17 amount of the lesser of:

- 18 1. One hundred percent (100%) of the underpaid amount; or
- 19 2. Two Hundred Thousand Dollars (\$200,000.00).

20 F. If the balance of the claim is paid on or after the ninety-
21 first day after the date the insurer is required to make a
22 determination or adjudication of the claim, the insurer shall pay a
23 penalty on the balance of the claim computed under subsection E of
24 this section plus eighteen percent (18%) annual interest on that

1 amount. Interest pursuant to this subsection accrues beginning on
2 the date the insurer was required to pay the claim and ending on the
3 date the claim and the penalty are paid in full.

4 G. For the purposes of subsections D and E of this section, the
5 underpaid amount shall be computed on the ratio of the amount
6 underpaid on the contracted rate to the contracted rate as applied
7 to the billed charges as submitted on the claim.

8 H. An insurer is not liable for a penalty under this section
9 if:

10 1. The failure to pay the claim is a result of a catastrophic
11 event that substantially interferes with the normal business
12 operations of the insurer; or

13 2. The claim was paid, but for less than the contracted rate,
14 and:

15 a. the preferred provider notifies the insurer of the
16 underpayment after the one-hundred-eightieth day after
17 the date the underpayment was received, and

18 b. the insurer pays the balance of the claim on or before
19 the forty-fifth day after the date the insurer
20 receives the notice.

21 I. Subsection H of this section does not relieve the insurer
22 of the obligation to pay the remaining unpaid contracted rate owed
23 the preferred provider.

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1 J. An insurer that pays a penalty pursuant to this section
2 shall clearly indicate on the explanation of payment statement in
3 the manner prescribed by the Insurance Commissioner by rule the
4 amount of the contracted rate paid and the amount paid as a penalty.

5 K. In addition to any other penalty or remedy authorized by
6 law, an insurer that violates Section 2 or 3 of this act in
7 processing more than two percent (2%) of clean claims submitted to
8 the insurer may be subject to available administrative penalties as
9 provided for by the administrative rules of the Oklahoma Insurance
10 Department. The Insurance Commissioner shall have authority to
11 impose any administrative penalty provided for by the administrative
12 rules of the Oklahoma Insurance Department. For each day an
13 administrative penalty is imposed under this subsection, the penalty
14 shall not exceed One Thousand Dollars (\$1,000.00) for each claim
15 that remains unpaid in violation of Section 2 or 3 of this act. In
16 determining whether an insurer has processed preferred provider
17 claims in compliance with Section 2 or 3 of this act, the Insurance
18 Commissioner shall consider paid claims, other than claims that have
19 been paid under Section 3 of this act, and shall compute a
20 compliance percentage for physician and provider claims, other than
21 institutional provider claims, and a compliance percentage for
22 institutional provider claims.

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SECTION 9. This act shall become effective November 1, 2008.

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