SECOND REGULAR SESSION

HOUSE BILL NO. 2435

94TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES LEMBKE (Sponsor), SCHAAF, PORTWOOD, COOPER (155) AND PAGE (Co-sponsors).

Read 1st time March 13, 2008 and copies ordered printed.

D. ADAM CRUMBLISS, Chief Clerk

5491L.01I

AN ACT

To repeal sections 376.383 and 376.384, RSMo, and to enact in lieu thereof two new sections relating to payment of insurance claims.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 376.383 and 376.384, RSMo, are repealed and two new sections enacted in lieu thereof, to be known as sections 376.383 and 376.384, to read as follows:

376.383. 1. For purposes of this section and section 376.384, the following terms shall mean:

(1) "Claimant", any individual, corporation, association, partnership or other legal entity asserting a right to payment arising out of a contract or a contingency or loss covered under a health benefit plan as defined in section 376.1350;

(2) "Deny" or "denial", when the health carrier refuses to reimburse all or part of the claim;

(3) "Health carrier", health carrier as defined in section 376.1350, except that health carrier shall not include a workers' compensation carrier providing benefits to an employee pursuant to chapter 287, RSMo;

(4) "Health care provider", health care provider as defined in section 376.1350;

(5) "Health care services", health care services as defined in section 376.1350;

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

(6) "Processing days", number of days the health carrier has the claim in its possession. Processing days shall not include days in which the health carrier is waiting for a response to a request for additional information;

(7) "Request for additional information", when the health carrier requests information from the claimant to determine if all or part of the claim will be reimbursed;

(8) **[**"Suspends the claim", giving notice to the claimant specifying the reason the claim is not yet paid, including but not limited to grounds as listed in the contract between the claimant and the health carrier; and

(9)**]** "Third-party contractor", a third party contracted with the health carrier to receive or process claims for reimbursement of health care services.

2. Within ten working days after receipt of a claim by a health carrier or a third-party contractor, a health carrier shall:

(1) Send an acknowledgment of the date of receipt; or

(2) Send notice of the status of the claim that includes a request for additional information **that specifies the information requested and from whom it is requested, such as the claimant, the patient, or another health care provider**.

If a health carrier pays the claim, subdivisions (1) and (2) shall not apply.

3. Within fifteen days after receipt of additional information by a health carrier or a third-party contractor, a health carrier shall pay the claim or any undisputed part of the claim in accordance with this section or send a notice of receipt and status of the claim:

(1) That denies all or part of the claim and specifies each reason for denial; or

(2) That makes a final request for additional information.

4. Within fifteen days after the day on which the health carrier or a third-party contractor receives the additional requested information in response to a final request for information, it shall pay the claim or any undisputed part of the claim or deny or suspend the claim.

5. If the health carrier has not paid the claimant on or before the forty-fifth day from the date of receipt of the claim, the health carrier shall pay the claimant one percent interest per month. The interest shall be calculated based upon the unpaid balance of the claim. The interest paid pursuant to this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest. A health carrier may combine interest payments and make payment once the aggregate amount reaches five dollars.

6. If a health carrier fails to pay**[**,**]** **or** deny **[**or suspend**]** the claim within forty processing days, and has received, on or after the fortieth day, notice from the health care provider that such claim has not been paid**[**,**]** **or** denied **[**or suspended**]**, the health carrier shall, in addition to

monthly interest due, pay to the claimant per day an amount **[**of**]** **equal to** fifty percent of the claim but not to exceed **[**twenty**]** **one hundred** dollars **per day** for failure to pay all or part of a claim or interest due thereon or deny **[**or suspend**]** as required by this section. **[**Such penalty shall not accrue for more than thirty days unless the claimant provides a second written or electronic notice on or after the thirty days to the health carrier that the claim remains unpaid and that penalties are claimed to be due pursuant to this section.**]** Penalties shall cease if the health carrier pays**[**,**]** **or** denies **[**or suspends**]** the claim. Said penalty shall also cease to accrue on the day after a petition is filed in a court of competent jurisdiction to recover payment of said claim. Upon a finding by a court of competent jurisdiction that the health carrier failed to pay a claim, interest or penalty without reasonable cause, the court shall enter judgment for reasonable attorney fees for services necessary for recovery. Upon a finding that a provider filed suit without reasonable grounds to recover a claim, the court shall award the health carrier reasonable attorney fees necessary to the defense.

7. The department of insurance**, financial institutions and professional registration** shall monitor **[**suspensions**]** **denials** and determine whether the health carrier acted reasonably. **If the department determines the health carrier acted unreasonably in denying the claim, the health carrier shall, for each such claim, pay a penalty in the amount of one thousand dollars.**

8. If a health carrier or third-party contractor has reasonable grounds to believe that a fraudulent claim is being made, the health carrier or third-party contractor shall notify the department of insurance of the fraudulent claim pursuant to sections 375.991 to 375.994, RSMo.

9. Denial of a claim shall be communicated to the claimant and shall include the specific reason why the claim was denied. **If a denied claim does not include a specific reason for the denial, the claim shall not be considered denied under this section and section 376.384.**

10. Requests for additional information shall specify what additional information is necessary to process the claim for payment. Information requested shall be reasonable and pertain to the health carrier's determination of liability. The health carrier shall acknowledge receipt of the requested additional information to the claimant within five working days or pay the claim.

376.384. 1. All health carriers shall:

(1) Permit nonparticipating health care providers to file a claim for reimbursement for a health care service provided in this state as defined in section 376.1350 for a period of up to one year from the date of service;

(2) Permit participating health care providers to file a claim for reimbursement for a health care service provided in this state for a period of up to six months from the date of service,

unless the contract between the health carrier and health care provider specifies a different standard;

(3) Not request a refund or offset against a claim more than twelve months after a health carrier has paid a claim except in cases of fraud or misrepresentation by the health care provider;

(4) Issue within one working day a confirmation of receipt of an electronically filed claim.

2. On or after January 1, 2003, all claims for reimbursement for a health care service provided in this shall be submitted in an electronic format consistent with federal administrative simplification standards adopted pursuant to the Health Insurance Portability and Accountability Act of 1996. Any claim submitted by a health care provider after January 1, 2003, in a nonelectronic format shall not be subject to the provisions of section 376.383. Any health carrier shall provide readily accessible electronic filing after this date to health care providers.

3. On or after January 1, 2002, the director of the department of insurance shall monitor health carrier compliance with the provisions of this section and section 376.383. Examinations, which may be based upon statistical samplings, to determine compliance may be conducted by the department or the director may contract with a qualified private entity. Compliance shall be defined as properly processing and paying ninety-five percent of all claims received in a given calendar year in accordance with the provisions of this section and section 376.383. The director may assess an administrative penalty in addition to the penalties outlined in section 376.383 of up to **[**twenty-five**] five hundred** dollars per claim for the percentage of claims found to be in noncompliance, but not to exceed an annual aggregate penalty of **[**two hundred fifty thousand**] five million** dollars, for any health carrier deemed to be not in compliance with this section and section 376.383. Any penalty assessed pursuant to this subsection shall be assessed in addition to penalties provided for pursuant to sections 375.942 and 375.1012, RSMo.

4. If the director finds that health carriers are failing to make interest payments to health care professionals authorized by section 376.383, the director is authorized to order such health carriers to remit such interest payments. The director is also authorized to assess a monetary penalty, payable to the state of Missouri, in a sum not to exceed twenty-five percent of the unpaid interest payment against health carriers.

5. A health carrier may request a waiver of the requirements of this section and section 376.383 if the basis for the request is an act of God or other good cause as determined by the director.

6. The director shall develop a method by which health care providers may submit complaints to the department identifying violations of this section and section 376.383 by a health carrier. The director shall consider such complaints when determining whether to examine a health carrier's compliance. Prior to filing a complaint with the department, health

care providers who believe that a health carrier has not paid a claim in accordance with this section and section 376.383 shall first contact the health carrier to determine the status of the claim to ensure that sufficient documentation supporting the claim has been provided and to determine whether the claim is considered to be complete. Complaints to the department regarding the payment of claims by a health carrier should contain information such as:

(1) The health care provider's name, address, and daytime phone number;

(2) The health carrier's name;

(3) The dates of service and the dates the claims were filed with the health carrier;

(4) Relevant correspondence between the health care provider and the health carrier, including requests from the health carrier for additional information; and

(5) Additional information which the health care provider believes would be of assistance in the department's review.

7. On or after January 1, 2003, all claims submitted electronically for reimbursement for a health care service provided in this state shall be submitted in a uniform format utilizing standard medical code sets. The uniform format and the standard medical code sets shall be promulgated by the department of insurance through rules consistent with but no more stringent than the federal administrative simplification standards adopted pursuant to the Health Insurance Portability and Accountability Act of 1996.

8. The department shall have authority to promulgate rules for the implementation of section 376.383 and this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and if applicable, sections 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2001, shall be invalid and void.

✓