ENROLLED ORIGINAL

AN ACT

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IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

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To require health benefits plans to compensate any person entitled to reimbursement for a covered service within 30 days after receipt of a claim that is accompanied by all reasonable and necessary documentation.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Prompt Pay Act of 2002".

New Chapter 31A, Title 31

Sec. 2. Definitions.

New § 31-331

For the purposes of this act, the term:

(1) "Clean claim" means a claim that has no material defect or impropriety, including any lack of reasonably required substantiating documentation, which substantially prevents timely payment from being made on the claim or with respect to a health insurer that has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with section 3. For the purposes of this paragraph, the term "material defect" means an imperfection in the submission of a claim consisting in the omission of information that is essential to process the claim in accordance with the health plan's published claim filing requirements. The requirements for electronic claim submissions shall be consistent with regulations promulgated by Secretary of Health and Human Services pursuant to section 1173 of the Social Security Act, approved August 14, 1935 (110 Stat. 2024; 42 U.S.C. §1320d-2).

(2) "Coding guidelines" means 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.

(3) "Commissioner" means the Commissioner of the Department of Insurance and Securities Regulation.

(4) "Health benefits plan" means any accident and health insurance policy or certificate, hospital and medical services corporation contract, health maintenance organization subscriber contract, plan provided by a multiple employer welfare arrangement, or plan provided by another benefit arrangement. The term "health benefit plan" does not mean accident only,

credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplemental or long-term care insurance; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(5) "Health insurer" means any person that provides one or more health benefit plans or insurance in the District of Columbia, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner.

(6) "Person" means an enrollee or subscriber in a health benefit plan, provider, or physician.

(7) "Provider" means a health care practitioner, group of health care practitioners, or other entity licensed, certified, or otherwise authorized by law to provide hospital, physician, or other heath care services.

(8) "Provider panel" means the providers that contract either directly, or through a subcontracting entity, with a health insurer to provide health care services to the health insurer's enrollees under the health insurer's health benefit plan. The term "provider panel" shall not include an arrangement in which any provider may participate solely by contracting with the health insurer to provide health care services at a discounted fee-for-service rate.

Sec. 3. Prompt payment.

New § 31-332

(a) For covered services rendered to its members, a health insurer shall reimburse any person entitled to reimbursement under the health benefits plan within 30 days after the receipt of a clean claim.

(b) If a health insurer fails to comply with subsection (a) of this section, the health insurer shall pay interest beginning on the 31st day after the receipt of the claim if the claim remains unpaid after 30 days. A formal claim by the person filing the original claim shall not be required.

(c) The interest payable shall be at a monthly rate of:

(1) One and one-half percent from the 31st day through the 60th day;

(2) Two percent from the 61st day through the 120th day; and

(3) Two and one-half percent after the 120th day.

(d) This section shall not apply to claims if the health insurer:

(1) Notifies the person submitting the claim within 30 days after the receipt of the claim that the legitimacy of the claim or the appropriate amount of reimbursement is in

dispute;

(2) States, in writing, to the person the specific reasons why the legitimacy of the claim, a portion of the claim, or the appropriate amount of reimbursement is in dispute; and

(3) Pays any undisputed portion of the claim within 30 days of the receipt of the claim.

(e) The health insurer shall process the disputed portion of the claim within 30 days after receipt of all reasonable and necessary documentation.

(f) If a health insurer fails to comply with the requirements of subsection (e) of this section, it shall pay interest at the rates set forth in subsection (c) of this section beginning on the 31st day after the filing of the receipt of the documentation as provided in subsection (e) of this section.

(g) A health insurer shall allow a provider a minimum of 180 days from the date a covered service is rendered or the date of inpatient discharge to submit a claim for reimbursement for the service.

(h) There shall be a rebuttable presumption that a claim has been received by a health insurer:

(1) Within 5 business days from the date the provider or person entitled to reimbursement placed the claim in the United States mail;

(2) Within 24 hours if the claim was submitted by the provider or provider's agent electronically and was not returned to the provider by a claims clearinghouse or returned to the provider by the insurer if submitted directly to the health insurer; or

(3) On the date recorded by the courier if the claim was delivered by courier.

(i) Each health insurer shall provide a manual or other document that sets forth the claims submission procedures to all contracting providers at the time of contracting and 30 days prior to any changes in the procedure.

(j) A health insurer shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect the record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including electronic or facsimile confirmation of receipt of a claim.

(k) A health insurer shall not be in violation of this act if its failure to pay a claim in accordance with the time periods provided in this act is caused:

(1) In material part by the person submitting the claim; or

(2) By impossibility due to matters beyond the health insurer's reasonable control, such as an act of God, insurrection, strike, fire, or power outages.

(l) This section shall not apply to claims for which payment has been or will be made directly to health care providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the health insurer's obligation on such claims.

Sec. 4. Retroactive denial of reimbursement.

New § 31-333

(a) A health insurer may only retroactively deny reimbursement to a health care provider:

(1) For services subject to coordination of benefits with another health insurer during the 18-month period after the date that the health insurer paid the health care provider; or

(2) Except as provided in paragraph (1) of this subsection, during the 6-month period after the date that the health insurer paid the health care provider.

(b)(1) A health insurer that retroactively denies reimbursement to a health care provider under subsection (a)(1) of this section 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.

(2) This subsection shall not apply if a health insurer retroactively denies reimbursement to a health care provider because:

(A) The information submitted to the health insurer was fraudulent;

(B) The information submitted to the health insurer was improperly coded and the health insurer has provided to the health care provider sufficient information regarding the coding guidelines used by the health insurer at least 30 days prior to the date the services subject to the retroactive denial were rendered; or

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

(3) Information submitted to the health insurer may be considered to be improperly coded under paragraph (1) of this subsection if the information submitted to the health insurer by the health care provider:

(A) Uses codes that do not conform with the coding guidelines used by the health insurer applicable as of the date that services were rendered; or

(B) Does not otherwise conform with the contractual obligations of the health care provider to the health insurer applicable as of the date that services were rendered.

(c) If a health insurer retroactively denies reimbursement for services as a result of coordination of benefits, the health care provider shall have 180 days after the date of denial, unless the health insurer permits a longer time period, to submit a claim for reimbursement for the service to the health insurer responsible for payment.

(d) A health insurer that retroactively denies reimbursement to a health care provider under this section shall provide the health care provider with a written statement specifying the basis for the retroactive denial.

(e) This section shall not apply to an adjustment to reimbursement made as part of an annual contracted reconciliation of a risk-sharing arrangement.

Sec. 5. Provider panels.

New § 31-334

(a) Except for Medicaid and Medicare provider panels, if a provider panel contract

between a provider and a health insurer, or other entity that provides hospital, physician, or other health care services to a health insurer, require a provider, as a condition of participating in one of the health insurer's or other entity's provider panels, to participate in any other provider panel owned or operated by the health insurer or other entity, the contract shall contain a provision permitting the provider to refuse participation in one or more of the other provider panels at the time the contract is executed or renewed. The status of a physician as a member of, or as being eligible for, other existing or new provider panels shall not be adversely affected by the exercise of the right to refuse participation.

(b) If a provider elects to terminate participation on a provider panel of a health insurer or entity that provides hospital, physicians, or health services to a health insurer, the provider shall:

(1) Notify the health insurer at least 90 days before termination; and

(2) For at least 90 days after the date of notice of termination, continue to furnish health care services to an enrollee of a health insurer for whom the provider was responsible for the delivery of health care services prior to the notice of termination.

Sec. 6. Claims payment report.

New § 31-335

A health insurer shall include with its annual report filed with the Commissioner a claims payment report to include the:

(1) Number of claims received in the previous calendar year;

(2) Number of claims denied in the previous calendar year;

(3) Number of claims paid:

(A) In the previous calendar year;

(B) In 30 days;

(C) In 60 days;

(D) In 120 days; and

(E) In more than 120 days; and

(4) Average number of days to pay a claim submitted in the previous calendar year.

Sec. 7. Penalties.

New § 31-336

An action by a health insurer that establishes a pattern or practice of repeated violation of this act, as determined by the Commissioner, shall constitute a violation as provided in the Insurance Trade and Economic Development Amendment Act of 2000, effective April 3, 2001 (D.C. Law 13-265; D.C. Official Code § 31-2231.01 *et seq.*).

New § 31-337

Sec. 8. Rules and regulations.

The Commissioner may adopt rules and regulations as necessary to implement this act.

Sec. 9. Applicability.

New § 31-338

(a) This act shall apply to any individual and group health benefits plan issued or renewed in the District of Columbia. Health insurers shall comply with this act on the earlier of October 16, 2002 or the effective date of the claims payment standards in section 1173 of the Social Security Act, approved August 14, 1935 (110 Stat. 2024; 42 U.S.C. §1320d-2).

(b) Section 3 shall apply to claims received on or after October 16, 2002.

(c) Section 4 shall apply to retroactive denials made on or after October 16, 2002.

(d) Section 5 shall apply to any contract issued or renewed on or after October 16, 2002.

(e) Section 6 shall apply to claims data collected beginning with the first full calendar year following the effective date of this act. A health insurer shall include this data in the annual report filed with the Commissioner beginning on March 15, 2004.

Sec. 10. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code §1-206.02(c)(3)).

Sec. 11. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of Congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of Columbia Register.

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Chairman
Council of the District of Columbia

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Mayor
District of Columbia