

CHAPTER NO. 890

HOUSE BILL NO. 1192

By Representatives Kisber, Caldwell, Lewis, Windle, Sherry Jones, Ferguson, Curtiss, Givens, Maddox, Sands, Fitzhugh, White, Walker

Substituted for: Senate Bill No. 1573

By Senators Cooper, Kyle, Cohen, Person, McNally, Crutchfield, Haun, Crowe, Davis, Graves

AN ACT to amend Tennessee Code Annotated, Title 56; and Title 71, Chapter 5, to establish procedures ensuring the prompt payment of provider claims submitted to health maintenance organizations, health insurers, nonprofit health service plans, managed care organizations, managed health insurance issuers, and behavioral health organizations, including any entity reimbursing the cost of health care services.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. The title of this act is and may be cited as the "Timely Reimbursement of Health Insurance Claims Act." The purpose of this act is to ensure the prompt and accurate payment of all provider claims for covered services delivered to eligible health insured patients. The General Assembly further intends that this act provide direct provider rights to prompt payment under Section 68-11-219, which requires a patient's assignment of a claim. Nothing in this act will require a health insurance entity to pay claims that are not covered under a health insurer entity's contract.

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 7, Part 1, is amended by adding the following new, appropriately designated section:

Tennessee Code Annotated 56-7-____.

(a) As used in this section:

(1)(A) "Clean claim" means a claim received by a health insurance entity for adjudication, and which requires no further information, adjustment or alteration by the provider of the services in order to be processed and paid by the health insurer. A claim is clean if it has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this act.

(B) A clean claim does not include a duplicate claim. A duplicate claim means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim.

(C) A clean claim does not include any claim submitted more than ninety (90) days after the date of service.

(D) The definition of clean claim includes resubmitted paper claims with previously identified deficiencies corrected.

(2) "Health insurance entities" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage, including but not limited to an insurance company, a health maintenance organization and a nonprofit hospital and medical service corporation.

(3) "Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any policy, certificate or agreement offered by a health insurance entity; provided, however, that health insurance coverage does not include policies or certificates covering only accident, credit, disability income, long-term care, hospital indemnity, Medicare supplement as defined in § 1882(g)(1) of the Social Security Act, specified disease, other limited benefit health insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(4) "Pay" means that the health insurance entity shall either send the provider cash or a cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health insurance entity. Payment shall occur on the date when the cash, cash equivalent or notice of credit is mailed or otherwise sent to the provider.

(5) "Submitted" means that the provider either mails or otherwise sends a claim to the health insurance entity. Submission shall occur on the date the claim is mailed or otherwise sent to the health insurance entity.

(b) Prompt Payment Standards.

(1)(A) Not later than thirty (30) calendar days after the date that a health insurance entity actually receives a claim submitted on paper from a provider, a health insurance entity shall:

(i) if the claim is clean, pay the total covered amount of the claim;

(ii) pay the portion of the claim that is clean and not in dispute and notify the provider in writing why the remaining portion of the claim will not be paid; or

(iii) notify the provider in writing of all reasons why the claim is not clean and will not be paid and what substantiating

documentation and information is required to adjudicate the claim as clean.

(B) Not later than twenty-one (21) calendar days after receiving a claim by electronic submission, a health insurance entity shall:

(i) if the claim is clean, pay the total covered amount of the claim;

(ii) pay the portion of the claim that is clean and not in dispute and notify the provider why the remaining portion of the claim will not be paid; or

(iii) notify the provider of the reason why the claim is not clean and will not be paid and what substantiating documentation or information is required to adjudicate the claim.

(2) No paper claim may be denied upon resubmission for lack of substantiating documentation or information that has been previously provided by the health care provider.

(3) Health insurance entities shall timely provide contracted providers with all necessary information to properly submit a claim.

(4) Any health insurance entity that does not comply with subdivision (b)(1) shall pay one percent (1.0%) interest per month, accruing from the day after the payment was due, on that amount of the claim that remains unpaid.

(c) Regulatory Oversight.

(1) The Commissioner of the Department of Commerce and Insurance shall ensure, as part of the department's ongoing regulatory oversight of health insurance entities, that health insurance entities properly process and pay claims in accordance with the "Timely Reimbursement of Health Insurance Claims Act".

(2) If the commissioner finds a health insurance entity has failed during any calendar year to properly process and pay ninety-five percent (95%) of all clean claims received from all providers during that year in accordance with this act, the commissioner may levy an aggregate penalty up to ten thousand dollars (\$10,000). If the commissioner finds a health insurance entity has failed during any calendar year to properly process and pay eighty-five percent (85%) of all clean claims received from all providers during that year in accordance with this Act, the commissioner may levy an aggregate penalty in an amount not less than ten thousand dollars (\$10,000) nor more than one hundred thousand dollars (\$100,000), if reasonable notice in writing is given of the intent to levy the penalty. If the commissioner finds a health insurance entity has failed during any calendar year to properly process and pay sixty percent (60%) of all clean claims received from all providers during that year in

accordance with this act, the commissioner may levy an aggregate penalty in an amount not less than one hundred thousand dollars (\$100,000) nor more than two hundred thousand dollars (\$200,000). In determining the amount of any fine, the commissioner shall take into account whether the failure to achieve the standards in this act is due to circumstances beyond the health insurance entities' control and whether the health insurance entity has been in the business of processing claims for two (2) years or less. The health insurance entity may request an administrative hearing contesting the assessment of any administrative penalty imposed by the commissioner within thirty (30) days after receipt of the notice of the assessment.

(3) The commissioner may issue an order directing a health insurance entity or a representative of a health insurance entity to cease and desist from engaging in any act or practice in violation of this act. Within fifteen (15) days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices in violation of this act have occurred.

(4) All hearings under this part shall be conducted pursuant to Tennessee's Uniform Administrative Procedures Act.

(5) In the case of any violations of this act, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued by the commissioner, the commissioner may institute a proceeding to obtain injunctive or other appropriate relief in the Chancery Court of Davidson County.

(6) Examinations to determine compliance with this Act may be conducted by the commissioner's staff. The commissioner may, if necessary, contract with qualified impartial outside sources to assist in examinations to determine compliance with this act. The expenses of any such examinations shall be assessed against Health Maintenance Organizations in accordance with TCA 56-32-215. For other health insurance entities, the commissioner shall bill the expenses of such examinations to those entities in accordance with T.C.A. §56-1-413.

(d) The commissioner shall adopt rules and regulations to ensure effective compliance with this act.

SECTION 3. Nothing in this act will require a health insurance entity to pay claims that are not covered under the terms of a health insurer entity's contract. This provision does not prevent a claim of an out of network provider from being a clean claim.

SECTION 4. Nothing contained herein shall be construed or interpreted as applying to the TennCare programs under Title XIX of the Social Security Act or any successor to the TennCare program administered pursuant to the federal Medicaid laws.

SECTION 5. This act shall not preclude the right of a claimant to pursue any other administrative, civil or criminal proceedings or remedies permitted under state or federal law.

This act shall also not preclude the Commissioner of the Department of Commerce and Insurance from pursuing any other administrative, civil or criminal proceedings or remedies permitted under state or federal law, except the commissioner may not impose any monetary penalties greater than those set forth in this act against health insurance entities found in violation of this act.

SECTION 6. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

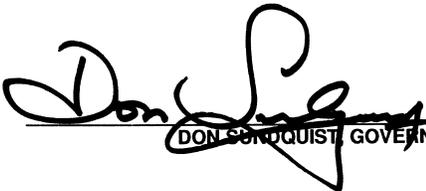
SECTION 7. This act shall take effect November 1, 2000, the public welfare requiring it and shall apply to all outstanding clean claims to which this act applies that remain unreimbursed sixty (60) days after the date this act takes effect.

PASSED: May 31, 2000


JIMMY RAIFEH, SPEAKER
HOUSE OF REPRESENTATIVES


JOHN S. WILDER
SPEAKER OF THE SENATE

APPROVED this 14th day of June 2000


DON SANDQUIST, GOVERNOR