CHAPTER 436

(SB 279)

AN ACT relating to health insurance.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

SECTION 1. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

As used in Sections 1 to 17, Section 18, and Section 19 of this Act:

(1) "Adjudicate" means an insurer pays, contests, or denies a clean claim;

(2) "Claims payment time frame" means the time period prescribed under Section 2 of this Act following receipt of a clean claim from a provider at the address published by the insurer, whether it is the address of the insurer or a delegated claims processor, within which an insurer is required to pay, contest, or deny a health care claim;

(3) "Clean claim" means a properly completed billing instrument, paper or electronic, that does not involve coordination of benefits for third-party liability, preexisting condition investigations, or subrogation.

(a) A clean claim from an institutional provider shall consist of:

1. The UB-92 data set or its successor submitted on the designated paper or electronic formats as adopted by the NUBC;

2. Entries stated as mandatory by the NUBC; and

3. Any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service;

(b) A clean claim for dentists shall consist of the form and data set approved by the American Dental Association;

(c) A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee; and

(d) A clean claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs.

(4) "Commissioner" means the commissioner of the Department of Insurance;

(5) "Covered person" means a person on whose behalf an insurer offering a health benefit plan is obligated to pay benefits or provide services;

(6) "Department" means the Department of Insurance;

(7) "Electronic" or "electronically" means electronic mail, computerized files, communications, or transmittals by way of technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities;

(8) "Health benefit plan" has the same meaning as provided in KRS 304.17A-005;

(9) "Health care provider" or "provider" has the same meaning provided in KRS 304.17A005 and, for the purposes of Sections 1 to 17, 18 and 19 of this Act only, shall include physical therapists licensed under KRS Chapter 327. Nothing contained in Sections 1 to

17, 18 and 19 of this Act shall be construed to include physical therapists as a health care provider or provider under KRS 304.17A-005;

(10) "Health claim attachment" means additional information from a covered person's medical record to the basic claim form required by the insurer;

(11) "Institutional provider" means a health care facility licensed under KRS 216B;

(12) "Insurer" has the same meaning provided in KRS 304.17A-005;

(13) "Kentucky Uniform Billing Committee (KUBC)" means the committee of health care providers, governmental payors, and commercial insurers established as a local arm of NUBC to implement the bill requirements of the NUBC and to prescribe any additional billing requirements unique to Kentucky insurers;

(14) "National Uniform Billing Committee (NUBC)" means the national committee of health care providers, governmental payors, and commercial insurers that develops the national uniform billing requirements for institutional providers as referenced in accordance with the Federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. Chapter 6A, Subchapter XXV, sec. 300gg et seq.;

(15) "Retrospective review" means utilization review that is conducted after health care services have been provided to a covered person; and

(16) "Utilization review" has the same meaning as provided in KRS 211.461.

SECTION 2. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Except for claims involving organ transplants, each insurer shall reimburse a provider for a clean claim or send a written or an electronic notice denying or contesting the claim within thirty (30) calendar days from the date that the claim is received by the insurer or any entity that administers or processes claims on behalf of the insurer. Clean claims involving organ transplants shall be paid, denied, or contested within sixty (60) calendar days from the date that the claim is received by the insurer or any entity that administers or processes claims on behalf of the insurers.

(2) Within the applicable claims payment time frame, an insurer shall:

(a) Pay the total amount of the claim in accordance with any contract between the insurer and the provider;

(b) Pay the portion of the claim that is not in dispute and notify the provider, in writing or electronically, the reasons the remaining portion of the claim will not be paid; or

(c) Notify the provider, in writing or electronically, of the reasons no part of the claim will be paid.

SECTION 3. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) (a) Within forty-eight (48) hours of receiving an original or corrected claim submitted electronically, an insurer, its agent, or designee shall acknowledge the date of receipt of the

claim by an electronic transmission to the provider, its billing agent, or designee that submitted the claim; and

(b) Within twenty (20) calendar days of receipt of an original or corrected claim submitted by mail or other nonelectronic means, an insurer shall acknowledge the date of receipt of the claim.

1. For claims containing all necessary information and having no errors, the insurer shall make available confirmation of receipt of the claim to the provider, billing agent, or designee that submitted the claim. Acknowledgment may be in writing or the insurer may list the claim and the date it was received on a file that can be accessed electronically by the provider; and

2. Claims that contain errors or lack necessary information shall be acknowledged by an electronic transmission or in writing to the provider, billing agent, or designee that submitted the claim.

(2) An insurer shall notify the provider, in writing or electronically, at the time that receipt of a claim is acknowledged, of all information that is missing or in error which preclude it from being a clean claim.

(3) When an insurer has notified a provider that a claim contains errors, upon receipt of a corrected claim, the insurer shall pay the corrected claim within the applicable claims payment time frame for a clean claim established in Section 2 of this Act.

(4) By January 1, 2001, an insurer shall have in place a mechanism to inform providers of the status of a claim either through: (a) Notation on the remittance; or

(b) By allowing providers to check claim status electronically at any time following submission of the claim to the insurer.

SECTION 4. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) An insurer may delay payment by contesting a clean claim only in the following instances:

(a) The insurer has information that another insurer is primarily responsible for the claim;

(b) The insurer will conduct a retrospective review of the services identified on the claim;

(c) The insurer has information that the claim was submitted fraudulently; or (d) The covered person's or group's premium has not been paid.

(2) An insurer shall pay any uncontested portion of a claim and provide written or electronic notification to the provider of the contested amount within the applicable claims payment time frame established in Section 2 of this Act.

(3) (a) If an insurer routinely requires a provider to submit attachments to the claim containing additional medical information summarizing the diagnosis, the treatment, or services rendered to the covered person before the claim will be paid, the insurer shall identify the specific routinely required information in its provider manual or other document that sets forth the procedure for filing claims with the insurer. The insurer shall provide sixty (60) days' advance written notice of modifications to the provider manual that materially change the type or content of the attachments to be submitted;

(b) If a provider submits a clean claim with the required attachments as specified in the provider manual or other document that sets forth the procedure for filing claims with the insurer, the insurer shall pay or deny the claim within the required claims payment time frame established in Section 2 of this Act; and

(c) If an insurer conducts a retrospective review of a claim and requires an attachment not specified in the provider manual or other document that sets forth the procedure for filing claims, the insurer shall:

1. Notify the provider, in writing or electronically within the claims payment time frame established in Section 2 of this Act, of the service that will be retrospectively reviewed and the specific information needed from the provider regarding the insurer's review of a claim;

2. Complete the retrospective review within twenty (20) business days of the insurer's receipt of the medical information described in this subsection; and

3. Add interest to the amount of the claim to be paid at a rate of twelve percent (12%) per annum, or at a rate in accordance with Section 16 of this Act accruing from the thirty-first day after the claim was received by the insurer through the date upon which the claim is paid.

(4) (a) If a claim or portion thereof is contested by an insurer on the basis that the insurer has not received information reasonably necessary to determine insurer liability for the claim or portion thereof, the insurer shall, within the applicable claims payment time frame established in Section 2 of this Act, provide written or electronic notice to the provider, covered person, or insurer, as appropriate, with an itemization of all new, never-before-provided information that is needed; and

(b) The insurer shall pay or deny the claims within thirty (30) calendar days of receiving the additional information described in paragraph (a) of this subsection.

SECTION 5. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) An insurer shall not require a provider to appeal errors in payment where the insurer has not paid the claim according to the contracted rate. Miscalculations in payments made by the insurer shall be corrected and paid within thirty (30) calendar days upon the insurer's receipt of documentation from the provider verifying the error.

(2) An insurer shall not be required to correct a payment error to a provider if the provider's request for a payment correction is filed more than twenty-four (24) months after the date that the provider received payment for the claim from the insurer.

(3) (a) Except in cases of fraud, an insurer may only retroactively deny reimbursement to a provider during the twenty-four (24) month period after the date that the insurer paid the claim submitted by the provider;

(b) An insurer that retroactively denies reimbursement to a provider under this section shall give the provider a written or electronic statement specifying the basis for the retroactive denial;

(c) If the retroactive denial of reimbursement results from coordination of benefits, the written statement shall specify the name and address of the entity acknowledging responsibility for payment of the denied claim; and

(d) If an insurer retroactively denies reimbursement for services as a result of coordination of benefits with another insurer, the provider shall have twelve (12) months from the date that the provider received notice of the denial, unless the insurer that retroactively denied reimbursement permits a longer period, to submit a claim for reimbursement for the service to the insurer, the medical assistance program, or the Medicare program responsible for payment.

SECTION 6. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) In contracts with providers or in the provider manual or other document that sets forth the procedures for filing claims, an insurer shall disclose to providers:

(a) The mailing or electronic address where claims should be sent for processing;

(b) The phone number a provider may call to have questions and concerns regarding claims addressed;

(c) Any entity to which the insurer has delegated claim payment functions; and

(d) The address of any separate claims processing centers for specific types of services.

(2) An insurer shall provide, no less than thirty (30) calendar days, prior written notice of any changes in the information required in subsection (1) of this section, to its contracted providers.

SECTION 7. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

If an insurer determines that payment was made for services rendered to an individual who was not eligible for coverage, or that payment was made for services not covered by a covered person's health benefit plan, the insurer shall give written notice to the provider and:

(1) Request a refund from the provider; or

(2) Make a recoupment of the overpayment from the provider in accordance with Section 8 of this Act.

SECTION 8. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

If an insurer chooses to collect an overpayment made to a provider through a recoupment against future provider payments, the insurer shall, within twenty-four (24) months from the date that the insurer paid the claim, give the provider written documentation that specifies:

(1) The amount of the recoupment;

(2) The covered person's name to whom the recoupment applies;

(3) Patient identification number; and

(4) Date of service.

SECTION 9. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) No insurer or any other person providing or administering a health benefit plan shall deny or reduce payment for a service, procedure, treatment, drug, or device covered under the covered person's health benefit plan if:

(a) The covered person's provider, during normal business hours, contacts the insurer or the insurer's designee or agent on the day the covered person is expected to be discharged to request review of the covered person's continued hospitalization and the insurer, designee, or agent fails to provide a utilization review decision within twenty-four (24) hours of the request and prior to the time upon which any previous authorization will expire; or

(b) The covered person's provider makes at least three (3) documented attempts during a four (4) consecutive hour period to contact the insurer, designee, or agent during normal business hours to request review of a continued hospital stay; preauthorization of treatment for a covered person who is already hospitalized; retrospective review of an emergency hospital admission where the covered person remains hospitalized at the time the review requested is made; and the insurer, designee, or private review agent fails to be accessible via a toll free telephone line for forty (40) hours per week during normal business hours.

(2) The insurer's liability to pay for the covered person's hospitalization under the circumstances set forth in subsection (1) of this section shall extend until the insurer, designee, or private review agent issues a utilization review decision on a request for review of the matters addressed under subsection (1)(b) of this section.

(3) The insurer's liability to pay under this section shall be conditioned on:

(a) The provider establishing verifiable documentation of the contact with, and subsequent failure of the insurer, designee, or agent to make the utilization review decision as set forth in subsection (1)(a) of this section; or

(b) The provider establishing verifiable documentation of the attempt to make contact with the insurer, designee or agent as addressed in subsection (1)(b) of this section.

(4) In either instance, the contact, or attempts to contact, as set forth in this section, shall be made by the means required by the insurer, designee, or agent for requesting utilization review.

(5) This section applies only when the request for review concerns covered health benefits and it shall not supersede any limitations or exclusions in the covered person's health benefit plan. This section shall not apply if, in requesting a review, the provider does not furnish the information requested by the insurer or agent to make a utilization review decision, or if actions by the provider impede an insurer's or private review agent's ability to issue a utilization review decision.

SECTION 10. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Beginning on January 1, 2001, upon issuance, delivery, or renewal of a health benefit plan in Kentucky, an insurer shall:

(a) Clearly indicate on each covered person's identification card the mailing address where a claim for payment shall be sent; and

(b) Issue new identification cards or an appropriate sticker to covered persons no later than thirty (30) calendar days following the effective date of any change in the address of the insurer, its agent, designee, or other entity that processes claims for the insurer.

(2) Identification cards for covered persons shall identify whether the covered person has health maintenance organization (HMO), point of service (POS), preferred provider organization (PPO), or indemnity fee for service (FFS) coverage.

SECTION 11. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) In order to improve the efficiency and effectiveness of the health care system through administrative simplification of billing requirements, the commissioner shall prescribe through the promulgation of administrative regulations, standardized health claim attachments to be used by all insurers requiring additional medical information to process health care claims. The Kentucky State Uniform Billing Committee shall make recommendations to the commissioner on the standardization of attachments.

(2) Any administrative regulations that prescribe standardized health claim attachments shall be updated to conform with federal standards following the release of national requirements for transactions and data elements in accordance with the Federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. Chapter 6A, Subchapter XXV, sec. 300gg et seq.

SECTION 12. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) No later than ninety (90) days following the effective date of this Act, the department shall promulgate administrative regulations requiring all insurers to report information, according to timetables prescribed by the department but no less than annually, on prompt payment of claims that shall include the following:

(a) Percentage of clean claims paid within the claims payment time frame;

(b) Percentage of clean claims paid after the claims payment time frame and the number of days for hospitals, physicians, and all other providers, excluding pharmacies, within which the claims were finally adjudicated, reporting them in thirty-one (31) to sixty (60) day, sixty-one (61) to ninety (90) day, and more than ninety (90) day intervals; and (c) Amount of interest paid.

(2) The department shall, as part of the market conduct survey of each insurer, audit the insurer to determine compliance with Sections 1 to 17 and Section 18 of this Act. Findings shall be made available to the public upon request.

(3) The commissioner shall annually present to the Interim Joint Committee on Banking and Insurance and to the Governor, a report on the payment practices of insurers and compliance with the provisions of Sections 1 to 17, Section 18, and Section 19 of this Act and the commissioner's enforcement activities, including the number of complaints received and those acted upon by the department.

SECTION 13. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

Sections 1 to 17, Section 18, and Section 19 of this Act apply to any entity an insurer contracts with to perform claims processing functions.

SECTION 14. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

Upon enactment, all health care claims incurred after the effective date of this Act, and contractual agreements between insurers and providers regarding the payment of health care claims entered into after the effective date of this Act, shall conform to Sections 1 to 17, Section 18, and Section 19 of this Act. An insurer shall not request or require a provider to pursue any other course of action regarding the payment of health care claims outside of the provisions set forth in Sections 1 to 17, Section 18, and Section 19 of this Act.

SECTION 15. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) A provision identifying the products and markets applicable to any discount as provided in the contract shall be required of all contracts with a:

(a) Provider or an organization of providers; or

(b) Preferred provider organization that has a network of preferred providers and the organization has contracted with the health care preferred provider.

(2) An insurer or entity shall not reimburse on a discounted fee basis unless the disclosure is provided in the contract with:

(a) A provider or organization of providers; or

(b) An organization that has a network of preferred providers and the insurance entity has the written consent of the healthcare preferred providers.

(3) An insurer or entity under contract with the insurer who violates this section commits an unfair claims settlement practice violation under Subtitle 12 of KRS Chapter 304, and is also subject to administrative penalties under Subtitle 99 of KRS Chapter 304.

SECTION 16. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) An insurer that fails to pay, deny, or settle a clean claim in accordance with Sections 1 to 17, Section 18, and Section 19 of this Act shall pay interest according to the following schedule on the amount of the claim that remains unpaid:

(a) For claims that are paid between thirty-one (31) and sixty (60) days from the date that the claim was received by the insurer or any entity that administers or processes claims on behalf of the insurer, interest at a rate of twelve percent (12%) per annum shall accrue from the date payment was due under Section 2 of this Act;

(b) For claims that are paid between sixty-one (61) days and ninety (90) days from the date that the claim was received by the insurer or any entity that administers or processes claims on behalf of the insurer, interest at a rate of eighteen percent (18%) per annum shall accrue from the date payment was due under Section 2 of this Act; and

(c) For claims that are paid more than ninety (90) days from the date that the claim was received by the insurer or any entity that administers or processes claims on behalf of

the insurer, interest at a rate of twenty-one percent (21%) per annum shall accrue from the date that payment was due under Section 2 of this Act.

(2) When paying a claim after the time required by Section 2 of this Act, the insurer shall add the interest payable to the amount of the unpaid claim without the necessity for any claim for that interest to be made by the provider filing the original claim. The interest obligation otherwise imposed by this section shall not apply if the failure to pay, deny, or settle a claim is due to, or results from, in whole or in part, acts or events beyond the control of the insurer, including but not limited to, acts of God, natural disasters, epidemics, strikes or other labor disruptions, war, civil disturbance, riot, or complete or partial disruptions of facilities.

SECTION 17. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) In addition to any other penalty or remedy authorized by law, the department may assess the following fines for noncompliance with Sections 1 to 17, Section 18, and Section 19 of this Act:

(a) A fine of one thousand dollars ($1,000) per day or ten percent (10%) of the unpaid claim amount, whichever is greater, for each day that a clean claim remains unpaid in violation of Sections 1 to 17, Section 18, and Section 19 of this Act.

(b) Except for the late payment of claims under subsection (2) of this section, a fine of up to ten thousand dollars ($10,000) where the commissioner determines that an insurer has willfully and knowingly violated Sections 1 to 17, Section 18, and Section 19 of this Act or has a pattern of repeated violations of Sections 1 to 17, Section 18, and Section 19 of this Act.

(2) For purposes of paragraph (a) of subsection (1) of this section, an insurer is in compliance when ninety-five percent (95%) of the clean claims paid during each calendar quarter, excluding pharmaceutical claims, were paid within thirty (30) days and the total dollar amount paid within thirty (30) days, excluding the amount paid for pharmaceutical claims, equaled at least ninety percent (90%) of the total dollar amount paid for clean claims during that calendar quarter.

Section 18. KRS 304.14-135 is amended to read as follows:

(1) The commissioner shall prescribe ***the following*** uniform health insurance claim forms which shall be used by all insurers transacting health insurance in this state and by all state agencies that require health insurance claim forms for their records ***as the sole instrument for reimbursement:***

(a) The uniform health insurance claim form for an institutional provider shall consist of the UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Billing Committee;

(b) The uniform health insurance claim form for a dentist shall consist of a data set and form approved by the American Dental Association;

(c) The uniform health insurance claim form for all other health care providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee; and

(d) A clean claim for pharmacists shall consist of a universal claim form or data set approved by the National Council on Prescription Drug Program.

(2) An insurer shall not require a provider to:

(a) Use a claim form that is different than the uniform claim form for the provider type as set out in subsection (1) of this section; (b) Modify the uniform claims form or its content; or (c) Submit additional claims forms.

Section 19. KRS 205.593 is amended to read as follows:

(1) In enrolling an individual or making any payments for benefits to the individual or on the individual's behalf, health insurers are prohibited from taking into account that the individual is eligible for or is provided medical assistance.

(2) Sections 1 to 17, Section 18, and Section 19 of this Act apply to any provider partnership, health maintenance organization, or other managed care organization under contract with the Department for Medicaid Services to manage care and process health care claims for services delivered to Medicaid recipients covered under Medicaid managed care.

Approved April 21, 2000