FIRST REGULAR SESSION

SENATE BILL NO. 391

91ST GENERAL ASSEMBLY

INTRODUCED BY SENATOR ROHRBACH.

Read 1st time January 31, 2001, and 1,000 copies ordered printed.

TERRY L. SPIELER, Secretary.

1620S.01I

AN ACT

To repeal section 376.383, RSMo 2000, relating to reimbursement for health care services, and to enact in lieu thereof two new sections relating to the same subject.

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

Section A. Section 376.383, RSMo 2000, is repealed and two new sections enacted in lieu thereof, to be known as sections 376.383 and 376.384, to read as follows: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. To the extent consistent with the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001, et seq., this section shall apply to any health **[**insurer**]** **carrier** as defined in section **[**376.806, any nonprofit health service plan and any health maintenance organization.**]** **376.1350. For purposes of this section, a "clean claim" shall be defined as a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim pursuant to this section.**

2. Within forty-five days after receipt of a claim for reimbursement **[**from a person entitled to reimbursement**]** **for a health care service provided in this state as defined in section 376.1350**, a health **[**insurer, nonprofit health service plan or health maintenance organization**]** **carrier** shall pay the **clean** claim in accordance with this section or send a notice of receipt and status of the claim that states:

(1) That the **[**insurer, nonprofit health service plan or health maintenance organization**]** **health carrier** refuses to reimburse all or part of the claim and the reason for the refusal; **[**or**]**

(2) **Until April 1, 2002,** that additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information **that** is necessary**; or**

EXPLANATION--Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

(3) On or after April 1, 2002, that additional information is necessary to determine if all or part of the claim will be reimbursed and a complete description of all specific additional information that is necessary to process the entire claim as a clean claim.

3. If **[**an insurer, nonprofit health service plan or health maintenance organization**] a health carrier** fails to comply with subsection 2 of this section, the **[**insurer, nonprofit health service plan or health maintenance organization**] health carrier** shall pay interest on the amount of the claim that remains unpaid forty-five days after the claim is filed at the monthly rate of one percent. 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 carrier may combine interest payments and make payment once the aggregated amount reaches five dollars.**

4. Within ten days after the day on which all additional information is received by an insurer, nonprofit health service plan or health maintenance organization, it shall pay the claim in accordance with this section or send a written notice that:

(1) States refusal to reimburse the claim or any part of the claim; and

(2) Specifies each reason for denial.

[An insurer, nonprofit health service plan or health maintenance organization**] A health carrier** that fails to comply with this subsection shall pay interest on any amount of the claim that remains unpaid at the monthly rate of one percent.

5. A **[**provider**] health care professional, as defined in section 376.1350,** who is paid interest **[**under**] pursuant to** this section shall pay the proportionate amount of **[**said**] such** interest to the enrollee or insured to the extent and for the time period that the enrollee or insured had paid for the services and for which reimbursement was due to the insured or enrollee.

6. **[**This section shall become effective April 1, 1999.**] On or after April 1, 2002, a health care professional, as defined in section 376.1350 shall file all claims for reimbursement from a health carrier, as defined in section 376.1350, using the HCFA 1500 universal form, and a health carrier shall only accept as a clean claim a claim submitted using the HCFA 1500 universal form.**

376.384. 1. For purposes of this section, "health care professional" means the same as such term is defined in section 376.1350 and "health carrier" means the same as such term is defined in section 376.1350. Any health carrier shall:

(1) Permit non-participating health care professionals to file a claim for reimbursement for a health care service provided in this state as defined in sections 376.1350 for a period of up to one year from the date of service;

(2) Permit participating health care professionals 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 six months from the date of service, unless the contract

between the health carrier and health care professional specifies a different standard;

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

(4) Issue within twenty-four hours 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 state as defined in section 376.1350, 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 after January 1, 2003, in a non-electronic format shall not be subject to the provisions of section 376.383.

3. The director of the department of insurance shall appoint a task force, to be comprised equally of health care professionals and health carriers, to develop industry standards for electronic data interchanges that act as clearinghouses for the submission and processing of claims for reimbursement for health care services provided in this state as defined in section 376.1350.