As Introduced

133rd General Assembly
Regular Session **H. B. No. 691**
2019-2020

Representatives Manchester, Plummer

A BILL

To amend sections 3901.38, 3901.381, 3901.383, 3901.3811, 3901.3812, and 3901.3814 and to enact section 5167.104 of the Revised Code to amend the prompt pay requirements for providers and third-party payers and to include Medicaid managed care organizations. 1 2 3 4 5 6

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

Section 1. That sections 3901.38, 3901.381, 3901.383, 3901.3811, 3901.3812, and 3901.3814 be amended and section 5167.104 of the Revised Code be enacted to read as follows: 7 8 9

Sec. 3901.38. As used in this section and sections 3901.381 to 3901.3814 of the Revised Code: 10 11

(A) "Beneficiary" means any policyholder, subscriber, member, employee, or other person who is eligible for benefits under a benefits contract, including a medicaid recipient enrolled in a medicaid MCO plan, as defined in section 5167.01 of the Revised Code. 12 13 14 15 16

(B) "Benefits contract" means a sickness and accident insurance policy providing hospital, surgical, or medical expense coverage, or a health insuring corporation contract or 17 18 19

other policy or agreement under which a third-party payer agrees 20
to reimburse for covered health care or dental services rendered 21
to beneficiaries, up to the limits and exclusions contained in 22
the benefits contract. 23

(C) "Hospital" has the same meaning as in section 3727.01 24
of the Revised Code. 25

(D) "Provider" means a hospital, nursing home, physician, 26
podiatrist, dentist, pharmacist, chiropractor, or other health 27
care provider entitled to reimbursement by a third-party payer 28
for services rendered to a beneficiary under a benefits 29
contract. 30

(E) "Reimburse" means indemnify, make payment, or 31
otherwise accept responsibility for payment for health care 32
services rendered to a beneficiary, or arrange for the provision 33
of health care services to a beneficiary. 34

(F) "Third-party payer" means any of the following: 35

(1) An insurance company; 36

(2) A health insuring corporation; 37

(3) A managed care organization; 38

(4) A medicaid managed care organization, as defined in 39
section 5167.01 of the Revised Code; 40

(5) A labor organization; 41

~~(4)~~ (6) An employer; 42

~~(5)~~ (7) An intermediary organization, as defined in 43
section 1751.01 of the Revised Code, that is not a health 44
delivery network contracting solely with self-insured employers; 45

~~(6)~~ (8) An administrator subject to sections 3959.01 to 46

3959.16 of the Revised Code;

~~(7)~~ (9) A health delivery network, as defined in section 1751.01 of the Revised Code;

~~(8)~~ (10) Any other person that is obligated pursuant to a benefits contract to reimburse for covered health care services rendered to beneficiaries under such contract.

Sec. 3901.381. (A) Except as provided in sections 3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.

(B)(1)(a) ~~Unless division (B)(2) or (3) of this section applies, when~~ When a third-party payer receives from a provider or beneficiary a claim on the standard claim form prescribed in rules adopted by the superintendent of insurance under section 3902.22 of the Revised Code, or in the case of a third-party payer providing coverage under the care management system established under section 5167.03 of the Revised Code, on the claim form required by the third-party payer, the third-party payer shall ~~pay or deny the claim not later than thirty days after receipt of the claim.~~ do one of the following:

(i) Pay the claim;

(ii) Request supporting documentation;

(iii) Deny the claim.

(b)(i) A third-party payer shall have ten days to request supporting claim documentation and shall then pay or deny the claim in accordance with division (B)(3)(b) of this section.

(ii) A third-party payer that does not request supporting

claim documentation shall have thirty days to either pay or deny the claim.

(2)(a) When a third-party payer denies a claim, the third-party payer shall notify the provider ~~and the~~ through the remittance process with industry standard codes and shall notify the beneficiary through appropriate means. ~~The notice~~

(b) Both notice types shall state, with specificity, why the third-party payer denied the claim.

(c) All claim denials shall be returned to the provider in the 835 file.

~~(2)(a) Unless division (B)(3) of this section applies, when~~ (3)(a) A third-party payer shall not deny a claim solely on the basis of a lack of supporting documentation.

(b) When a provider or beneficiary has used the standard claim form, but the third-party payer determines that reasonable supporting documentation is needed to establish the third-party payer's responsibility to make payment, the third-party payer shall pay or deny the claim not later than ~~forty-five~~ five days after receipt of the ~~claim~~supporting documentation from the provider.

(c) Supporting documentation includes ~~the verification~~ all of the following:

(i) Verification of employer and beneficiary coverage under a benefits contract~~, confirmation~~;

(ii) Confirmation of premium payment, if required ~~medical~~;

(iii) Medical information regarding the beneficiary and the services provided~~, information~~;

(iv) Information on the responsibility of another third-party payer to make payment or confirmation of the amount of payment by another third-party payer~~, and information~~; 102 103 104

(v) Determination of eligibility for benefits; 105

(vi) Information that is needed to correct material deficiencies in the claim related to a diagnosis or treatment or the provider's identification. 106 107 108

(d) All requests for information shall be returned to the provider in the 835 file. 109 110

(e)(i) Managed care organizations shall provide claim and remark adjustment reason codes that specify the type of documentation requested. 111 112 113

(ii) Managed care organizations shall update the claim status on the managed care organization's portal with a date and time stamp upon receipt of supporting documentation. 114 115 116

(f) A third-party payer shall not request medical records or itemized reports prior to payment for any of the following reasons: 117 118 119

(i) For purposes of determining whether services billed are documented in the record; 120 121

(ii) For purposes of utilization management, if the services were to treat an emergency medical condition; 122 123

(iii) The amount of the claim. 124

(g) A third-party payer shall not request medical records or itemized reports prior to payment for any of the following claim types: 125 126 127

(i) The claim is for services that were prior authorized; 128

(ii) The claim is for inpatient services for which the provider notified the plan within forty-eight hours of admission or the plan requested medical records during the course of the inpatient stay;

(iii) The claim was subject to any other type of prepayment review.

(h) Not later than ~~thirty~~ ten days after receipt of the claim, the third-party payer shall ~~notify~~ provide written notice to all relevant external sources that the supporting documentation is needed. All such notices shall state, with specificity, the supporting documentation needed. ~~If the notice was not provided in writing, the provider, beneficiary, or third-party payer may request the third-party payer to provide the notice in writing, and the third-party payer shall then provide the notice in writing.~~ If any of the supporting documentation is under the control of the beneficiary, the beneficiary shall provide the supporting documentation to the third-party payer.

~~The number of days that elapse between the third-party payer's last request for supporting documentation within the thirty-day period and the third-party payer's receipt of all of the supporting documentation that was requested shall not be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days for payment or denial of a claim. Except as provided in division (B)(2)(b) of this section, if the third-party payer requests additional supporting documentation after receiving the initially requested documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall be counted for purposes of~~

~~determining the third-party payer's compliance with the time period of not more than forty-five days.~~

~~(b) If a third-party payer determines, after receiving initially requested documentation, that it needs additional supporting documentation pertaining to a beneficiary's preexisting condition, which condition was unknown to the third-party payer and about which it was reasonable for the third-party payer to have no knowledge at the time of its initial request for documentation, and the third-party payer subsequently requests this additional supporting documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall not be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days.~~

~~(c)~~The provider shall provide in writing the requested supporting documentation to the third party.

(i) When a third-party payer denies a claim after supporting documentation has been received, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim.

~~(d) If a~~ (j)(i) A third-party payer ~~determines that~~ shall publicly post on its web site a list of the twenty most claimed health care services and the supporting documentation related to medical information that is routinely necessary to process a claim for ~~payment of a particular~~ the listed health care ~~service, the third-party payer shall establish a description of the supporting documentation that is routinely necessary and make the description~~ services. Such information shall be made

available to providers in a readily accessible format. A third-party payer shall accept all such documentation electronically.

(ii) The third-party payer shall update the list described in division (B)(3)(j)(i) of this section annually.

(4) If a third-party payer does not approve, request supporting documentation, or deny a claim within the timelines established by this section, the third-party payer shall immediately remit full payment of the claim.

(5) Third-party payers and providers shall, in connection with a claim, use the most current CPT code in effect, as published by the American medical association, the most current ICD-10 code in effect, as published by the United States department of health and human services, the most current CDT code in effect, as published by the American dental association, or the most current HCPCS code in effect, as published by the United States centers for medicare and medicaid services.

~~(3) When a provider or beneficiary submits a claim by using the standard claim form prescribed in the superintendent's rules, but the information provided in the claim is materially deficient, the third-party payer shall notify the provider or beneficiary not later than fifteen days after receipt of the claim. The notice shall state, with specificity, the information needed to correct all material deficiencies. Once the material deficiencies are corrected, the third-party payer shall proceed in accordance with division (B)(1) or (2) of this section.~~

~~It is not a violation of the notification time period of not more than fifteen days if a third-party payer fails to notify a provider or beneficiary of material deficiencies in the claim related to a diagnosis or treatment or the provider's~~

~~identification. A third-party payer may request the information necessary to correct these deficiencies after the end of the notification time period. Requests for such information shall be made as requests for supporting documentation under division (B)(2) of this section, and payment or denial of the claim is subject to the time periods specified in that division.~~

(C) For purposes of this section, if a dispute exists between a provider and a third-party payer as to the day a claim form was received by the third-party payer, both of the following apply:

(1) If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer by mail and retains a record of the day the claim was mailed, there exists a rebuttable presumption that the claim was received by the third-party payer on the fifth business day after the day the claim was mailed, unless it can be proven otherwise.

(2) If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer electronically, there exists a rebuttable presumption that the claim was received by the third-party payer twenty-four hours after the claim was submitted, unless it can be proven otherwise.

(D) Nothing in this section requires a third-party payer, not including a medicaid managed care organization, to provide more than one notice to an employer whose premium for coverage of employees under a benefits contract has not been received by the third-party payer.

(E) ~~Compliance with the provisions of division (B)(3) of this section shall be determined separately from compliance with~~

~~the provisions of divisions (B)(1) and (2) of this section.~~

~~(F)~~ A third-party payer shall transmit electronically any payment with respect to claims that the third-party payer receives electronically and pays to a contracted provider under this section and under sections 3901.383, 3901.384, and 3901.386 of the Revised Code. A provider shall not refuse to accept a payment made under this section or sections 3901.383, 3901.384, and 3901.386 of the Revised Code on the basis that the payment was transmitted electronically.

(F) As used in this section, "835 file" means an electronic transaction that is compliant with the requirements of HIPPA, as defined in section 3965.01 of the Revised Code, and is used by providers to record and document claim payment information.

Sec. 3901.383. (A) A provider and a third-party payer may do either of the following:

(1) Enter into a contractual agreement under which time periods shorter than those set forth in section 3901.381 of the Revised Code are applicable to the third-party payer in paying a claim for any amount due for health care services rendered by the provider;

(2) Enter into a contractual agreement under which the timing of payments by the third-party payer is not directly related to the receipt of a claim form. The contractual arrangement may include periodic interim payment arrangements, capitation payment arrangements, or other periodic payment arrangements acceptable to the provider and the third-party payer. Under a capitation payment arrangement, the third-party payer shall begin paying the capitated amounts to the

beneficiary's primary care provider not later than sixty days after the date the beneficiary selects or is assigned to the provider. Under any other contractual periodic payment arrangement, the contractual agreement shall state, with specificity, the timing of payments by the third-party payer.

(B) ~~Regardless of whether a third-party payer is exempted under division (D) of section 3901.3814 from sections 3901.38 and 3901.381 to 3901.3813 of the Revised Code, a~~ A provider and ~~the~~ a third-party payer, including a third-party payer that provides coverage under the medicaid program, shall not enter into a contractual arrangement under which time periods longer than those provided for in paragraph (c)(1) of 42 C.F.R. 447.46 are applicable to the third-party payer in paying a claim for any amount due for health care services rendered by the provider.

Sec. 3901.3811. (A) No third-party payer shall fail to comply with sections 3901.381 and 3901.384 to 3901.3810 of the Revised Code.

(B)~~-~~(1) A provider may notify the superintendent of insurance or the director of medicaid of a third-party payer's failure to comply with section 3901.381 of the Revised Code in either or both of the following situations:

(a) Twenty per cent or more of the claims submitted by the provider to the third-party payer are in violation of section 3901.381 of the Revised Code during a calendar month;

(b) An individual claim is in violation of section 3901.381 of the Revised Code and the claim cannot be resolved through a claim dispute process.

(2) The superintendent or director shall investigate such

claims within fifteen days of receipt according to the procedure established in division (B) of section 3901.3812 of the Revised Code. 305 306 307

(C) The superintendent of insurance, or the medicaid director in the case of third-party payers providing coverage under the medicaid program, may require third-party payers to submit reports of their compliance with division (A) of this section. If reports are required, the superintendent or director shall prescribe the content, format, and frequency of the reports in consultation with third-party payers. ~~The~~ Neither the superintendent nor the director shall ~~not~~ require reports to be submitted more frequently than once every three months. 308 309 310 311 312 313 314 315 316

~~The~~ Neither the superintendent nor the director shall ~~not~~ use findings from reports submitted by a third-party payer under this division as the basis of a finding of a violation of division (A) of this section or the imposition of penalties under section 3901.3812 of the Revised Code. However, the information contained in the reports may cause the superintendent or the director to conduct a market conduct examination of the third-party payer. During this examination, the superintendent or director may examine data collected from the same time period as covered by these reports and the superintendent's or the director's examination findings may be used as the basis for finding a violation of division (A) of this section. 317 318 319 320 321 322 323 324 325 326 327 328 329

Sec. 3901.3812. ~~(A)~~ (A)(1) Upon receiving notification from a provider that a third-party payer is in violation of section 3901.381 of the Revised Code, the superintendent of insurance, or the director of medicaid in the case of a third-party payer providing coverage under the care management system 330 331 332 333 334

established under section 5167.03 of the Revised Code, shall investigate the claim. All documentation requested by the superintendent or the director shall be provided to the superintendent or director by the provider and the third-party payer. The superintendent and the director may establish rules in accordance with Chapter 119. of the Revised Code as needed to carry out the requirements of this division. 335 336 337 338 339 340 341

(2) If the superintendent or director is notified in accordance with division (B)(1)(a) of section 3901.3811 of the Revised Code and the superintendent or director determine that the third-party payer is in violation of section 3901.381 of the Revised Code, the superintendent or director shall impose a fine equal to one hundred per cent of the aggregated bill claims that were found to be delinquent. 342 343 344 345 346 347 348

(3) If the superintendent or director is notified in accordance with division (B)(1)(b) of section 3901.3811 of the Revised Code and the superintendent or director determine that the third-party payer is in violation of section 3901.381 of the Revised Code, the department or the director shall impose a fine equal to fifty per cent of the billed claim for every fourteen days that the claim remains delinquent. 349 350 351 352 353 354 355

(4) The fines prescribed under divisions (A)(2) and (3) of this section shall be paid to the provider in question. The superintendent and director shall adopt rules prescribing the means by which the fines are paid to the provider. Such rules shall not be subject to division (F) of section 121.95 of the Revised Code. 356 357 358 359 360 361

(B) If, after completion of an examination involving information collected from a six-month period, the superintendent or director finds that a third-party payer has 362 363 364

committed a series of violations that, taken together, constitutes a consistent pattern or practice of violating division (A) of section 3901.3811 of the Revised Code, the superintendent or director may impose on the third-party payer any of the administrative remedies specified in division ~~(B)~~ (C) of this section. In making a finding under this division, the superintendent or director shall apply the error tolerance standards for claims processing contained in the market conduct examiners handbook issued by the national association of insurance commissioners in effect at the time the claims were processed.

Before imposing an administrative remedy, the superintendent or director shall provide written notice to the third-party payer informing the third-party payer of the reasons for the superintendent's finding, the administrative remedy the superintendent or director proposes to impose, and the opportunity to submit a written request for an administrative hearing regarding the finding and proposed remedy. If the third-party payer requests a hearing, the superintendent or director shall conduct the hearing in accordance with Chapter 119. of the Revised Code not later than fifteen days after receipt of the request.

~~(B)(1)~~ (C)(1) In imposing administrative remedies under division ~~(A)~~ (B) of this section for violations of section 3901.381 of the Revised Code, the superintendent or director may do any of the following:

(a) Levy a monetary penalty in an amount determined in accordance with division ~~(B)(3)~~ (C)(3) of this section;

(b) Order the payment of interest directly to the provider in accordance with section 3901.389 of the Revised Code;

(c) Order the third-party payer to cease and desist from engaging in the violations;

(d) If a monetary penalty is not levied under division ~~(B)(1)(a)~~ (C)(1)(a) of this section, impose any of the administrative remedies provided for in section 3901.22 of the Revised Code, other than those specified in divisions (D)(4) and (5) and (G) of that section. This division does not apply to third-party payers providing coverage under the care management system established under section 5167.03 of the Revised Code.

(2) In imposing administrative remedies under division ~~(A)~~ (B) of this section for violations of sections 3901.384 to 3901.3810 of the Revised Code, the superintendent or director may do any of the following:

(a) Levy a monetary penalty in an amount determined in accordance with division ~~(B)(3)~~ (C)(3) of this section;

(b) Order the payment of interest directly to the provider in accordance with section 3901.38 of the Revised Code;

(c) Order the third-party payer to cease and desist from engaging in the violations;

(d) If a monetary penalty is not levied under division ~~(B)(2)(a)~~ (C)(2)(a) of this section, impose any of the administrative remedies provided for in section 3901.22 of the Revised Code, other than those specified in divisions (D)(4) and (5) and (G) of that section. For violations of sections 3901.384 to 3901.3810 of the Revised Code that did not comply with section 3901.381 of the Revised Code, the superintendent may also use section 3901.22 of the Revised Code except divisions (D)(4) and (5) of that section. This division does not apply to third-party payers providing coverage under the care management

system established under section 5167.03 of the Revised Code. 424

(3) A finding by the superintendent or director that a third-party payer has committed a series of violations that, taken together, constitutes a consistent pattern or practice of violating division (A) of section 3901.3811 of the Revised Code, shall constitute a single offense for purposes of levying a fine under division ~~(B)(1)(a)~~ (C)(1)(a) and ~~(B)(2)(a)~~ (C)(2)(a) of this section. For a first offense, the superintendent or director may levy a fine of not more than one hundred thousand dollars. For a second offense that occurs on or earlier than four years from the first offense, the superintendent or director may levy a fine of not more than one hundred fifty thousand dollars. For a third or additional offense that occurs on or earlier than seven years after a first offense, the superintendent or director may levy a fine of not more than three hundred thousand dollars. In determining the amount of a fine to be levied within the specified limits, the superintendent or director shall consider the following factors: 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441

(a) The extent and frequency of the violations; 442

(b) Whether the violations were due to circumstances beyond the third-party payer's control; 443 444

(c) Any remedial actions taken by the third-party payer to prevent future violations; 445 446

(d) The actual or potential harm to others resulting from the violations; 447 448

(e) If the third-party payer knowingly and willingly committed the violations; 449 450

(f) The third-party payer's financial condition; 451

(g) Any other factors the superintendent considers appropriate.

(C) The remedies imposed by the superintendent or director under this section are in addition to, and not in lieu of, such other remedies as providers and beneficiaries may otherwise have by law.

(D) ~~Any~~ Except as provided in divisions (A)(2) and (3) of this section, any fine collected under this section shall be paid into the state treasury as follows:

~~(1)~~ (1) For fines collected by the superintendent of insurance:

(a) Twenty-five per cent of the total to the credit of the department of insurance operating fund created by section 3901.021 of the Revised Code;

~~(2)~~ (b) Sixty-five per cent of the total to the credit of the general revenue fund;

~~(3)~~ (c) Ten per cent of the total to the credit of claims processing education account, which is hereby created within the department of insurance operating fund created by section 3901.021 of the Revised Code.

(d) All money credited to the claims processing education account shall be used by the department of insurance to make technical assistance available to third-party payers, providers, and beneficiaries for effective implementation of the provisions of sections 3901.38 and 3901.381 to 3901.3814 of the Revised Code.

(2) One hundred per cent of the fines collected by the director of medicaid shall be deposited into the general revenue

fund. 480

Sec. 3901.3814. Sections 3901.38 and 3901.381 to 3901.3813 of the Revised Code do not apply to the following: 481 482

(A) Policies offering coverage that is regulated under Chapters 3935. and 3937. of the Revised Code; 483 484

(B) An employer's self-insurance plan and any of its administrators, as defined in section 3959.01 of the Revised Code, to the extent that federal law supersedes, preempts, prohibits, or otherwise precludes the application of any provisions of those sections to the plan and its administrators; 485 486 487 488 489

(C) A third-party payer for coverage provided under the medicare advantage program operated under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended; 490 491 492 493

(D) A third-party payer for coverage provided under the fee-for-service component of the medicaid program under Chapter 5164. of the Revised Code; 494 495 496

(E) A third-party payer for coverage provided under the tricare program offered by the United States department of defense. 497 498 499

Sec. 5167.104. (A) A medicaid managed care organization shall comply with sections 3901.38 to 3901.3814 of the Revised Code, as applicable. 500 501 502

(B) The medicaid director shall comply with sections 3901.38 to 3901.3814 of the Revised Code, as applicable. 503 504

Section 2. That existing sections 3901.38, 3901.381, 3901.383, 3901.3811, 3901.3812, and 3901.3814 of the Revised Code are hereby repealed. 505 506 507