Bill No. CS for CS for SB 362

Amendment No. ___ Barcode 281204

CHAMBER ACTION

Senate House

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Senator Saunders moved the following amendment:

**Senate Amendment**

On page 5, line 10, through

page 6, line 19, delete those lines

and insert:

(2) As used in this section, the term "claim" for a noninstitutional provider means a paper or electronic billing instrument submitted to the insurer's designated location which consists of the HCFA 1500 data set, or its successor, which has all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 or other appropriate billing instrument that has all mandatory entries for any other noninstitutional provider. For institutional providers, "claim" means a paper or electronic billing instrument submitted to the insurer's designated location which consists of the UB-92 data set or its successor having all mandatory entries.~~Health insurers shall reimburse all claims or any portion of any claim from an insured or an insured's assignees, for payment under a health insurance~~

~~policy, within 45 days after receipt of the claim by the health insurer. If a claim or a portion of a claim is contested by the health insurer, the insured or the insured's assignees shall be notified, in writing, that the claim is contested or denied, within 45 days after receipt of the claim by the health insurer. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim.~~

(3) All claims for payment, whether electronic or nonelectronic:

(a) Are considered received on the date the claim is received by the insurer at its designated claims receipt location.

(b) Must not duplicate a claim previously submitted unless it is determined that the original claim was not received or is otherwise lost.~~A health insurer, upon receipt of the additional information requested from the insured or the insured's assignees shall pay or deny the contested claim or portion of the contested claim, within 60 days.~~

(4)(a) For an electronically submitted claim, a health insurer shall, within 24 hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim.

(b) For an electronically submitted claim, a health insurer shall, within 20 days after receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the insurer's action on the claim and payment of the claim is considered to be made on the date the notice or payment is mailed or electronically transferred.

(c)1. Notification of the health insurer's determination of a contested claim must be accompanied by an itemized list of additional information or documents the insurer can reasonably determine are necessary to process the claim.

2. A provider must submit the additional information or documentation, as specified on the itemized list, within 35 days after receipt of the notification. Failure of a provider to submit by mail or electronically the additional information or documentation requested within 35 days after receipt of the notification may result in denial of the claim.

3. A health insurer may not make more than one request for documents under this paragraph in connection with a claim unless the provider fails to submit all of the requested documents to process the claim or the documents submitted by the provider raise new, additional issues not included in the original written itemization, in which case the health insurer may provide the provider with one additional opportunity to submit the additional documents needed to process the claim. In no case may the health insurer request duplicate documents.

(d) For purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payment shall be used to the greatest extent possible by the health insurer and the provider.

(e) A claim must be paid or denied within 90 days after receipt of the claim. Failure to pay or deny a claim within 120 days after receipt of the claim creates an uncontestable obligation to pay the claim.~~An insurer shall pay or deny any claim no later than 120 days after receiving the claim.~~

(5)(a) For all nonelectronically submitted claims, a

health insurer shall, effective November 1, 2003, provide to the provider acknowledgement of receipt of the claim within 15 days after receipt of the claim or provide the provider, within 15 days after receipt, with electronic access to the status of a submitted claim.

(b) For all nonelectronically submitted claims, a health insurer shall, within 40 days after receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the insurer's action on the claim and payment of the claim are considered to be made on the date the notice or payment was mailed or electronically transferred.

(c)1. Notification of the health insurer's determination of a contested claim must be accompanied by an itemized list of additional information or documents the insurer can reasonably determine are necessary to process the claim.

2. A provider must submit the additional information or documentation, as specified on the itemized list, within 35 days after receipt of the notification. Failure of a provider to submit by mail or electronically the additional information or documentation requested within 35 days after receipt of the notification may result in denial of the claim.

3. A health insurer may not make more than one request for documents under this paragraph in connection with a claim unless the provider fails to submit all of the requested documents to process the claim or the documents submitted by the provider raise new, additional issues not included in the original written itemization, in which case the health insurer may provide the provider with one additional opportunity to submit the additional documents needed to process the claim.

In no case may the health insurer request duplicate documents.

(d) For purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payment shall be used to the greatest extent possible by the health insurer and the provider.

(e) A claim must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny a claim within 140 days after receipt of the claim creates an uncontestable obligation to pay the claim. ~~Payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery.~~

(6) Payment of a claim is considered made on the date the payment is mailed or electronically transferred. An overdue payment of a claim bears simple interest of 12 percent per year. Interest on an overdue payment for a claim or for any portion of a claim begins to accrue when the claim should have been paid, denied, or contested. The interest is payable with the payment of the claim. ~~All overdue payments shall bear simple interest at the rate of 10 percent per year.~~