
THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1763 Session of
2011

INTRODUCED BY MICCARELLI, DIGIROLAMO, HALUSKA, HARKINS, O'NEILL,
SWANGER, YOUNGBLOOD AND DAVIDSON, JUNE 29, 2011

REFERRED TO COMMITTEE ON INSURANCE, JUNE 29, 2011

AN ACT

1 Providing for physician contracts with health insurers.

2 The General Assembly of the Commonwealth of Pennsylvania
3 hereby enacts as follows:

4 Section 1. Short title.

5 This act shall be known and may be cited as the Fair Health
6 Care Provider Contracting Act.

7 Section 2. Definitions.

8 The following words and phrases when used in this act shall
9 have the meanings given to them in this section unless the
10 context clearly indicates otherwise:

11 "Capitation." The payment by a health insurer to physicians,
12 physician groups or physician organizations of a per-member-per-
13 month amount, such as percentage of premium, by which a health
14 insurer transfers to the physicians, physician groups or
15 physician organizations the financial risk for those covered
16 services as set forth in the contract between the health insurer
17 and the physicians, physician groups or physician organizations.

1 "CCI." The Centers for Medicare and Medicaid Services'
2 published list of edits and adjustments that are made to health
3 care providers' claims submitted for services or supplies
4 provided to patients insured under the Federal Medicare program
5 and under other Federal insurance programs.

6 "Clean claim." A claim for payment for a covered service
7 that has no defect or impropriety. The term does not include a
8 claim from a physician who is under investigation for fraud or
9 abuse regarding that claim.

10 "Clinical information." Clinical, operative or other medical
11 records and reports kept in the ordinary course of a
12 physician's, physician group's or physician organization's
13 business. The term shall include, where applicable, requested
14 statements of medical necessity.

15 "CMS-1500." The current health care provider claim form
16 number 1500 created by the Centers for Medicare and Medicaid
17 Services.

18 "Covered services." With respect to a particular health
19 insurer, a health care benefit that is within the coverage
20 described in the plan documents applicable to an eligible plan
21 member of the health insurer.

22 "CPT," "CPT codes" or "AMA CPT book." Current medical
23 nomenclature in the publication entitled "CPT Standard Edition,"
24 "CPT Professional Edition," "CPT Assistant" and "Principles of
25 CPT Coding" published by the American Medical Association
26 containing a systematic listing and coding of procedures and
27 services provided to patients by physicians and certain
28 nonphysician health professionals.

29 "CPT conventions." Rules for the application of codes that
30 go across all sections and subsections of the American Medical

1 Association CPT book.

2 "CPT guidelines." Guidelines set out in the introduction, in
3 the beginning to each of the six major sections, in the
4 subsections and in the code level parenthetical statements and
5 cross references contained in the American Medical Association
6 publication "CPT, Professional Edition." The term shall not
7 include any reference to another publication that is not subject
8 to the existing CPT Editorial Panel process, such as "CPT
9 Assistant" or Principles of CPT coding.

10 "Edit." A practice or procedure pursuant to which one or
11 more adjustments are made to CPT codes or HCPCS Level II codes
12 included in a claim that results in:

13 (1) payment being made based on some, but not all, of
14 the CPT codes or HCPCS Level II codes included in the claim;

15 (2) payment being made based on different CPT codes or
16 HCPCS Level II codes than those included in the claim;

17 (3) payment for one or more of the CPT codes or HCPCS
18 Level II codes included in the claim being reduced by
19 application of Multiple Procedure Logic;

20 (4) payment for one or more of the CPT codes or HCPCS
21 Level II codes being denied; or

22 (5) any combination of the above.

23 "ERISA." The Employee Retirement Income Security Act of 1974
24 (Public Law 93-406, 88 Stat. 829), as amended, and the rules and
25 regulations promulgated thereunder.

26 "Fully insured plan." A plan as to which a health insurer
27 assumes all or a majority of health care cost and utilization
28 risk.

29 "HCPCS Level II codes." Alphanumeric codes used to identify
30 those codes not included in CPT and that are commonly referred

1 to as Healthcare Common Procedure Coding System Level II codes.

2 "Health insurer." An entity and its health subsidiaries and
3 affiliates licensed under:

4 (1) 40 Pa.C.S. Ch. 61 (relating to hospital plan
5 corporations); or

6 (2) 40 Pa.C.S. Ch. 63 (relating to professional health
7 services plan corporations).

8 "HIPAA." The Health Insurance Portability and Accountability
9 Act of 1996 (Public Law 104-191, 110 Stat. 136).

10 "Individually negotiated contract." A contract pursuant to
11 which the parties to the contract, as a result of negotiation,
12 agreed to one or more modifications to the terms of a health
13 insurer's applicable standard form agreement that:

14 (1) Substantially modify the standard form agreement.

15 (2) Are made to individually suit, in whole or in part, the
16 needs of a participating physician, participating physician
17 group or participating physician organization, such as higher
18 or customized rates and other customized payment
19 methodologies.

20 "Most favored nation." A clause within a health care
21 provider contract that places an obligation on a participating
22 physician, participating physician group or participating
23 physician organization to grant to a health insurer contract
24 terms and conditions that are identical to every other contract
25 negotiated by the participating physician, participating
26 physician group or participating physician organization with
27 another health insurer or third-party payor entity including
28 more advantageous terms for the participating physician,
29 participating physician group or participating physician
30 organization.

1 "Nonparticipating." A physician, physician group or
2 physician organization that is not a participating physician,
3 participating physician group or participating physician
4 organization.

5 "Overpayment." With respect to a claim submitted by or on
6 behalf of a physician, physician group or physician
7 organization, any erroneous or excess payment that a health
8 insurer makes for any reason such as:

9 (1) payment at an incorrect rate;

10 (2) duplicate payments for the same physician service;

11 (3) payment with respect to an individual who was not a
12 plan member on the date the physician provided the physician
13 services that are the subject of the payment; and

14 (4) payment for any noncovered service.

15 "Participating physician." A physician who has entered into
16 a valid written contract with a health insurer, or who has
17 agreed pursuant to an arrangement with a physician group,
18 physician organization or other entity which has a valid written
19 contract with a health insurer, to provide covered services to
20 that health insurer's plan members and, where applicable, who
21 meets the health insurer's credentialing requirements during the
22 effective period of the contract. The term term does not include
23 a physician who has entered into an agreement with a rental
24 network.

25 "Participating physician group." A physician group that has
26 entered into a valid written contract with a health insurer to
27 provide covered services to that health insurer's plan members.

28 "Participating physician organization." A physician
29 organization that has entered into a valid written contract with
30 a health insurer to provide covered services to that health

1 insurer's plan members.

2 "Physician." The term shall have have the same meaning as
3 given to it in section 2 of the act of October 5, 1978
4 (P.L.1109, No.261), known as the Osteopathic Medical Practice
5 Act and section 2 of the act of December 20, 1985 (P.L.417,
6 No.112), known as the Medical Practice Act of 1985.

7 "Physician group." Two or more physicians, and those
8 claiming by or through them, who practice under a single
9 taxpayer identification number.

10 "Physician organization." Any association, partnership,
11 corporation or other form of organization, such as independent
12 practice associations and physician hospital organizations, that
13 arranges for care to be provided to plan members by physicians
14 organized under multiple taxpayer identification numbers.

15 "Physician services." Covered services that a physician
16 provides to a plan member, as specified in applicable agreements
17 with a health insurer or otherwise.

18 "Physician specialty society." A United States medical
19 specialty society that represents diplomats certified by a board
20 recognized by the American Board of Medical Specialties.

21 "Plan." A benefit plan through which a plan member obtains
22 health care benefits set forth in pertinent plan documents.

23 "Plan documents." Documents defining the health care
24 benefits available to a plan member, such as the plan member's
25 summary plan description, certificate of coverage or other
26 applicable coverage document and the terms and conditions under
27 which the benefits are available under the plan.

28 "Plan member." An individual enrolled in or covered by a
29 plan offered and administered by a health insurer.

30 "Precertification," "precertify" or "precertifies." The

1 prior approval by a health insurer that the service or supply is
2 medically necessary and not experimental or investigational.

3 "Product network." A network of participating physicians
4 who, pursuant to contracts with a health insurer, provide
5 covered services to plan members for one or more products or
6 types of products offered by the health insurer in exchange for
7 a specified type of compensation."

8 "Provider website." The secure and password-protected online
9 resources for participating physicians to obtain information
10 about a health insurer, its products and policies and other
11 information.

12 "Public website." The online resources for the public to
13 obtain information about a health insurer, its products and
14 policies and other information.

15 "Self-insured plan." Any plan other than a fully insured
16 plan.

17 "Significant edit." An edit that a health insurer reasonably
18 believes, based on its experience with submitted claims, shall
19 cause, on the initial review of submitted claims, the denial of
20 or reduction in payment for a particular CPT code or HCPCS Level
21 II code more than 250 times per year.

22 Section 3. Availability of fee schedules and scheduled payment
23 dates.

24 The following shall apply:

25 (1) A health insurer shall develop and implement a plan
26 on the effective date of this section to reasonably permit
27 its participating physician, participating physician group or
28 participating physician organization to view, by CDROM or
29 electronically, at the health insurer's option, on a
30 confidential basis, complete fee information showing the

1 applicable fee schedule amounts for the participating
2 physician, participating physician group or participating
3 physician organization pursuant to that participating
4 physician's, participating physician group's or participating
5 physician organization's direct written agreement with the
6 health insurer.

7 (2) A participating physician, participating physician
8 group or participating physician organization may elect to
9 receive a hard copy of the fee schedule in lieu of the
10 foregoing.

11 (3) The fee schedule information shall be provided by
12 the fee-for-service dollar amount allowable for each CPT code
13 for those CPT codes that a participating physician,
14 participating physician group or participating physician
15 organization in the same specialty typically uses in
16 providing covered services.

17 (4) A participating physician, participating physician
18 group or participating physician organization may request and
19 the health insurer shall provide the fee-for-service dollar
20 amount allowable for other CPT codes that its participating
21 physician, participating physician group or participating
22 physician organization actually bills the health insurer.

23 (5) A health insurer may base actual compensation on the
24 health insurer's maximum allowable amount and other contract
25 adjustments.

26 (6) Each health insurer, upon written request from a
27 participating physician, participating physician group or
28 participating physician organization that, in each case, has
29 entered into a written contract directly with that health
30 insurer shall provide, by hard copy, the fee schedule for up

1 to 100 CPT codes customarily and routinely used by the
2 participating physician, participating physician group or
3 participating physician organization, as specified by the
4 participating physician, participating physician group or
5 participating physician organization.

6 (7) Each health insurer shall be obligated to honor only
7 two requests under paragraph (6) made annually by the
8 participating physician, participating physician group or
9 participating physician organization.

10 (8) Each health insurer shall attempt to include
11 provisions in its agreements with delegated entities that
12 require comparable disclosure.

13 (9) Each health insurer may not require its
14 participating physicians, participating physician groups or
15 participating physician organizations to provide that health
16 insurer with billing rates as a precondition to that health
17 insurer providing fee information under this section.

18 Section 4. Reduced precertification requirements.

19 (a) Posting.--Except as provided under subsection (b), each
20 health insurer shall post to its provider website, on the
21 effective date of this section, those services or supplies for
22 which precertification is routinely required for its products,
23 and shall update the posting to the extent the services or
24 supplies for which precertification is routinely required
25 changes.

26 (b) Specification of services.--Notwithstanding subsection
27 (a), a health insurer's self-insured plan customers may specify
28 services or supplies for which precertification is required that
29 differ from or are in addition to the services or supplies for
30 which that health insurer routinely requires precertification

1 for its fully insured plans, and the self-insured plans may
2 contract with a different entity to provide precertification
3 services.

4 (c) Utilization.--Each health insurer shall propose to its
5 self-insured plan customers that they utilize the health
6 insurer's standard list of services and supplies for which
7 precertification is required.

8 (d) Customized list.--With a self-insured plan's approval,
9 each health insurer shall post the self-insured plan's
10 customized list of precertification requirements to the health
11 insurer's provider website.

12 Section 5. Notice of policy and procedure changes.

13 (a) Written notice.--Each health insurer shall, if it
14 intends to make any material adverse changes in the terms of its
15 contracts, including policies and procedures, with its
16 participating physicians, participating physician groups or
17 participating physician organizations give at least 90 days'
18 written notice to each participating physician, participating
19 physician group or participating physician organization affected
20 thereby with whom the health insurer has directly contracted,
21 except to the extent that a shorter notice period is required to
22 comply with changes in applicable law. The written notice shall
23 reasonably apprise its participating physician, participating
24 physician group or participating physician organization of the
25 changes and the changes shall not become effective before the
26 conclusion of the notice period.

27 (b) Termination.--If a participating physician,
28 participating physician group or participating physician
29 organization objects to the changes that are subject to the
30 notice, the participating physician, participating physician

1 group or participating physician organization must, within 30
2 days of the date of the notice, which shall be the date the
3 notice is sent by United States mail, by facsimile, or if the
4 health insurer offers it, electronically at the option of the
5 physician, physician group or physician organization, give
6 written notice to terminate his contract with the health
7 insurer, which shall take effect at the end of the notice period
8 of the material adverse change unless, within 65 days of the
9 date of the original notice of changes, the health insurer gives
10 written notice to the objecting participating physician,
11 participating physician group or participating physician
12 organization that it shall not implement, as to the objecting
13 participating physician, participating physician group or
14 participating physician organization, the material adverse
15 changes to which the participating physician, participating
16 physician group or participating physician organization
17 objected.

18 Section 6. Disclosure of and commitments concerning claims
19 payment practices.

20 (a) Payment rules.--Each health insurer agrees that, except
21 for Medicaid, State children's health insurance programs and
22 other similar government programs for low-income persons and for
23 members of State established high risk pools, its automated
24 "bundling" and other claims payment rules shall be consistent in
25 all material respects, for claims submitted by or on behalf of
26 the health insurer's plan members.

27 (b) Disclosure.--Each health insurer agrees to disclose its
28 significant edits on its provider website on the effective date
29 of this section, or as soon thereafter as practicable.

30 (c) Update.--Each health insurer shall update its disclosure

1 of significant edits once per calendar year to reflect changes
2 in the health insurer's significant edits and the health
3 insurer's experience with submitted claims. The health insurer
4 shall promptly disclose newly adopted significant edits. The
5 following shall apply:

6 (1) On the effective date of this section, or as soon
7 thereafter as practicable, each health insurer shall publish
8 on its provider website, for each commercially available
9 claims editing software product then in use by the health
10 insurer, a list identifying each customized edit added to the
11 standard claims editing software product at the health
12 insurer's request.

13 (2) On the effective date of this section, a health
14 insurer shall not routinely require submission of clinical
15 information, before or after payment of claims, in connection
16 with that health insurer's adjudication of a physician's
17 claims for payment, except as to claims for unlisted codes,
18 claims to which a modifier 22 is appended, and other limited
19 categories of claims as to which the health insurer
20 determines that routine review of clinical information is
21 appropriate, except that the health insurer shall disclose
22 any of its categories of the nature on its public website and
23 its provider website.

24 (d) Required submission.--Notwithstanding subsection (c)(2),
25 a health insurer may require submission of clinical information
26 in connection with a health insurer's adjudication of a
27 physician's claims for payment for the purpose of investigating
28 fraudulent or abusive, whether intentional or unintentional,
29 billing practices, but only so long as, and only during the
30 times as, the health insurer has a reasonable basis for

1 believing that the investigation is warranted.

2 (e) Contest.--A participating physician may contest any
3 requirement that the participating physician submit clinical
4 information in connection with a health insurer's adjudication
5 of the participating physician's claims for payment for the
6 purpose of investigating fraudulent or abusive, whether
7 intentional or unintentional, billing practices.

8 (f) Intent.--Nothing under this section is intended or shall
9 be construed to limit a health insurer's right to require
10 submission of clinical information when the requirement is not
11 in connection with a health insurer's adjudication of a
12 physician's claims for payment or is otherwise permitted by this
13 section, such as the right to require submission of clinical
14 information for precertification purposes as consistent with
15 this section.

16 (g) Publication.--On the effective date of this section,
17 each health insurer shall publish on its provider website those
18 limited code combinations as to which it has determined that
19 particular services or procedures, relative to modifiers 25 and
20 59, are not appropriately reported together with those modifiers
21 and the health insurer's application of the rule differs from
22 CPT codes, except that no determination shall be inconsistent
23 with the undertakings set forth under this section.

24 Section 7. Dispute resolution process for physician billing
25 disputes.

26 (a) Establishment.--On the effective date of this section,
27 each of the health insurers shall take actions necessary to
28 establish a billing dispute external review process. The billing
29 dispute external review process shall provide for a billing
30 dispute reviewer to resolve disputes with physicians and

1 physician groups arising from covered services provided to the
2 health insurer's plan members by the physicians and physician
3 groups concerning:

4 (1) the health insurer's application of the health
5 insurer's coding and payment rules and methodologies for fee-
6 for-service claims, including, but not limited to, any
7 bundling, downcoding, application of a CPT modifier and other
8 reassignment of a code by the health insurer, to patient-
9 specific factual situations, including, but not limited to,
10 the appropriate payment when two or more CPT codes are billed
11 together or whether a payment-enhancing modifier is
12 appropriate; or

13 (2) any retained claims, if the retained claims are
14 submitted by the physician to the billing dispute reviewer
15 prior to the later to occur of 90 days after the effective
16 date of this section or 30 days after exhaustion of the
17 health insurer's internal appeals process. Each matter shall
18 be a billing dispute.

19 (b) Jurisdiction.--The billing dispute reviewer shall not
20 have jurisdiction over any other disputes, such as those
21 disputes that fall within the scope of the external review
22 process set forth under subsection (a), compliance disputes and
23 disputes concerning the scope of covered services, nor shall any
24 billing dispute reviewer have jurisdiction or authority to
25 revise or establish any reimbursement policy of the health
26 insurer.

27 (c) Intent.--Nothing contained under this section shall be
28 intended, or shall be construed, to supersede, alter or limit
29 the rights or remedies otherwise available to any plan member
30 under section 502(a) of ERISA or to supersede in any respect the

1 claims procedures for plan members of section 503 of ERISA, or
2 required by applicable Federal or State law or regulation.

3 (d) Appeal process.--

4 (1) The physician or physician group must exhaust the
5 health insurer's internal appeals process before submitting a
6 billing dispute to the billing dispute reviewer.

7 (2) A physician or physician group shall be deemed to
8 have exhausted the health insurer's internal appeals process
9 if the health insurer does not communicate a decision on an
10 internal appeal within 30 days of the health insurer's
11 receipt of all documentation reasonably needed to decide the
12 internal appeal. If the health insurer and physician or
13 physician group disagree as to whether the requirements of
14 this paragraph have been satisfied, the disagreement shall be
15 resolved by the billing dispute reviewer.

16 (e) Time.--Billing disputes shall be submitted to the
17 billing dispute reviewer no more than 90 days after a physician
18 or physician group exhausts the health insurer's internal
19 appeals process. The billing dispute reviewer shall not hear or
20 decide any billing dispute submitted more than 90 days after the
21 health insurer's internal appeals process has been exhausted.

22 (f) Documentation.--The health insurer shall supply
23 appropriate documentation to the billing dispute reviewer no
24 later than 30 days after requested by the billing dispute
25 reviewer, which request shall not be made until billing disputes
26 have been submitted with amounts in dispute that in aggregate
27 exceed \$500.

28 (g) Cooperation.--Each health insurer shall cooperate with
29 organized State physician organizations in order to select the
30 persons or organizations that shall serve as the billing dispute

1 reviewer, on a local or regional basis.

2 Section 8. All products clauses prohibition.

3 (a) Capitated fee arrangement.--No health insurer may
4 require a participating physician to participate in a capitated
5 fee arrangement in order to participate in product networks in
6 which such participating physician is compensated on a fee-for-
7 service basis.

8 (b) Product networks.--No health insurer shall require a
9 participating physician to participate in its Medicare Advantage
10 or Medicaid product networks in order to participate in its
11 commercial product networks.

12 (c) Participation.--If a participating physician or
13 participating physician group comprised of participating
14 physicians or participating physician organization chooses not
15 to participate in all of the health insurer's product networks
16 or terminates participation in some of the health insurer's
17 product networks, the reimbursement levels offered to or applied
18 by the health insurer to the participating physician or
19 participating physician group or participating physician
20 organization for the product network in which the participating
21 physician or participating physician group or participating
22 physician organization continues to participate shall not be
23 lower than the health insurer's standard reimbursement levels in
24 the geographic market. This subsection shall not apply if a
25 participating physician or participating physician group
26 comprised of participating physicians or participating physician
27 organization has agreed in an individually negotiated contract
28 to participate in more than one product network for a specified
29 period of time, in which case the terms of the individually
30 negotiated contract shall govern.

1 (d) Reimbursement level or incentive.--Notwithstanding
2 subsection (c), the health insurer may offer a higher
3 reimbursement level or other incentive to any participating
4 physician, participating physician group or participating
5 physician organization who elects to participate or elects to
6 continue participation in more than one of the health insurer's
7 product networks.

8 (e) Obligation.--Nothing under this section shall obligate a
9 health insurer to pay more than the lesser of the participating
10 physician's billed charges or the health insurer's applicable
11 fee-for-service amount.

12 Section 9. Termination without cause.

13 (a) Written notice.--Unless an individually negotiated
14 contract between a health insurer and a participating physician,
15 participating physician group or participating physician
16 organization specifies a different period of notice, or
17 specifies that the contract may not be terminated except for
18 cause during a defined period of time, either party to a
19 contract between a health insurer and a participating physician,
20 participating physician group or participating physician
21 organization shall have the right to terminate the contract
22 without cause upon prior written notice provided to the other
23 party which notice shall be a definite period set forth in the
24 agreement, which period shall be no less than 60 or more than
25 120 calendar days.

26 (b) Obligations.--In the event of a contract termination by
27 either party, the following obligations shall apply with respect
28 to the continuation of care for those patients of a
29 participating physician, participating physician group or
30 participating physician organization who are entitled to

1 continuation of care as reasonably defined under the
2 participating physician's, participating physician group's or
3 participating physician organization's contract with the health
4 insurer or under applicable law:

5 (1) In the case of a continuation of care situation as
6 described in the introductory paragraph, the participating
7 physician, participating physician group or participating
8 physician organization shall continue to render necessary
9 care to the health insurer's plan member consistent with
10 contractual or legal obligations. If, on notice from the
11 participating physician, participating physician group,
12 participating physician organization or the health insurer's
13 plan member that a plan member is in a continuation of care
14 situation, the health insurer does not use due diligence to
15 make alternative care available to the plan member within 90
16 days after receipt of the notice for continuation of care
17 services provided after termination, the health insurer shall
18 pay to the participating physician, participating physician
19 group or participating physician organization the standard
20 rates paid to nonparticipating physicians for that
21 geographical area.

22 (2) Notwithstanding paragraph (1), a health insurer's
23 obligations under this section shall not apply to the extent
24 that other participating physicians, participating physician
25 groups or participating physician organizations are not
26 available to replace the termination physician, physician
27 group or physician organization due to:

- 28 (i) geographic or travel-time barriers; or
29 (ii) contractual provisions between the terminating
30 physician, physician group or physician organization and

1 a facility at which the health insurer's plan member
2 receives care that limits or precludes other
3 participating physicians, participating physician groups
4 or participating physician organizations from rendering
5 replacement services to the health insurer's plan
6 members.

7 Section 10. Patient-specific issues involving clinical
8 judgment, and medical necessity definition.

9 (a) Adoption.--Each health insurer shall adopt and apply as
10 to its current agreements and include in its future agreements
11 with participating physicians the definition of "medically
12 necessary" or a comparable term in each agreement. The term
13 shall mean health care services that a physician, exercising
14 prudent clinical judgment, would provide to a patient for the
15 purpose of preventing, evaluating, diagnosing or treating an
16 illness, injury, disease or its symptoms, and that are:

17 (1) in accordance with generally accepted standards of
18 medical practice;

19 (2) clinically appropriate, in terms of type, frequency,
20 extent, site and duration, and considered effective for the
21 patient's illness, injury or disease; and

22 (3) not primarily for the convenience of the patient,
23 physician or other health care provider and not more costly
24 than an alternative service or sequence of services at least
25 as likely to produce equivalent therapeutic or diagnostic
26 results as to the diagnosis or treatment of that patient's
27 illness, injury or disease.

28 (b) Definition.--As used in this section, the term shall
29 have the meaning given to it in this subsection unless the
30 context clearly indicates otherwise:

1 "Generally accepted standards of medical practice."
2 Standards that are based on credible scientific evidence
3 published in peer-reviewed medical literature generally
4 recognized by the relevant medical community, physician
5 specialty society recommendations and the views of physicians
6 practicing in relevant clinical areas and any other relevant
7 factors.

8 Section 11. Policy issues involving clinical judgment.

9 In formulating and adopting medical policies with respect to
10 covered services, each health insurer shall rely on credible
11 scientific evidence published in peer-reviewed medical
12 literature generally recognized by the relevant medical
13 community, and shall continue to make the policies readily
14 available to its plan members and participating physicians via
15 its public website or by other electronic means. In formulating
16 and adopting the policies, each health insurer shall take into
17 account national physician specialty society recommendations and
18 the views of prudent physicians practicing in relevant clinical
19 areas and any other clinically relevant factors.

20 Section 12. Future consideration by health insurers of an
21 administrative exemption program.

22 (a) Exemption.--Each health insurer shall consider the
23 feasibility and desirability of exempting certain participating
24 physicians from certain administrative requirements based on
25 criteria such as the participating physician's delivery of
26 quality and cost-effective medical care and accuracy and
27 appropriateness of claims submissions.

28 (b) Construction.--No health insurer shall be obliged to
29 implement any exemption process, and this section shall not be
30 construed to limit a health insurer's ability to implement any

1 program on a pilot or experimental basis, base exemptions on any
2 health insurer determined basis or otherwise to implement one or
3 more programs in only some markets.

4 Section 13. Timelines for processing and payment of clean
5 claims.

6 Beginning on the effective date of this section, each health
7 insurer shall direct the issuance of a check or an electronic
8 funds transfer in payment for clean claims for covered services
9 within 30 calendar days.

10 Section 14. No automatic downcoding of evaluation and
11 management claims.

12 (a) Prohibition.--On the effective date of this section, no
13 health insurer shall automatically reassign or reduce the code
14 level of evaluation and management codes billed for covered
15 services, downcoding, except that a health insurer may reassign
16 a new patient visit code to an established patient visit code
17 based solely on CPT codes, CPT guidelines and CPT conventions.

18 (b) Denial.--Health insurers shall continue to have the
19 right to deny, pend or adjust the claims for covered services on
20 other bases and shall have the right to reassign or reduce the
21 code level for selected claims for covered services or claims
22 for covered services submitted by selected physicians, physician
23 groups or physician organizations, based on a review of the
24 information in the clinical information at the time the service
25 was rendered for the particular claims or a review of
26 information derived from a health insurer's fraud or abuse
27 billing detection programs that create a reasonable belief of
28 fraudulent or abusive, whether intentional or unintentional,
29 billing practices, provided that the decision to reassign or
30 reduce is based primarily on a review of clinical information.

1 Section 15. Bundling and other computerized claim editing.

2 (a) Duties.--Each health insurer shall do all of the
3 following:

4 (1) Take actions necessary on the health insurer's part
5 to cause the claim-editing software program it uses to
6 continue to produce editing results consistent with the
7 standards set forth in this section.

8 (2) Process and separately reimburse those codes listed
9 in the American Medical Association CPT book as modifier 51
10 exempt CPT codes without reducing payment under the health
11 insurer's multiple procedure logic, if the American Medical
12 Association CPT book provides that the services are
13 appropriately reported together.

14 (3) Process and separately reimburse codes listed in the
15 American Medical Association CPT book as add-on billing codes
16 without reducing payment under the health insurer's multiple
17 procedure logic, if the American Medical Association CPT book
18 provides that the add-on CPT codes are appropriately billed
19 with proper primary procedure codes.

20 (b) Clinical information.--No health insurer shall require
21 physicians to submit clinical information of their patient
22 encounters solely because the physicians seek payment for both
23 surgical procedures and CPT evaluation and management services
24 for the same patient on the same date of service, if the correct
25 CPT evaluation and management code, surgical code and modifier
26 are included on the initial claim submission.

27 (c) Code recognition.--If a claim contains a CPT code for an
28 evaluation and management service, appended with a CPT modifier
29 25 and a CPT code for performance of a nonevaluation and
30 management service procedure code, both codes shall be

1 recognized and separately eligible for payment, unless the
2 clinical information indicates that use of the CPT modifier 25
3 was inappropriate or the health insurer has disclosed, pursuant
4 to the limited number of finite code combinations that are not
5 appropriately reported together.

6 (d) Payment.--Payment shall only be made for one evaluation
7 and management service for any single day unless payment for
8 more than one is appropriate pursuant to the American Medical
9 Association CPT book and is supported by appropriate diagnoses
10 in the clinical information.

11 (e) Edits.--Each health insurer shall remove from its claim
12 review and payment systems any edits that generally deny payment
13 for CPT evaluation and management codes with a CPT modifier 25
14 appended when submitted with surgical or other procedure codes
15 for the same patient on the same date of service except for a
16 limited number of exceptions, which shall be disclosed on the
17 health insurer's provider website.

18 (f) Prohibition.--Nothing in this section shall prohibit a
19 health insurer from requiring use of the appropriate CPT code
20 modifiers for evaluation and management billing codes on the
21 original claim forms, or preclude a health insurer from
22 requiring a physician, physician group or physician organization
23 to submit to an audit of claims submitted by the physician,
24 physician group or physician organization for payment directly
25 to the physician, physician group or physician organization,
26 such as claims for surgical procedures and evaluation and
27 management services on the same date of service submitted with
28 the appropriate modifier, and to provide their clinical
29 information in connection with an audit.

30 (g) Supervision code.--A CPT code for supervision and

1 interpretation or radiologic guidance shall be separately
2 recognized and eligible for payment to the extent that the
3 associated procedure code is recognized and eligible for payment
4 if:

5 (1) the associated procedure code does not include
6 supervision and interpretation or radiologic guidance
7 according to the American Medical Association CPT book; and

8 (2) for each procedure, no health insurer shall be
9 required to pay for supervision or interpretation or
10 radiologic guidance by more than one qualified health care
11 professional.

12 (h) Reassignment.--No health insurer shall reassign any CPT
13 code into any other CPT code or deem a CPT code ineligible for
14 payment based solely on the format of the published CPT
15 descriptions.

16 (i) Modifier 59 codes.--CPT codes submitted with a modifier
17 59 attached shall be eligible for payment to the extent they
18 follow the American Medical Association CPT book and they
19 designate a distinct or independent procedure performed on the
20 same day by the same physician, but only to the extent that:

21 (1) although the procedures or services are not normally
22 reported together they are appropriately reported together
23 under the particular presenting circumstances; and

24 (2) it would not be more appropriate to append any other
25 CPT recognized modifier to such CPT codes.

26 (j) Global periods.--No global periods for surgical
27 procedures shall be longer than the period then designated by
28 Centers for Medicare and Medicaid Services, except that this
29 limitation shall not restrict a health insurer from establishing
30 a global period for surgical procedures, except where Centers

1 for Medicare and Medicaid Services has determined a global
2 period is not appropriate or has identified a global period not
3 associated with a specific number of days.

4 (k) Automatic change.--No health insurer shall automatically
5 change a CPT code to one reflecting a reduced intensity of the
6 service when the CPT code is one among or across a series that
7 includes without limitation CPT codes that differentiate among
8 simple, intermediate and complex, complete or limited, and size.
9 Section 16. Overpayment recovery procedures.

10 (a) Time limit.--Except as provided under subsection (b), no
11 health insurer shall initiate overpayment recovery efforts more
12 than 18 months after the payment was received by the physician,
13 except that no time limit shall apply to the initiation of
14 overpayment recovery efforts:

15 (1) based on a reasonable belief of fraud or other
16 intentional misconduct;

17 (2) required by a self-insured plan; or

18 (3) required by a Federal or State program.

19 (b) Underpayment.--Notwithstanding subsection (a), if a
20 physician asserts a claim of underpayment, a health insurer may
21 defend or set off a claim based on overpayments going back in
22 time as far as the claimed underpayment.

23 (c) Appeal.--If a physician requests an appeal within 30
24 days of receipt of a request for repayment of an overpayment, no
25 health insurer shall require the physician to repay the alleged
26 overpayment before such appeal is concluded.

27 (d) Limitation.--Nothing under this section shall be deemed
28 to limit a health insurer's right to pursue recovery of
29 overpayments that occurred prior to the effective date of this
30 section where the health insurer has provided the physician with

1 notice of the recovery efforts prior to the effective date of
2 this section.

3 Section 17. Effect of health insurer confirmation of patient
4 procedure medical necessity.

5 (a) Revocation.--If the health insurer certifies or
6 precertifies, approves or preapproves that a proposed service is
7 medically necessary for one of its plan members, the health
8 insurer shall not subsequently revoke that medical necessity
9 determination absent evidence of fraud, evidence that the
10 information submitted was materially erroneous or incomplete or
11 evidence of material change in that plan member's health
12 condition between the date that the certification or
13 precertification was provided and the date of the service that
14 makes the proposed service no longer medically necessary for the
15 plan member.

16 (b) New request.--If a health insurer certifies or
17 precertifies the medical necessity of a course of treatment
18 limited by number, time period or otherwise, a request for
19 services beyond the certified course of treatment shall be
20 deemed to be a new request and that health insurer's denial of
21 such request shall not be deemed to be inconsistent with this
22 section.

23 Section 18. Gag clauses.

24 (a) Exchange of information.--No health insurer shall
25 include in its contracts with participating physicians,
26 participating physician groups or participating physician
27 organizations any provision limiting:

28 (1) The free, open and unrestricted exchange of
29 information between its physicians and its plan members
30 regarding the nature of the plan member's medical conditions

1 or treatment and provider options and the relative risks and
2 benefits and costs to the plan member of the options.

3 (2) Whether or not the treatment is covered under the
4 plan member's plan.

5 (3) Any right to appeal any adverse decision by the
6 health insurer regarding coverage of treatment that has been
7 recommended or rendered.

8 (b) Penalty.--A health insurer shall not penalize or
9 sanction participating physicians in any way for engaging in any
10 free, open and unrestricted communication with a plan member
11 with respect to the foregoing subjects or for advocating for any
12 service on behalf of a plan member.

13 Section 19. Arbitration.

14 (a) Refund.--With respect to any arbitration proceeding
15 between a health insurer and its participating physician who
16 practices individually or in a participating physician group of
17 fewer than six physicians, the health insurer agrees that it
18 shall refund any applicable filing fees and arbitrators' fees
19 paid by the physician if the physician is the prevailing party
20 with respect to the arbitration proceeding. This subsection
21 shall not apply to any arbitration proceeding in which the
22 participating physician purports to represent any physician
23 outside of his or her physician group.

24 (b) Prohibited language.--No health insurer shall include
25 any of the following language in any agreement with a physician,
26 physician group or physician organization:

27 (1) requiring that any arbitration panel have multiple
28 members;

29 (2) preventing the recovery of any statutory or
30 otherwise legally available damages or other relief in an

1 arbitration proceeding;

2 (3) restricting the statutory or otherwise legally
3 available scope or standard of review;

4 (4) completely prohibiting discovery;

5 (5) shortening any statute of limitations; or

6 (6) requiring that any arbitration proceeding occur more
7 than 50 miles from the principal office of the physician,
8 physician group or physician organization.

9 Section 20. Most favored nations clauses.

10 A health insurer shall not include any "most favored nations"
11 clauses in its contracts with participating physicians,
12 participating physician groups and participating physician
13 organizations, except for individually negotiated contracts.

14 Section 21. Enforcement by the court.

15 Upon adjudication of both internal and external review
16 processes, if a health insurer has not complied with this
17 section, a physician may challenge this assertion by initiating
18 a claim in a court of competent jurisdiction.

19 Section 40. Effective date.

20 This act shall take effect immediately.