H-0460.2

HOUSE BILL 1183

State of Washington 64th Legislature 2015 Regular Session

By Representatives Harris and Cody

Read first time 01/15/15. Referred to Committee on Health Care & Wellness.

AN ACT Relating to radiology benefit managers; and adding a new chapter to Title 19 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Advanced diagnostic imaging services" has the same meaning as in RCW 70.250.010.

(2) "Claim" means a request from a radiology clinic, radiologist, or advanced diagnostic imaging services provider to be reimbursed for the cost of having performed a procedure.

(3) "Clerical error" means a minor error:

(a) In the keeping, recording, or transcribing of records or documents or in the handling of electronic or hard copies of correspondence;

(b) That does not result in financial harm to a radiology benefit manager; and

(c) That does not involve performing an incorrect procedure.

(4) "Fraud" has the same meaning as defined in RCW 19.340.020.

(5) "Insurer" has the same meaning as in RCW 48.01.050.

(6) "Maximum allowable cost" means the maximum amount that a radiology benefit manager will reimburse a radiology clinic, radiologist, or advanced diagnostic imaging services provider for the cost of a procedure.

(7) "Person" has the same meaning as in RCW 48.01.070.

(8) "Radiologist" has the same meaning as in RCW 18.84.020.

(9)(a) "Radiology benefit manager" means a person that contracts with, or is owned by, an insurer or a third-party payor to:

(i) Process claims for services and procedures performed by a licensed radiologist or advanced diagnostic imaging service provider; or

(ii) Pay or authorize payment to radiology clinics, radiologists, or advanced diagnostic imaging services providers or services or procedures;

(b) "Radiology benefit manager" does not include a health care service contractor as defined in RCW 48.44.010, a health maintenance organization as defined in RCW 48.46.020, or an issuer as defined in RCW 48.01.053.

(10) "Third-party payor" has the same meaning as in RCW 48.39.005.

NEW SECTION. **Sec. 2.** (1) To conduct business in this state, a radiology benefit manager must register with the department of revenue's business licensing service and annually renew the registration.

(2) To register under this section, a radiology benefit manager must:

(a) Have a business license and be in good standing in the state of Washington;

(b) Submit an application requiring the following information:

(i) The identity of the radiology benefit manager;

(ii) The name, business address, phone number, and medical director for the radiology benefit manager; and

(iii) Where applicable, the federal tax employer identification number for the entity; and

(c) Pay a registration fee of two hundred dollars.

(3) To renew a registration under this section, a radiology benefit manager must pay a renewal fee of two hundred dollars.

(4) All receipts from registrations and renewals collected by the department of revenue must be deposited into the business license account created in RCW 19.02.210.

NEW SECTION. **Sec. 3.** A radiology benefit manager that audits claims or an independent third party that contracts with a radiology benefit manager to audit claims:

(1) Must establish, in writing, a procedure for a radiology clinic, radiologist, or advanced diagnostic imaging services provider to appeal the person's findings with respect to a claim or authorization request and must provide a radiology clinic, radiologist, or advanced diagnostic imaging services provider with a notice regarding the procedure, in writing or electronically, prior to conducting an audit of the radiology clinic, radiologist, or advanced diagnostic imaging services provider's claims;

(2) May not conduct an audit of a claim more than twenty-four months after the date the claim was adjudicated by the radiology benefit manager;

(3) Must give at least fifteen days' advance written notice prior to an on-site audit to the radiology clinic, radiologist, or advanced diagnostic imaging services provider's business site;

(4) May not conduct an on-site audit during the first five days of any month without the consent of the radiology clinic, radiologist, or advanced diagnostic imaging services provider;

(5) Must conduct the audit in consultation with a radiologist or advanced diagnostic imaging services provider who is licensed by this or another state if the audit involves clinical or professional judgment;

(6) May not conduct an on-site audit of more than two hundred fifty unique procedures of a single radiology clinic, radiologist, or advanced diagnostic imaging services provider in any twelve-month period except in cases of alleged fraud;

(7) May not conduct more than one on-site audit at the place of business of a radiology clinic, radiologist, or advanced diagnostic imaging services provider during any twelve-month period;

(8) Must audit each radiology clinic, radiologist, or advanced diagnostic imaging services provider under the same standards and parameters that the radiology benefit manager uses to audit other similarly situated radiology clinics, radiologists, or advanced diagnostic imaging services providers;

(9) Must pay any outstanding claims of a radiology clinic, radiologist, or advanced diagnostic imaging services provider no more than forty-five days after the earlier of the date all appeals are concluded or the date a final report is issued under section 8(3) of this act;

(10) May not include interest in the amount of any overpayment assessed on a claim unless the overpaid claim was for a procedure that was not performed correctly;

(11) May not recoup costs associated with:

(a) Clerical errors; or

(b) Other errors that do not result in financial harm to the radiology benefit manager or a consumer; and

(12) May not charge a radiology clinic, radiologist, or advanced diagnostic imaging services provider for a denied or disputed claim until the audit and the appeals procedure established under subsection (1) of this section are final.

NEW SECTION. **Sec. 4.** A radiology benefit manager's finding that a claim was incorrectly presented or paid must be based on identified transactions and not based on probability sampling, extrapolation, or other means that project an error using the number of patients served who have a similar diagnosis.

NEW SECTION. **Sec. 5.** A radiology benefit manager that contracts with an independent third party to conduct audits may not:

(1) Agree to compensate the independent third party based on a percentage of the amount of overpayments recovered; or

(2) Disclose information obtained during an audit except to the contracting entity, the radiology clinic, radiologist, or advanced diagnostic imaging services provider subject to the audit, or the holder of the policy or certificate of insurance that paid the claim.

NEW SECTION. **Sec. 6.** (1) An appeal requested under section 3(1) of this act must be completed within thirty calendar days of the radiology clinic, radiologist, or advanced diagnostic imaging services provider submitting the claim for which an appeal has been requested.

(2) A radiology benefit manager must provide as part of the appeals process established under section 3(1) of this act:

(a) A telephone number at which a radiology clinic, radiologist, or advanced diagnostic imaging services provider may contact the radiology benefit manager and speak with an individual who is responsible for processing appeals;

(b) A final response to an appeal of a maximum allowable cost within seven business days; and

(c) If the appeal is denied, the reason for the denial.

(3) If an appeal is upheld under this section, the radiology benefit manager shall make an adjustment on a date no later than one day after the date of determination.

NEW SECTION. **Sec. 7.** For purposes of this chapter, a radiology benefit manager, or an independent third party that contracts with a radiology benefit manager to conduct audits, must allow as evidence of validation of a claim:

(1) An electronic or physical copy of a valid referral or authorization of the procedure, if the procedure was performed;

(2) Billing data showing payment for the procedure by the patient or the patient's designee; or

(3) Electronic records, including electronic beneficiary signature logs, electronically scanned and stored patient records maintained at or accessible to the audited radiology clinic, radiologist, or advanced diagnostic imaging services provider's central operations, and any other reasonably clear and accurate electronic documentation that corresponds to a claim.

NEW SECTION. **Sec. 8.** (1)(a) After conducting an audit, a radiology benefit manager must provide the radiology clinic, radiologist, or advanced diagnostic imaging services provider that is the subject of the audit with a preliminary report of the audit. The preliminary report must be received by the radiology clinic, radiologist, or advanced diagnostic imaging services provider no later than forty-five days after the date on which the audit was completed and must be sent:

(i) By mail or common carrier with a return receipt requested; or

(ii) Electronically with electronic receipt confirmation.

(b) A radiology benefit manager shall provide a radiology clinic, radiologist, or advanced diagnostic imaging services provider receiving a preliminary report under this subsection no fewer than forty-five days after receiving the report to contest the report or

any findings in the report in accordance with the appeals procedure established under section 3(1) of this act and to provide additional documentation in support of the claim. The radiology benefit manager shall consider a reasonable request for an extension of time to submit documentation to contest the report or any findings in the report.

(2) If an audit results in the dispute or denial of a claim, the radiology benefit manager conducting the audit shall allow the radiology clinic, radiologist, or advanced diagnostic imaging services provider to resubmit the claim using any commercially reasonable method, including facsimile, mail, or electronic mail.

(3) A radiology benefit manager must provide a radiology clinic, radiologist, or advanced diagnostic imaging services provider that is the subject of an audit with a final report of the audit no later than sixty days after the later of either the date the preliminary report was received or the date the radiology clinic, radiologist, or advanced diagnostic imaging services provider contested the report using the appeals procedure established under section 3(1) of this act. The final report must include a final accounting of all moneys to be recovered by the person.

(4) Recoupment of disputed funds from a radiology clinic, radiologist, or advanced diagnostic imaging services provider by a radiology benefit manager or repayment of funds to a person by a radiology clinic, radiologist, or advanced diagnostic imaging services provider, unless otherwise agreed to by the person and the radiology clinic, radiologist, or advanced diagnostic imaging services provider, shall occur after the audit and the appeals procedure established under section 3(1) of this act are final.

NEW SECTION. **Sec. 9.** This chapter does not:

(1) Preclude a radiology benefit manager from instituting an action for fraud against a radiology clinic, radiologist, or advanced diagnostic imaging services provider;

(2) Apply to an audit of radiology clinic, radiologist, or advanced diagnostic imaging services provider records when fraud or other intentional and willful misrepresentation is indicated by physical review, review of claims data or statements, or other investigative methods; or

(3) Apply to a state agency that is conducting audits or a person that has contracted with a state agency to conduct audits of

radiology clinic, radiologist, or advanced diagnostic imaging services provider records for services paid for by the state medical assistance program.

NEW SECTION. **Sec. 10.** Sections 1 through 9 of this act constitute a new chapter in Title 19 RCW.

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