ENGROSSED SUBSTITUTE SENATE BILL 5812

State of Washington 56th Legislature 1999 Regular Session

By Senate Committee on Health & Long-Term Care (originally sponsored by Senators Thibaudeau, Deccio, Wojahn, Winsley, Gardner, Prentice and Costa)

Read first time 03/03/99.

1 AN ACT Relating to the prompt payment of health care claims; adding
2 a new section to chapter 48.43 RCW; and creating a new section.

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

4 NEW SECTION. **Sec. 1.** The legislature finds and declares that
5 there is a need for a consistent and enforceable standard for the
6 payment to Washington state health care facilities and health care
7 providers of claims submitted to health plans after health care
8 services are provided to health plan members. The legislature finds
9 that Washington state health care facilities and health care providers
10 have experienced mounting delays in reimbursement for services
11 provided.

12 NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW
13 to read as follows:
14 (1) For the purposes of this section:
15 (a) "Payer" means any group or individual disability insurance
16 policy, health care service contract, and health maintenance agreement,
17 the department of labor and industries, the health care authority,
18 public employees benefit board, the medical assistance administration

1 of the department of social and health services, and any self-insured
2 health plan subject to the jurisdiction of the state of Washington.
3 "Payer" does not include short-term care, long-term care, dental,
4 vision, accident, fixed indemnity, disability income contracts,
5 civilian health and medical program for the uniform services (CHAMPUS),
6 10 U.S.C. 55, limited benefit or credit insurance, coverage issued as
7 a supplement to liability insurance, insurance arising out of the
8 workers' compensation or similar law, automobile medical payment
9 insurance, or insurance under which benefits are payable with or
10 without regard to fault and which is statutorily required to be
11 contained in any liability insurance policy or equivalent self-
12 insurance.

13 (b) "Claim" means a request for payment for health care services
14 that is submitted to a payer by a provider in a written, electronic, or
15 other equivalent format.

16 (c) "Clean claim" means the same as the medicare standard set forth
17 in Title XVIII of the social security act, 42 U.S.C. Sec.
18 1395u(C)(2)(A) as it exists on the effective date of this act, and
19 shall be accepted as uniform billing number 92 and health care
20 financing administration number 1500 forms that are completed
21 accurately or their electronic equivalent or other formats adopted by
22 the national uniform billing committee. The clean claim may be
23 submitted by electronic transfer. A payer may not impose as a
24 condition of payment any requirements on a provider to modify the
25 uniform billing form or its content or submit additional claims forms.
26 Denial of a claim must be communicated to the provider and must include
27 the specific reason why the claim was denied which indicates reasonable
28 compliance with this law, such as no information received from the
29 employer, provider, or enrollee. When the legitimacy or
30 appropriateness of the health care service is disputed, a payer may
31 request additional medical information that describes and summarizes
32 the diagnosis, treatment, and services rendered to the member or
33 subscriber. When necessary to determine eligibility for benefits or
34 for determination of coverage, a payer may obtain additional
35 information from the provider or its subscriber or member, the employer
36 of the subscriber or member, or any other nonprovider third party.

37 (d) "Provider" means any health care facility or professional
38 health care practitioner acting within the scope of its licensure or
39 certification.

1 (e) "All claims" means claims that are clean and claims that are
2 not clean.
3 (2)(a) For covered services rendered to members or enrollees, a
4 payer shall pay providers as soon as practical but subject to the
5 following minimum standards: (i) Ninety-five percent of the volume of
6 clean claims shall be paid within thirty days; and (ii) ninety-five
7 percent of the volume of all claims shall be paid or denied within
8 sixty days.
9 (b) The date of a claim is when the payer receives written or
10 electronic notice of the claim, in accordance with health care
11 financing administration guidelines as they exist on the effective date
12 of this act. If a payer and provider have agreed in writing to the
13 submission of claims by a specific mode of transmission, the payer
14 shall calculate the time period beginning on the date that the claim is
15 received in the agreed-upon mode of transmission.
16 (3) Any payer failing to pay a claim within the standards
17 established under subsection (2) of this section shall pay interest on
18 such claims beginning with the sixty-first day for all claims. The
19 interest shall be assessed at the rate of one percent per month, and
20 shall be calculated monthly as simple interest prorated for any portion
21 of a month. The payer shall add the interest payable to the amount of
22 the unpaid claim without the necessity for a claim for interest due to
23 be made by the provider. Any interest owed to the provider by the
24 payer shall not be applied by the payer to an enrollee's deductible,
25 copay, coinsurance, or any similar obligation of the enrollee.
26 (4) Providers or payers may seek enforcement of this section
27 through the following means, in addition to any other available to them
28 through other laws:
29 (a) Binding arbitration pursuant to the procedures in chapter 7.04
30 RCW. The arbitrating authority shall order the payment of restitution,
31 interest, and any costs incurred by the party or parties initiating the
32 investigation, including costs of arbitration and reasonable attorneys'
33 fees.
34 (c) Providers or payers who determine that any provision of this
35 section has been violated may seek enforcement by the department of
36 health who shall take action in the name of the department to enforce
37 the provisions of this section only upon the request of a provider or
38 payer. The department shall investigate the alleged violation and,
39 within thirty days, upon finding that a violation has occurred, shall

refer the matter to the office of administrative hearings for a hearing under the provisions of chapter 34.12 RCW. The decision of the administrative law judge shall be the final administrative decision. The administrative law judge shall be authorized to order the payment of restitution, together with interest and any costs incurred by the party or parties initiating the investigation, including reasonable attorneys' fees, and the payment of the reasonable costs incurred by the department in investigating the violation and participating in the hearing.

(5)(a) The department of health shall establish an oversight board composed of a seven-member panel composed of three representatives from payers, three representatives from providers, and one representative from the department of health.

(b) The board shall study trends and issues and make recommendations regarding future legislative, regulatory, or private solutions which will promote timely and accurate payment of health claims.

(c) The board shall consider and provide recommendations to payers and providers regarding electronic billing and billing standards and develop a standard and common procedure for all claims to be electronically accepted by payers by January 1, 2001. The board shall also monitor the activity of the federal committees charged with developing and reviewing standard claims forms.

(6) Every payer shall be responsible for ensuring that any person acting on behalf of or at the direction of the payer or acting pursuant to payer standards or requirements complies with this section.

(7) This section does not apply to claims about which there is substantial evidence of fraud or misrepresentation by providers or patients, or instances where the payer has not been granted reasonable access to information under the provider's control.

(8) Neither a provider nor a payer shall be required to comply with this section if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

NEW SECTION. **Sec. 3.** If any provision of this act or its application to any person or circumstance is held invalid, the

1 remainder of the act or the application of the provision to other
2 persons or circumstances is not affected.

--- END ---