

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2023

A N A C T

RELATING TO BUSINESS AND PROFESSIONS -- BOARD OF MEDICAL LICENSURE
AND DISCIPLINE -- PROMPT PROCESSING OF INSURANCE CLAIMS

Introduced By: Senators Tikoian, F. Lombardi, Raptakis, Felag, Britto, and Ciccone

Date Introduced: February 01, 2023

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 5-37-5.1 of the General Laws in Chapter 5-37 entitled "Board of
2 Medical Licensure and Discipline" is hereby amended to read as follows:

3 **5-37-5.1. Unprofessional conduct.**

4 The term "unprofessional conduct" as used in this chapter includes, but is not limited to,
5 the following items or any combination of these items and may be further defined by regulations
6 established by the board with the prior approval of the director:

7 (1) Fraudulent or deceptive procuring or use of a license or limited registration;

8 (2) All advertising of medical business that is intended or has a tendency to deceive the
9 public;

10 (3) Conviction of a felony; conviction of a crime arising out of the practice of medicine;

11 (4) Abandoning a patient;

12 (5) Dependence upon controlled substances, habitual drunkenness, or rendering
13 professional services to a patient while the physician or limited registrant is intoxicated or
14 incapacitated by the use of drugs;

15 (6) Promotion by a physician or limited registrant of the sale of drugs, devices, appliances,
16 or goods or services provided for a patient in a manner as to exploit the patient for the financial
17 gain of the physician or limited registrant;

18 (7) Immoral conduct of a physician or limited registrant in the practice of medicine;

- 1 (8) Willfully making and filing false reports or records in the practice of medicine;
- 2 (9) Willfully omitting to file or record, or willfully impeding or obstructing a filing or
3 recording, or inducing another person to omit to file or record, medical or other reports as required
4 by law;
- 5 (10) Failing to furnish details of a patient's medical record to succeeding physicians,
6 healthcare facility, or other healthcare providers upon proper request pursuant to § 5-37.3-4;
- 7 (11) Soliciting professional patronage by agents or persons or profiting from acts of those
8 representing themselves to be agents of the licensed physician or limited registrants;
- 9 (12) Dividing fees or agreeing to split or divide the fees received for professional services
10 for any person for bringing to or referring a patient;
- 11 (13) Agreeing with clinical or bioanalytical laboratories to accept payments from these
12 laboratories for individual tests or test series for patients;
- 13 (14) Making willful misrepresentations in treatments;
- 14 (15) Practicing medicine with an unlicensed physician except in an accredited
15 preceptorship or residency training program, or aiding or abetting unlicensed persons in the practice
16 of medicine;
- 17 (16) Gross and willful overcharging for professional services; including filing of false
18 statements for collection of fees for which services are not rendered, or willfully making or assisting
19 in making a false claim or deceptive claim or misrepresenting a material fact for use in determining
20 rights to health care or other benefits;
- 21 (17) Offering, undertaking, or agreeing to cure or treat disease by a secret method,
22 procedure, treatment, or medicine;
- 23 (18) Professional or mental incompetency;
- 24 (19) Incompetent, negligent, or willful misconduct in the practice of medicine, which
25 includes the rendering of medically unnecessary services, and any departure from, or the failure to
26 conform to, the minimal standards of acceptable and prevailing medical practice in his or her area
27 of expertise as is determined by the board. The board does not need to establish actual injury to the
28 patient in order to adjudge a physician or limited registrant guilty of the unacceptable medical
29 practice in this subsection;
- 30 (20) Failing to comply with the provisions of chapter 4.7 of title 23;
- 31 (21) Surrender, revocation, suspension, limitation of privilege based on quality of care
32 provided, or any other disciplinary action against a license or authorization to practice medicine in
33 another state or jurisdiction; or surrender, revocation, suspension, or any other disciplinary action
34 relating to a membership on any medical staff or in any medical or professional association or

1 society while under disciplinary investigation by any of those authorities or bodies for acts or
2 conduct similar to acts or conduct that would constitute grounds for action as described in this
3 chapter;

4 (22) Multiple adverse judgments, settlements, or awards arising from medical liability
5 claims related to acts or conduct that would constitute grounds for action as described in this
6 chapter;

7 (23) Failing to furnish the board, its chief administrative officer, investigator, or
8 representatives, information legally requested by the board;

9 (24) Violating any provision or provisions of this chapter or the rules and regulations of
10 the board or any rules or regulations promulgated by the director or of an action, stipulation, or
11 agreement of the board;

12 (25) Cheating on or attempting to subvert the licensing examination;

13 (26) Violating any state or federal law or regulation relating to controlled substances;

14 (27) Failing to maintain standards established by peer-review boards, including, but not
15 limited to: standards related to proper utilization of services, use of nonaccepted procedure, and/or
16 quality of care;

17 (28) A pattern of medical malpractice, or willful or gross malpractice on a particular
18 occasion;

19 (29) Agreeing to treat a beneficiary of health insurance under title XVIII of the Social
20 Security Act, 42 U.S.C. § 1395 et seq., “Medicare Act,” and then charging or collecting from this
21 beneficiary any amount in excess of the amount or amounts permitted pursuant to the Medicare
22 Act;

23 (30) Sexual contact between a physician and patient during the existence of the
24 physician/patient relationship;

25 (31) Knowingly violating the provisions of § 23-4.13-2(d); ~~or~~

26 (32) Performing a pelvic examination or supervising a pelvic examination performed by
27 an individual practicing under the supervision of a physician on an anesthetized or unconscious
28 female patient without first obtaining the patient’s informed consent to pelvic examination, unless
29 the performance of a pelvic examination is within the scope of the surgical procedure or diagnostic
30 examination to be performed on the patient for which informed consent has otherwise been
31 obtained or in the case of an unconscious patient, the pelvic examination is required for diagnostic
32 purposes and is medically necessary;

33 (33) Refusing to submit medical bills to a health insurer solely based on the reason that a
34 bill may arise from a motor vehicle accident or third-party claim; or

1 (34) Failure to process any request for medical records or medical bills within fourteen (14)
2 days of a written request, which shall be a violation subject to the penalties set forth in § 5-37-27.

3 SECTION 2. Section 23-17-19.1 of the General Laws in Chapter 23-17 entitled "Licensing
4 of Healthcare Facilities" is hereby amended to read as follows:

5 **23-17-19.1. Rights of patients.**

6 Every healthcare facility licensed under this chapter shall observe the following standards
7 and any other standards that may be prescribed in rules and regulations promulgated by the
8 licensing agency with respect to each patient who utilizes the facility:

9 (1) The patient shall be afforded considerate and respectful care.

10 (2) Upon request, the patient shall be furnished with the name of the physician responsible
11 for coordinating his or her care.

12 (3) Upon request, the patient shall be furnished with the name of the physician or other
13 person responsible for conducting any specific test or other medical procedure performed by the
14 healthcare facility in connection with the patient's treatment.

15 (4) The patient shall have the right to refuse any treatment by the healthcare facility to the
16 extent permitted by law.

17 (5) The patient's right to privacy shall be respected to the extent consistent with providing
18 adequate medical care to the patient and with the efficient administration of the healthcare facility.
19 Nothing in this section shall be construed to preclude discreet discussion of a patient's case or
20 examination of appropriate medical personnel.

21 (6) The patient's right to privacy and confidentiality shall extend to all records pertaining
22 to the patient's treatment except as otherwise provided by law.

23 (7) The healthcare facility shall respond in a reasonable manner to the request of a patient's
24 physician, certified nurse practitioner, and/or a physician's assistant for medical services to the
25 patient. The healthcare facility shall also respond in a reasonable manner to the patient's request
26 for other services customarily rendered by the healthcare facility to the extent the services do not
27 require the approval of the patient's physician, certified nurse practitioner, and/or a physician's
28 assistant or are not inconsistent with the patient's treatment.

29 (8) Before transferring a patient to another facility, the healthcare facility must first inform
30 the patient of the need for, and alternatives to, a transfer.

31 (9) Upon request, the patient shall be furnished with the identities of all other healthcare
32 and educational institutions that the healthcare facility has authorized to participate in the patient's
33 treatment and the nature of the relationship between the institutions and the healthcare facility.

34 (10)(a) Except as otherwise provided in this subparagraph, if the healthcare facility

1 proposes to use the patient in any human-subjects research, it shall first thoroughly inform the
2 patient of the proposal and offer the patient the right to refuse to participate in the project.

3 (b) No facility shall be required to inform prospectively the patient of the proposal and the
4 patient's right to refuse to participate when: (i) The facility's human-subjects research involves the
5 investigation of potentially lifesaving devices, medications, and/or treatments and the patient is
6 unable to grant consent due to a life-threatening situation and consent is not available from the
7 agent pursuant to chapter 4.10 of title 23 or the patient's decision maker if an agent has not been
8 designated or an applicable advanced directive has not been executed by the patient; and (ii) The
9 facility's institutional review board approves the human-subjects research pursuant to the
10 requirements of 21 C.F.R. Pt. 50 and/or 45 C.F.R. Pt. 46 (relating to the informed consent of human
11 subjects). Any healthcare facility engaging in research pursuant to the requirements of
12 subparagraph (b) herein shall file a copy of the relevant research protocol with the department of
13 health, which filing shall be publicly available.

14 (11) Upon request, the patient shall be allowed to examine and shall be given an
15 explanation of the bill rendered by the healthcare facility irrespective of the source of payment of
16 the bill.

17 (12) Upon request, the patient shall be permitted to examine any pertinent healthcare
18 facility rules and regulations that specifically govern the patient's treatment.

19 (13) The patient shall be offered treatment without discrimination as to race, color, religion,
20 national origin, or source of payment.

21 (14) Patients shall be provided with a summarized medical bill within thirty (30) days of
22 discharge from a healthcare facility. Upon request, the patient shall be furnished with an itemized
23 copy of his or her bill within fourteen (14) days of receipt of written request. When patients are
24 residents of state-operated institutions and facilities, the provisions of this subsection shall not
25 apply. Violation of this right shall be subject to the penalties set forth in § 5-37-25.

26 (15) Upon request, the patient shall be allowed the use of a personal television set provided
27 that the television complies with underwriters' laboratory standards and O.S.H.A. standards, and
28 so long as the television set is classified as a portable television.

29 (16) No charge of any kind, including, but not limited to, copying, postage, retrieval, or
30 processing fees, shall be made for furnishing a health record or part of a health record to a patient,
31 his or her attorney, or authorized representative if the record, or part of the record, is necessary for
32 the purpose of supporting an appeal under any provision of the Social Security Act, 42 U.S.C. §
33 301 et seq., and the request is accompanied by documentation of the appeal or a claim under the
34 provisions of the Workers' Compensation Act, chapters 29 — 38 of title 28 or for any patient who

1 is a veteran and the medical record is necessary for any application for benefits of any kind. A
2 provider shall furnish a health record requested pursuant to this section by mail, electronically, or
3 otherwise, within ~~thirty (30)~~ fourteen (14) days of the receipt of the written request. For the
4 purposes of this section, "provider" shall include any out-of-state entity that handles medical
5 records for in-state providers. Further, for patients of school-based health centers, the director is
6 authorized to specify by regulation an alternative list of age appropriate rights commensurate with
7 this section.

8 (17) The patient shall have the right to have his or her pain assessed on a regular basis.

9 (18) Notwithstanding any other provisions of this section, upon request, patients receiving
10 care through hospitals, nursing homes, assisted-living residences and home healthcare providers,
11 shall have the right to receive information concerning hospice care, including the benefits of
12 hospice care, the cost, and how to enroll in hospice care.

13 SECTION 3. Section 27-18-61 of the General Laws in Chapter 27-18 entitled "Accident
14 and Sickness Insurance Policies" is hereby amended to read as follows:

15 **27-18-61. Prompt processing of claims.**

16 (a)(1) A health care entity or health plan operating in the state shall pay all complete claims
17 for covered health care services submitted to the health care entity or health plan by a health care
18 provider or by a policyholder within forty (40) calendar days following the date of receipt of a
19 complete written claim or within thirty (30) calendar days following the date of receipt of a
20 complete electronic claim. Each health plan shall establish a written standard defining what
21 constitutes a complete claim and shall distribute this standard to all participating providers.

22 (2) No health care entity or health plan shall deny a claim for any medical bill based solely
23 on the reason such bill may arise from a motor vehicle accident or other third-party claim. This
24 subsection shall not apply to any medical bills arising from a worker's compensation claim pursuant
25 to chapter 33 of title 28.

26 (3) No health care entity of a health plan shall make payment under a policyholder's first
27 party coverage without the express written consent of the policyholder.

28 (b) If the health care entity or health plan denies or pends a claim, the health care entity or
29 health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing the
30 health care provider or policyholder of any and all reasons for denying or pending the claim and
31 what, if any, additional information is required to process the claim. No health care entity or health
32 plan may limit the time period in which additional information may be submitted to complete a
33 claim.

34 (c) Any claim that is resubmitted by a health care provider or policyholder shall be treated

1 by the health care entity or health plan pursuant to the provisions of subsection (a) of this section.

2 (d) A health care entity or health plan which fails to reimburse the health care provider or
3 policyholder after receipt by the health care entity or health plan of a complete claim within the
4 required timeframes shall pay to the health care provider or the policyholder who submitted the
5 claim, in addition to any reimbursement for health care services provided, interest which shall
6 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day
7 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a complete
8 written claim, and ending on the date the payment is issued to the health care provider or the
9 policyholder.

10 (e) Exceptions to the requirements of this section are as follows:

11 (1) No health care entity or health plan operating in the state shall be in violation of this
12 section for a claim submitted by a health care provider or policyholder if:

13 (i) Failure to comply is caused by a directive from a court or federal or state agency;

14 (ii) The health care entity or health plan is in liquidation or rehabilitation or is operating in
15 compliance with a court-ordered plan of rehabilitation; or

16 (iii) The health care entity or health plan's compliance is rendered impossible due to
17 matters beyond its control that are not caused by it.

18 (2) No health care entity or health plan operating in the state shall be in violation of this
19 section for any claim: (i) initially submitted more than ninety (90) days after the service is rendered,
20 or (ii) resubmitted more than ninety (90) days after the date the health care provider received the
21 notice provided for in subsection (b) of this section; provided, this exception shall not apply in the
22 event compliance is rendered impossible due to matters beyond the control of the health care
23 provider and were not caused by the health care provider.

24 (3) No health care entity or health plan operating in the state shall be in violation of this
25 section while the claim is pending due to a fraud investigation by a state or federal agency.

26 (4) No health care entity or health plan operating in the state shall be obligated under this
27 section to pay interest to any health care provider or policyholder for any claim if the director of
28 business regulation finds that the entity or plan is in substantial compliance with this section. A
29 health care entity or health plan seeking such a finding from the director shall submit any
30 documentation that the director shall require. A health care entity or health plan which is found to
31 be in substantial compliance with this section shall thereafter submit any documentation that the
32 director may require on an annual basis for the director to assess ongoing compliance with this
33 section.

34 (5) A health care entity or health plan may petition the director for a waiver of the provision

1 of this section for a period not to exceed ninety (90) days in the event the health care entity or health
2 plan is converting or substantially modifying its claims processing systems.

3 (f) For purposes of this section, the following definitions apply:

4 (1) "Claim" means: (i) a bill or invoice for covered services; (ii) a line item of service; or
5 (iii) all services for one patient or subscriber within a bill or invoice.

6 (2) "Date of receipt" means the date the health care entity or health plan receives the claim
7 whether via electronic submission or as a paper claim.

8 (3) "Health care entity" means a licensed insurance company or nonprofit hospital or
9 medical or dental service corporation or plan or health maintenance organization, or a contractor
10 as described in § 23-17.13-2(2), which operates a health plan.

11 (4) "Health care provider" means an individual clinician, either in practice independently
12 or in a group, who provides health care services, and otherwise referred to as a non-institutional
13 provider.

14 (5) "Health care services" include, but are not limited to, medical, mental health, substance
15 abuse, dental and any other services covered under the terms of the specific health plan.

16 (6) "Health plan" means a plan operated by a health care entity that provides for the
17 delivery of health care services to persons enrolled in those plans through:

18 (i) Arrangements with selected providers to furnish health care services; and/or

19 (ii) Financial incentive for persons enrolled in the plan to use the participating providers
20 and procedures provided for by the health plan.

21 (7) "Policyholder" means a person covered under a health plan or a representative
22 designated by that person.

23 (8) "Substantial compliance" means that the health care entity or health plan is processing
24 and paying ninety-five percent (95%) or more of all claims within the time frame provided for in
25 subsections (a) and (b) of this section.

26 (g) Any provision in a contract between a health care entity or a health plan and a health
27 care provider which is inconsistent with this section shall be void and of no force and effect.

28 SECTION 4. Section 27-19-52 of the General Laws in Chapter 27-19 entitled "Nonprofit
29 Hospital Service Corporations" is hereby amended to read as follows:

30 **27-19-52. Prompt processing of claims.**

31 (a)(1) A health care entity or health plan operating in the state shall pay all complete claims
32 for covered health care services submitted to the health care entity or health plan by a health care
33 provider or by a policyholder within forty (40) calendar days following the date of receipt of a
34 complete written claim or within thirty (30) calendar days following the date of receipt of a

1 complete electronic claim. Each health plan shall establish a written standard defining what
2 constitutes a complete claim and shall distribute this standard to all participating providers.

3 (2) No health care entity or health plan shall deny a claim for any medical bill based solely
4 on the reason such bill may arise from a motor vehicle accident or other third-party claim. This
5 subsection shall not apply to any medical bills arising from a worker's compensation claim pursuant
6 to chapter 33 of title 28.

7 (3) No health care entity of a health plan shall make payment under a policyholder's first
8 party coverage without the express written consent of the policyholder.

9 (b) If the health care entity or health plan denies or pends a claim, the health care entity or
10 health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing the
11 health care provider or policyholder of any and all reasons for denying or pending the claim and
12 what, if any, additional information is required to process the claim. No health care entity or health
13 plan may limit the time period in which additional information may be submitted to complete a
14 claim.

15 (c) Any claim that is resubmitted by a health care provider or policyholder shall be treated
16 by the health care entity or health plan pursuant to the provisions of subsection (a) of this section.

17 (d) A health care entity or health plan which fails to reimburse the health care provider or
18 policyholder after receipt by the health care entity or health plan of a complete claim within the
19 required timeframes shall pay to the health care provider or the policyholder who submitted the
20 claim, in addition to any reimbursement for health care services provided, interest which shall
21 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day
22 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a complete
23 written claim, and ending on the date the payment is issued to the health care provider or the
24 policyholder.

25 (e) Exceptions to the requirements of this section are as follows:

26 (1) No health care entity or health plan operating in the state shall be in violation of this
27 section for a claim submitted by a health care provider or policyholder if:

28 (i) Failure to comply is caused by a directive from a court or federal or state agency;

29 (ii) The health care provider or health plan is in liquidation or rehabilitation or is operating
30 in compliance with a court-ordered plan of rehabilitation; or

31 (iii) The health care entity or health plan's compliance is rendered impossible due to
32 matters beyond its control that are not caused by it.

33 (2) No health care entity or health plan operating in the state shall be in violation of this
34 section for any claim: (i) initially submitted more than ninety (90) days after the service is rendered,

1 or (ii) resubmitted more than ninety (90) days after the date the health care provider received the
2 notice provided for in § 27-18-61(b); provided, this exception shall not apply in the event
3 compliance is rendered impossible due to matters beyond the control of the health care provider
4 and were not caused by the health care provider.

5 (3) No health care entity or health plan operating in the state shall be in violation of this
6 section while the claim is pending due to a fraud investigation by a state or federal agency.

7 (4) No health care entity or health plan operating in the state shall be obligated under this
8 section to pay interest to any health care provider or policyholder for any claim if the director of
9 the department of business regulation finds that the entity or plan is in substantial compliance with
10 this section. A health care entity or health plan seeking such a finding from the director shall submit
11 any documentation that the director shall require. A health care entity or health plan which is found
12 to be in substantial compliance with this section shall after this submit any documentation that the
13 director may require on an annual basis for the director to assess ongoing compliance with this
14 section.

15 (5) A health care entity or health plan may petition the director for a waiver of the provision
16 of this section for a period not to exceed ninety (90) days in the event the health care entity or health
17 plan is converting or substantially modifying its claims processing systems.

18 (f) For purposes of this section, the following definitions apply:

19 (1) "Claim" means:

20 (i) A bill or invoice for covered services;

21 (ii) A line item of service; or

22 (iii) All services for one patient or subscriber within a bill or invoice.

23 (2) "Date of receipt" means the date the health care entity or health plan receives the claim
24 whether via electronic submission or has a paper claim.

25 (3) "Health care entity" means a licensed insurance company or nonprofit hospital or
26 medical or dental service corporation or plan or health maintenance organization, or a contractor
27 as described in § 23-17.13-2(2), that operates a health plan.

28 (4) "Health care provider" means an individual clinician, either in practice independently
29 or in a group, who provides health care services, and referred to as a non-institutional provider.

30 (5) "Health care services" include, but are not limited to, medical, mental health, substance
31 abuse, dental and any other services covered under the terms of the specific health plan.

32 (6) "Health plan" means a plan operated by a health care entity that provides for the
33 delivery of health care services to persons enrolled in those plans through:

34 (i) Arrangements with selected providers to furnish health care services; and/or

1 (ii) Financial incentive for persons enrolled in the plan to use the participating providers
2 and procedures provided for by the health plan.

3 (7) "Policyholder" means a person covered under a health plan or a representative
4 designated by that person.

5 (8) "Substantial compliance" means that the health care entity or health plan is processing
6 and paying ninety-five percent (95%) or more of all claims within the time frame provided for in §
7 27-18-61(a) and (b).

8 (g) Any provision in a contract between a health care entity or a health plan and a health
9 care provider which is inconsistent with this section shall be void and of no force and effect.

10 SECTION 5. Section 27-20-47 of the General Laws in Chapter 27-20 entitled "Nonprofit
11 Medical Service Corporations" is hereby amended to read as follows:

12 **27-20-47. Prompt processing of claims.**

13 (a)(1) A health care entity or health plan operating in the state shall pay all complete claims
14 for covered health care services submitted to the health care entity or health plan by a health care
15 provider or by a policyholder within forty (40) calendar days following the date of receipt of a
16 complete written claim or within thirty (30) calendar days following the date of receipt of a
17 complete electronic claim. Each health plan shall establish a written standard defining what
18 constitutes a complete claim and shall distribute the standard to all participating providers.

19 (2) No health care entity or health plan shall deny a claim for any medical bill based solely
20 on the reason such bill may arise from a motor vehicle accident or other third-party claim. This
21 subsection shall not apply to any medical bills arising from a worker's compensation claim pursuant
22 to chapter 33 of title 28.

23 (3) No health care entity of a health plan shall make payment under a policyholder's first
24 party coverage without the express written consent of the policyholder.

25 (b) If the health care entity or health plan denies or pends a claim, the health care entity or
26 health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing the
27 health care provider or policyholder of any and all reasons for denying or pending the claim and
28 what, if any, additional information is required to process the claim. No health care entity or health
29 plan may limit the time period in which additional information may be submitted to complete a
30 claim.

31 (c) Any claim that is resubmitted by a health care provider or policyholder shall be treated
32 by the health care entity or health plan pursuant to the provisions of subsection (a) of this section.

33 (d) A health care entity or health plan which fails to reimburse the health care provider or
34 policyholder after receipt by the health care entity or health plan of a complete claim within the

1 required timeframes shall pay to the health care provider or the policyholder who submitted the
2 claim, in addition to any reimbursement for health care services provided, interest which shall
3 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day
4 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a complete
5 written claim, and ending on the date the payment is issued to the health care provider or the
6 policyholder.

7 (e) Exceptions to the requirements of this section are as follows:

8 (1) No health care entity or health plan operating in the state shall be in violation of this
9 section for a claim submitted by a health care provider or policyholder if:

10 (i) Failure to comply is caused by a directive from a court or federal or state agency;

11 (ii) The health care entity or health plan is in liquidation or rehabilitation or is operating in
12 compliance with a court-ordered plan of rehabilitation; or

13 (iii) The health care entity or health plan's compliance is rendered impossible due to
14 matters beyond its control that are not caused by it.

15 (2) No health care entity or health plan operating in the state shall be in violation of this
16 section for any claim: (i) initially submitted more than ninety (90) days after the service is rendered,
17 or (ii) resubmitted more than ninety (90) days after the date the health care provider received the
18 notice provided for in § 27-18-61(b); provided, this exception shall not apply in the event
19 compliance is rendered impossible due to matters beyond the control of the health care provider
20 and were not caused by the health care provider.

21 (3) No health care entity or health plan operating in the state shall be in violation of this
22 section while the claim is pending due to a fraud investigation by a state or federal agency.

23 (4) No health care entity or health plan operating in the state shall be obligated under this
24 section to pay interest to any health care provider or policyholder for any claim if the director of
25 the department of business regulation finds that the entity or plan is in substantial compliance with
26 this section. A health care entity or health plan seeking such a finding from the director shall submit
27 any documentation that the director shall require. A health care entity or health plan which is found
28 to be in substantial compliance with this section shall after this submit any documentation that the
29 director may require on an annual basis for the director to assess ongoing compliance with this
30 section.

31 (5) A health care entity or health plan may petition the director for a waiver of the provision
32 of this section for a period not to exceed ninety (90) days in the event the health care entity or health
33 plan is converting or substantially modifying its claims processing systems.

34 (f) For purposes of this section, the following definitions apply:

1 (1) "Claim" means: (i) a bill or invoice for covered services; (ii) a line item of service; or
2 (iii) all services for one patient or subscriber within a bill or invoice.

3 (2) "Date of receipt" means the date the health care entity or health plan receives the claim
4 whether via electronic submission or has a paper claim.

5 (3) "Health care entity" means a licensed insurance company or nonprofit hospital or
6 medical or dental service corporation or plan or health maintenance organization, or a contractor
7 as described in § 23-17.13-2(2), that operates a health plan.

8 (4) "Health care provider" means an individual clinician, either in practice independently
9 or in a group, who provides health care services, and referred to as a non-institutional provider.

10 (5) "Health care services" include, but are not limited to, medical, mental health, substance
11 abuse, dental and any other services covered under the terms of the specific health plan.

12 (6) "Health plan" means a plan operated by a health care entity that provides for the
13 delivery of health care services to persons enrolled in the plan through:

14 (i) Arrangements with selected providers to furnish health care services; and/or

15 (ii) Financial incentive for persons enrolled in the plan to use the participating providers
16 and procedures provided for by the health plan.

17 (7) "Policyholder" means a person covered under a health plan or a representative
18 designated by that person.

19 (8) "Substantial compliance" means that the health care entity or health plan is processing
20 and paying ninety-five percent (95%) or more of all claims within the time frame provided for in §
21 27-18-61(a) and (b).

22 (g) Any provision in a contract between a health care entity or a health plan and a health
23 care provider which is inconsistent with this section shall be void and of no force and effect.

24 SECTION 6. Section 27-41-64 of the General Laws in Chapter 27-41 entitled "Health
25 Maintenance Organizations" is hereby amended to read as follows:

26 **27-41-64. Prompt processing of claims.**

27 (a)(1) A health care entity or health plan operating in the state shall pay all complete claims
28 for covered health care services submitted to the health care entity or health plan by a health care
29 provider or by a policyholder within forty (40) calendar days following the date of receipt of a
30 complete written claim or within thirty (30) calendar days following the date of receipt of a
31 complete electronic claim. Each health plan shall establish a written standard defining what
32 constitutes a complete claim and shall distribute this standard to all participating providers.

33 (2) No health care entity or health plan shall deny a claim for any medical bill based solely
34 on the reason such bill may arise from a motor vehicle accident or other third-party claim. This

1 [subsection shall not apply to any medical bills arising from a worker's compensation claim pursuant](#)
2 [to chapter 33 of title 28.](#)

3 [\(3\) No health care entity of a health plan shall make payment under a policyholder's first](#)
4 [party coverage without the express written consent of the policyholder.](#)

5 (b) If the health care entity or health plan denies or pends a claim, the health care entity or
6 health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing the
7 health care provider or policyholder of any and all reasons for denying or pending the claim and
8 what, if any, additional information is required to process the claim. No health care entity or health
9 plan may limit the time period in which additional information may be submitted to complete a
10 claim.

11 (c) Any claim that is resubmitted by a health care provider or policyholder shall be treated
12 by the health care entity or health plan pursuant to the provisions of subsection (a) of this section.

13 (d) A health care entity or health plan which fails to reimburse the health care provider or
14 policyholder after receipt by the health care entity or health plan of a complete claim within the
15 required timeframes shall pay to the health care provider or the policyholder who submitted the
16 claim, in addition to any reimbursement for health care services provided, interest which shall
17 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day
18 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a complete
19 written claim, and ending on the date the payment is issued to the health care provider or the
20 policyholder.

21 (e) Exceptions to the requirements of this section are as follows:

22 (1) No health care entity or health plan operating in the state shall be in violation of this
23 section for a claim submitted by a health care provider or policyholder if:

24 (i) Failure to comply is caused by a directive from a court or federal or state agency;

25 (ii) The health care entity or health plan is in liquidation or rehabilitation or is operating in
26 compliance with a court-ordered plan of rehabilitation; or

27 (iii) The health care entity or health plan's compliance is rendered impossible due to
28 matters beyond its control, which are not caused by it.

29 (2) No health care entity or health plan operating in the state shall be in violation of this
30 section for any claim: (i) initially submitted more than ninety (90) days after the service is rendered,
31 or (ii) resubmitted more than ninety (90) days after the date the health care provider received the
32 notice provided for in § 27-18-61(b); provided, this exception shall not apply in the event
33 compliance is rendered impossible due to matters beyond the control of the health care provider
34 and were not caused by the health care provider.

1 (3) No health care entity or health plan operating in the state shall be in violation of this
2 section while the claim is pending due to a fraud investigation by a state or federal agency.

3 (4) No health care entity or health plan operating in the state shall be obligated under this
4 section to pay interest to any health care provider or policyholder for any claim if the director of
5 the department of business regulation finds that the entity or plan is in substantial compliance with
6 this section. A health care entity or health plan seeking that finding from the director shall submit
7 any documentation that the director shall require. A health care entity or health plan which is found
8 to be in substantial compliance with this section shall submit any documentation the director may
9 require on an annual basis for the director to assess ongoing compliance with this section.

10 (5) A health care entity or health plan may petition the director for a waiver of the provision
11 of this section for a period not to exceed ninety (90) days in the event the health care entity or health
12 plan is converting or substantially modifying its claims processing systems.

13 (f) For purposes of this section, the following definitions apply:

14 (1) "Claim" means: (i) a bill or invoice for covered services; (ii) a line item of service; or
15 (iii) all services for one patient or subscriber within a bill or invoice.

16 (2) "Date of receipt" means the date the health care entity or health plan receives the claim
17 whether via electronic submission or as a paper claim.

18 (3) "Health care entity" means a licensed insurance company or nonprofit hospital or
19 medical or dental service corporation or plan or health maintenance organization, or a contractor
20 as described in § 23-17.13-2(2) that operates a health plan.

21 (4) "Health care provider" means an individual clinician, either in practice independently
22 or in a group, who provides health care services, and is referred to as a non-institutional provider.

23 (5) "Health care services" include, but are not limited to, medical, mental health, substance
24 abuse, dental and any other services covered under the terms of the specific health plan.

25 (6) "Health plan" means a plan operated by a health care entity that provides for the
26 delivery of health care services to persons enrolled in the plan through:

27 (i) Arrangements with selected providers to furnish health care services; and/or

28 (ii) Financial incentive for persons enrolled in the plan to use the participating providers
29 and procedures provided for by the health plan.

30 (7) "Policyholder" means a person covered under a health plan or a representative
31 designated by that person.

32 (8) "Substantial compliance" means that the health care entity or health plan is processing
33 and paying ninety-five percent (95%) or more of all claims within the time frame provided for in §
34 27-18-61(a) and (b).

1 (g) Any provision in a contract between a health care entity or a health plan and a health
2 care provider which is inconsistent with this section shall be void and of no force and effect.

3 SECTION 7. This act shall take effect upon passage.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

RELATING TO BUSINESS AND PROFESSIONS -- BOARD OF MEDICAL LICENSURE
AND DISCIPLINE -- PROMPT PROCESSING OF INSURANCE CLAIMS

1 This act would prohibit a health insurer from denying a claim for any medical bill based
2 on the sole reasoning that the bill may arise from a motor vehicle accident or other third-party claim
3 and prohibit a medical provider from refusing to submit medical bills to a health insured based
4 solely on the reasoning that the bill may arise from a motor vehicle accident or other third-party
5 claim. This bill would further prohibit an insurance company from making payment under an
6 insured's first party coverage without the written consent of the insured. This act would also require
7 any request for medical records or bills to be fulfilled within fourteen (14) days of a written request.

8 This act would take effect upon passage.

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