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H.B. 140

HEALTH CLAIMS PROCESSING AND HEALTH CLAIMS AUDITING ACT

2001 GENERAL SESSION

STATE OF UTAH

Sponsor: Chad E. Bennion

This act modifies the Health Code to establish a Health Claims Processing and Health Claims Auditing Act. The act requires health care service providers to timely respond to a health claims adjudicator's request for information or face certain penalties. The act establishes the elements of a claims auditing violation. The act creates a private right of action for health claims adjudicators to sue service providers for penalties when service providers violate the response time, or other provisions of the Health Claims Processing and Health Claims Auditing Act, or if a service provider commits a fraudulent act under the Insurance Code.

This act affects sections of Utah Code Annotated 1953 as follows:

ENACTS:

26-45-101, Utah Code Annotated 1953

26-45-102, Utah Code Annotated 1953

26-45-103, Utah Code Annotated 1953

26-45-104, Utah Code Annotated 1953

26-45-105, Utah Code Annotated 1953

26-45-106, Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **26-45-101** is enacted to read:

CHAPTER 26. HEALTH CLAIMS PROCESSING AND HEALTH CLAIMS AUDITING ACT

26-45-101. Title.

This chapter is known as the "Health Claims Processing and Health Claims Auditing Act."

Section 2. Section **26-45-102** is enacted to read:

26-45-102. Purpose.

The purpose of this chapter is to:

(1) enable health claims adjudicators to obtain and review information from service providers related to health care services for which the service providers have requested or received compensation, payment, or reimbursement; and

(2) provide a private right of action and remedy to health claims adjudicators.

Section 3. Section **26-45-103** is enacted to read:

26-45-103. Definitions.

As used in this chapter:

(1) "COBRA" means the health coverage continuation provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985.

(2) (a) "Conceal" means to take affirmative action to prevent others from discovering information.

(b) "Conceal" does not include inadvertent failure to disclose.

(3) "Group health plan" means the same as "Group Health Plan" under COBRA.

(4) "Health claims" means an electronic or written request for payment, compensation, reimbursement, or benefit submitted to a health claims adjudicator for adjudication, review, audit, or payment of benefits under any group health plan a group or individual, insurance policy, or other similar arrangement.

(5) "Health claims adjudicator" means any of the entities described in this Subsection (5) which adjudicate, review, audit, or pay for any health claims:

(a) an insurer described in Subsection 31A-31-102(3);

(b) a third-party administrator; and

(c) an employee welfare fund or plan, whether or not it is subject to supervision by the commissioner of insurance under Title 31A, Insurance Code, including a:

(i) self-insured plan;

(ii) reinsured plan;

(iii) medical, dental, optometric, or similar health service plan;

(iv) a plan qualified under the federal Employee Retirement Income Security Act of 1974; or

(v) other trust.

(6) "Health claims audit" means an investigation conducted by a health claims adjudicator for the purpose of determining whether there has been any improper, incomplete, or incorrect billing, coding, or request for compensation, payment, or reimbursement.

(7) "Person" means an individual, firm, company, corporation, association, limited liability company, partnership, organization, society, business trust, service provider, agency of government, or any legal entity.

(8) "Service provider" means:

(a) an individual licensed or certified by the state under Title 58, Occupations and Professions;

(b) an individual similarly licensed in another jurisdiction;

(c) an individual practicing any nonmedical treatment rendered in accordance with a recognized religious method of healing; and

(d) a hospital, healthcare facility, ambulance service, emergency medical service provider, or other person whose services are compensated directly or indirectly by a group health plan.

Section 4. Section **26-45-104** is enacted to read:

26-45-104. Request for health claims information -- Notice to service provider.

(1) (a) A health claims adjudicator may send a written request for information to a service provider for the purpose of processing one or more health claims or for conducting a health claims audit in accordance with this section.

(b) The request for information must:

(i) identify the information or records sought with reasonable specificity;

(ii) include a release from the subject of the records or his legal representative in compliance with normal professional practice and medical ethics, which release must be dated within four years of the request for information; and

(iii) include a statement that the failure of the service provider to respond to the request of the health claims adjudicator in accordance with this section may result in legal action by the health claims adjudicator and the imposition of penalties under Section 26-45-106.

(c) The information or records sought must:

(i) be related to treatment, services, or procedures for which the service provider has requested or received compensation, payment, or reimbursement from the health claims

adjudicator;

(ii) be related to treatment, services, or procedures which the service provider has previously provided and which are relevant to a determination of whether the health claims adjudicator is obligated in its own capacity, or on behalf of a third party, to pay health claims under a group health plan, a group or individual insurance policy, or a similar arrangement; and

(iii) pertain to treatment or services provided within the four years preceding the date of the request for information.

(2) A service provider who receives a written request for information in compliance with this section must, within 20 days of receipt of the request, provide the health claims adjudicator with the requested information that is in the possession of the service provider, unless the service provider has requested and received the consent of the health claims adjudicator to extend the 20-day period.

(3) A provider who fails to comply with this section is subject to the penalties and damages under Section 26-45-106.

Section 5. Section **26-45-105** is enacted to read:

26-45-105. Health claims violations.

It is a violation of this chapter and is subject to sanctions under Section 26-45-106, if the service provider:

(1) commits a fraudulent insurance act within the meaning of Subsection 31A-31-103(2);

(2) does not comply with the request for information requirements of Section 26-45-104;

(3) misrepresents or conceals a material fact concerning any of the following:

(a) a claim for payment or benefit pursuant to any group health plan;

(b) payments made in accordance with the terms of any insurance policy; or

(c) a treatment code, office visit code, Current Procedural Terminology Code, or other similar code; or

(4) when submitting a claim to a health claims adjudicator knowingly with the intent to deceive or defraud:

(a) withholds information material to the payment of the claim; or

(b) provides false or misleading information.

Section 6. Section **26-45-106** is enacted to read:

26-45-106. Remedies and enforcement.

(1) If a service provider commits a violation under Section 26-45-105, a health claims adjudicator has a private right of action and remedy against the service provider. The private right of action and remedy includes the right of the health claims adjudicator to pursue an action in court to:

(a) enforce provisions of this chapter;

(b) recover the penalties described in Subsection (2);

(c) obtain preliminary and other equitable or declaratory relief; and

(d) recover an award of attorney's fees and litigation costs reasonably incurred by the health claims adjudicator in pursuing the private right of action.

(2) (a) A service provider who commits a health claim violation under Section 26-45-105 shall pay to the health claims adjudicator the following penalties:

(i) for the first violation within a 90-day period for the same or a different health claim, a penalty equal to the greater of $100 or 1/3 of the amount of the health claim;

(ii) for the second violation within a 90-day period for the same or a different health claim, a penalty equal to the greater of $500 or 2/3 of the amount of the health claim; and

(iii) for the third violation within a 90-day period for the same or a different health claim, a penalty equal to the greater of $1,000 or 100% of the amount of the health claim.

(b) If the service provider does not pay the penalties imposed under this Subsection (2)(a) to the health claims adjudicator within 20 days of written demand by the health claims adjudicator, the health claims adjudicator may offset the penalties against any current and future payments otherwise due from the health claims adjudicator to the service provider on other health claims. If no payments are currently due from the health claim adjudicator to the service provider on other health claims, the health claims adjudicator may pursue a private action against the service provider in accordance with Subsection (1).

(c) A penalty imposed under this Subsection (2):

(i) must be separately identified on the documentation used by the health claims adjudicator to pay or adjust a health claim; and

(ii) shall be automatically assessed without further action or notice by the health claims adjudicator.

(d) Any penalty or award of costs and fees imposed under this section may not be billed or charged by the service provider to the patient or the person covered by a group health plan,

insurance policy, or similar arrangement.

Legislative Review Note
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A limited legal review of this legislation raises no obvious constitutional or statutory concerns.

Office of Legislative Research and General Counsel