SENATE BILL NO. 959

March 3, 1998, Introduced by Senators DE GROW and SHUGARS and referred to the Committee on Health Policy and Senior Citizens.

A bill to amend 1980 PA 350, entitled

"The nonprofit health care corporation reform act,"

by amending section 403 (MCL 550.1403) and by adding sections 403d and 403e.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 403. (1) A health care corporation, on a timely basis, shall pay to a member or a participating provider benefits as are entitled and provided under the applicable certificate. ~~When~~ IF not paid on a timely basis, benefits payable to a member OR TO A PROVIDER shall bear simple interest from a date 60 days after a ~~satisfactory~~ COMPLETED claim form OR THE LAST ITEM NECESSARY TO COMPLETE THE CLAIM FORM was received by the health care corporation, at a rate of 12% interest per annum. The interest shall be paid in addition to, and at the time of payment of, the claim.

(2) ~~A~~ IF A CLAIM IS INCOMPLETE, THE health care corporation shall specify in writing ~~the materials which constitute a satisfactory claim form~~ WHAT IS NECESSARY TO COMPLETE THE CLAIM not later than 30 days after receipt of ~~a~~ THE claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form shall be considered to be paid on a timely basis if paid within 60 days after receipt of the claim form by the corporation. IF THE CORPORATION WRONGLY DETERMINES THAT A CLAIM IS INCOMPLETE, INTEREST SHALL ACCRUE AS PROVIDED IN SUBSECTION (1).

SEC. 403D. (1) FOR PURPOSES OF THIS SECTION:

(A) "CLAIM" MEANS A REQUEST SUBMITTED BY A PARTICIPATING PROVIDER OR OTHER PERSON TO A HEALTH CARE CORPORATION FOR THE PAYMENT OF BENEFITS AS ARE ENTITLED AND PROVIDED UNDER THE APPLICABLE CERTIFICATE.

(B) "CPT" MEANS THE PHYSICIAN'S CURRENT PROCEDURAL TERMINOLOGY PUBLISHED BY THE AMERICAN MEDICAL ASSOCIATION.

(C) "ELECTRONIC TRANSMISSION" INCLUDES, BUT IS NOT LIMITED TO, TRANSMISSION BY COMPUTER MODEM, FACSIMILE, OR OTHER ELECTRONIC METHOD OF TRANSMISSION.

(D) "HCFA" MEANS THE HEALTH CARE FINANCING ADMINISTRATION, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(E) "HCPCS" MEANS THE HCFA COMMON PROCEDURE CODING SYSTEM.

(F) "ICD-9-CM" MEANS THE INTERNATIONAL CLASSIFICATION OF DISEASES, CLINICAL MODIFICATION.

(2) EXCEPT FOR CLAIMS SUBMITTED BY ELECTRONIC TRANSMISSION AND AS OTHERWISE PROVIDED, A PARTICIPATING PROVIDER OR OTHER PERSON SHALL SUBMIT A CLAIM TO A HEALTH CARE CORPORATION ONLY ON A UNIFORM CLAIM FORM ESTABLISHED BY THE COMMISSIONER UNDER SUB-SECTION (3). A HEALTH CARE CORPORATION SHALL PERMIT, BUT SHALL NOT REQUIRE, A MEMBER TO SUBMIT A CLAIM ON A UNIFORM CLAIM FORM.

(3) THE COMMISSIONER IN CONSULTATION WITH REPRESENTATIVES OF STATEWIDE PROFESSIONAL ASSOCIATIONS OF PARTICIPATING PROVIDERS SHALL ESTABLISH BY MAY 1, 1998, IN PLAIN ENGLISH, A UNIFORM CLAIM FORM TO BE USED BY EACH HEALTH CARE CORPORATION FOR PAPER BILLING. IN ESTABLISHING THE UNIFORM CLAIM FORM, THE COMMIS-SIONER SHALL EXAMINE AND STRIVE FOR UNIFORMITY WITH EXISTING NATIONAL FORMS, STANDARDS, AND CODES INCLUDING CPT AND HCFA FORMS, CODES, AND MODIFIERS. THE COMMISSIONER SHALL ANNUALLY REVISE THE UNIFORM CLAIM FORM AND THE REVISIONS SHALL TAKE EFFECT ON JANUARY 1 OF EACH CALENDAR YEAR EXCEPT THAT TEMPORARY REVI-SIONS SHALL TAKE EFFECT WHEN MADE EFFECTIVE BY THE COMMISSIONER.

(4) UPON RECEIPT OF A COMPLETED UNIFORM CLAIM FORM, A HEALTH CARE CORPORATION SHALL PAY THE CLAIM IN THE TIME, MANNER, AND AMOUNT REQUIRED BY THIS ACT, THE APPLICABLE CERTIFICATE, AND PAR-TICIPATING CONTRACT. THE PAYMENT OF THE AMOUNT OF THE CLAIM SHALL BE DETERMINED ACCORDING TO THE HEALTH CARE CORPORATION'S REIMBURSEMENT PRACTICES IN EFFECT ON THE DATE OF SERVICE IDENTI-FIED ON THE UNIFORM CLAIM FORM, NOTWITHSTANDING ANY AGREEMENT TO THE CONTRARY. AS USED IN THIS SUBSECTION, "REIMBURSEMENT PRACTICES" INCLUDES, BUT IS NOT LIMITED TO, CPT, HCPCS, AND

ICD-9-CM CODES, AND FEE SCHEDULES OR METHODS FOR DETERMINING PARTICIPATING PROVIDER PAYMENT.

(5) A HEALTH CARE CORPORATION THAT REQUIRES AN IDENTIFYING NUMBER FOR PARTICIPATING PROVIDERS FOR REFERRED OR ORDERED SERVICES OR TO IDENTIFY SERVICES PERFORMED BY A SPECIFIC PARTICIPATING PROVIDER WHO IS PART OF A PRACTICE GROUP OR A HEALTH CARE FACILITY OR AGENCY SHALL ACCEPT AS THE IDENTIFYING NUMBER THE NATIONAL PARTICIPATING PROVIDER IDENTIFIER ISSUED BY HCFA TO THE PARTICIPATING PROVIDER.

(6) A HEALTH CARE CORPORATION THAT REQUIRES A NUMBER TO IDENTIFY SERVICES REFERRED OR ORDERED BY A PARTICIPATING PROVIDER WHO LACKS A NATIONAL PARTICIPATING PROVIDER IDENTIFIER SHALL ACCEPT THE PARTICIPATING PROVIDER'S LICENSE NUMBER, IF ANY, ISSUED BY THE BUREAU OF OCCUPATIONAL AND PROFESSIONAL REGULATION, DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES, REGARDLESS OF WHETHER THE PARTICIPATING PROVIDER IS PART OF A PRACTICE GROUP OR A HEALTH CARE FACILITY OR AGENCY.

(7) IF A HEALTH CARE CORPORATION HAS DIRECTLY, OR INDIRECTLY BY ARRANGEMENT WITH ANOTHER PERSON, THE CAPABILITY TO RECEIVE CLAIMS BY ELECTRONIC TRANSMISSION, A PARTICIPATING PROVIDER OR OTHER PERSON MAY SUBMIT A CLAIM BY ELECTRONIC TRANSMISSION. THIS SECTION DOES NOT REQUIRE A HEALTH CARE CORPORATION, PARTICIPATING PROVIDER, OR OTHER PERSON TO ACQUIRE THE CAPABILITY TO TRANSMIT OR TO RECEIVE CLAIMS BY ELECTRONIC TRANSMISSION.

(8) IF THE COMMISSIONER HAS PROBABLE CAUSE TO BELIEVE THAT A HEALTH CARE CORPORATION IS VIOLATING OR HAS VIOLATED THIS SECTION, HE OR SHE SHALL GIVE WRITTEN NOTICE TO THE CORPORATION,

PURSUANT TO THE ADMINISTRATIVE PROCEDURES ACT, SETTING FORTH THE GENERAL NATURE OF THE COMPLAINT AGAINST THE CORPORATION AND THE PROCEEDINGS CONTEMPLATED UNDER THIS SECTION. BEFORE THE ISSUANCE OF A NOTICE OF HEARING, THE STAFF OF THE BUREAU OF INSURANCE RESPONSIBLE FOR THE MATTERS THAT WOULD BE AT ISSUE IN THE HEARING SHALL GIVE THE CORPORATION AN OPPORTUNITY TO CONFER AND DISCUSS THE POSSIBLE COMPLAINT AND PROCEEDINGS IN PERSON WITH THE COMMISSIONER OR A REPRESENTATIVE OF THE COMMISSIONER, AND THE MATTER MAY BE DISPOSED OF SUMMARILY UPON AGREEMENT OF THE PARTIES. THIS SUBSECTION SHALL NOT BE CONSTRUED TO DIMINISH THE RIGHT OF A PERSON TO BRING AN ACTION FOR DAMAGES UNDER THIS SECTION.

(9) A HEARING HELD PURSUANT TO SUBSECTION (8) SHALL BE HELD IN ACCORDANCE WITH SECTION 2030 OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.2030, AND PURSUANT TO THE ADMINISTRATIVE PROCEDURES ACT. IF, AFTER THE HEARING, THE COMMISSIONER DETERMINES THAT THE HEALTH CARE CORPORATION IS VIOLATING OR HAS VIOLATED THIS SECTION, THE COMMISSIONER SHALL REDUCE HIS OR HER FINDINGS AND DECISION TO WRITING AND SHALL ISSUE AND CAUSE TO BE SERVED UPON THE CORPORATION A COPY OF THE FINDINGS AND AN ORDER REQUIRING THE CORPORATION TO CEASE AND DESIST FROM ENGAGING IN THE PROHIBITED ACTIVITY. THE COMMISSIONER MAY AT ANY TIME, BY ORDER, AND AFTER NOTICE AND OPPORTUNITY FOR A HEARING, REOPEN AND ALTER, MODIFY, OR SET ASIDE, IN WHOLE OR IN PART, AN ORDER ISSUED BY HIM OR HER UNDER THIS SUBSECTION, WHEN IN HIS OR HER OPINION CONDITIONS OF FACT OR LAW HAVE SO CHANGED AS TO REQUIRE THAT ACTION OR IF THE PUBLIC INTEREST SO REQUIRES.

(10) A HEALTH CARE CORPORATION THAT VIOLATES A CEASE AND DESIST ORDER OF THE COMMISSIONER ISSUED UNDER SUBSECTION (9), AFTER NOTICE AND AN OPPORTUNITY FOR A HEARING, AND UPON ORDER OF THE COMMISSIONER, MAY BE SUBJECT TO A CIVIL FINE OF NOT MORE THAN $1,000.00 FOR EACH VIOLATION.

(11) IN ADDITION TO OTHER REMEDIES PROVIDED BY LAW, AN AGGRIEVED MEMBER MAY BRING AN ACTION FOR ACTUAL MONETARY DAMAGES SUSTAINED AS A RESULT OF A VIOLATION OF THIS SECTION. IF SUCCESSFUL ON THE MERITS, THE MEMBER SHALL BE AWARDED ACTUAL MONETARY DAMAGES OR $200.00, WHICHEVER IS GREATER, TOGETHER WITH REASONABLE ATTORNEY FEES. IF THE HEALTH CARE CORPORATION SHOWS BY A PREPONDERANCE OF THE EVIDENCE THAT A VIOLATION OF THIS SECTION RESULTED FROM A BONA FIDE ERROR NOTWITHSTANDING THE MAINTENANCE OF PROCEDURES REASONABLY ADAPTED TO AVOID THE ERROR, THE AMOUNT OF RECOVERY SHALL BE LIMITED TO ACTUAL MONETARY DAMAGES.

(12) THIS SECTION APPLIES TO ALL CLAIMS SUBMITTED TO A HEALTH CARE CORPORATION ON OR AFTER JULY 1, 1998.

(13) THIS SECTION DOES NOT APPLY TO A PERSON LICENSED, CERTIFIED, OR REGISTERED UNDER PARTS 166 OR 177 OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.16601 TO 333.16648 AND 333.17701 TO 333.17770.

SEC. 403E. A HEALTH CARE CORPORATION SHALL NOT REFUSE TO PAY FOR A COVERED MEDICAL SERVICE PERFORMED ON THE SAME DAY BY THE SAME PROVIDER BY CLAIMING THAT THE MEDICAL SERVICE WAS PART OF ANOTHER MEDICAL SERVICE.