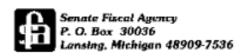
**HEALTH BENEFITS: TIMELY PAYMENT** 





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S.B. 588: COMMITTEE SUMMARY

Senate Bill 588 (as introduced 6-12-03) Sponsor: Senator Shirley Johnson

Committee: Health Policy

Date Completed: 12-3-03

## **CONTENT**

The bill would amend the Insurance Code to include home health care providers and durable medical equipment providers under provisions requiring timely payment of health care benefits.

The Code requires health plans to abide by certain timely payment requirements when paying claims to health professionals and health facilities that are not pharmacies and that do not involve claims arising out of Sections 3101 to 3177 of the Code (which deal with motor vehicle personal and property protection) or the Worker's Disability Compensation Act. Under the bill, the requirements also would apply when a health plan paid claims to home health care providers and durable medical equipment providers.

MCL 500.2006

## **BACKGROUND**

The following timely processing and payment procedures presently apply to health professionals and health facilities, in billing for services rendered, and to health plans in processing and paying claims:

- -- A clean claim must be paid within 45 days after receipt of the claim by the health plan. A clean claim that is not paid within 45 days bears simple interest at an annual rate of 12%.
- -- A health plan must notify the provider within 30 days after receiving the claim of all known reasons that prevent it from being a clean claim.
- -- A provider has 45 days, and any additional time the health plan permits, after receiving the notice to correct all defects in the claim.
- -- If a provider's response makes the claim a clean claim, the health plan must pay the provider within the 45-day time period.
- -- If a provider's response does not make the claim a clean claim, the health plan must notify the provider of an adverse claim determination and of the reasons for it within the 45-day time period.
- -- A provider must bill a health plan within one year after the date of service or discharge from a health facility in order for a claim to be a clean claim.
- -- A provider may not resubmit the same claim to the health plan unless the 45-day time period has passed.

Notices required under these provisions must be made either in writing or electronically.

If a health plan determines that at least one of the services listed on a claim is payable, the health plan must pay for the payable services and may not deny the entire claim because other services listed are defective. This requirement does not apply if the provider has an overriding contractual reimbursement arrangement.

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A health plan may not terminate the affiliation status or the participation of a provider with a health maintenance organization provider panel or otherwise discriminate against a provider because the provider claims that a health plan has violated the timely payment requirements. A provider alleging that a timely processing or payment procedure has been violated may file a complaint with the Commissioner of the Office of Financial and Insurance Services and has a right to determination of the matter by the Commissioner or his or her designee. A provider is not prohibited from seeking court action.

In addition to any other penalty provided for by law, the Commissioner may impose a civil fine of up to \$1,000 for each violation not to exceed \$10,000 in the aggregate for multiple violations.

A clean claim is one that is a claim for covered services for an eligible individual and does all of the following:

- -- Identifies the provider that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.
- -- Sufficiently identifies the patient and health plan subscriber.
- -- Lists the date and place of service.
- -- If necessary, substantiates the medical necessity and appropriateness of the service provided.
- -- If prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained.
- -- Identifies the service rendered using a generally accepted system of procedure or service coding.
- -- Includes additional documentation based upon services rendered as reasonably required by the health plan.

Legislative Analyst: Julie Koval

## **FISCAL IMPACT**

The bill would have no fiscal impact on State or local government.

Fiscal Analyst: Maria Tyszkiewicz

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.