



Senate

General Assembly

January Session, 2003

File No. 217

Senate Bill No. 351

Senate, April 8, 2003

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT CONCERNING DEFICIENCIES IN INSURANCE CLAIM INFORMATION.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subdivision (15) of section 38a-816 of the general statutes
2 is repealed and the following is substituted in lieu thereof (*Effective*
3 *October 1, 2003*):

4 (15) (A) Failure by an insurer, or any other entity responsible for
5 providing payment to a health care provider pursuant to an insurance
6 policy, to pay accident and health claims, including, but not limited to,
7 claims for payment or reimbursement to health care providers, within
8 the time periods set forth in subparagraph (B) of this subdivision,
9 unless the Insurance Commissioner determines that a legitimate
10 dispute exists as to coverage, liability or damages or that the claimant
11 has fraudulently caused or contributed to the loss. Any insurer, or any
12 other entity responsible for providing payment to a health care
13 provider pursuant to an insurance policy, who fails to pay such a claim

14 or request within the time periods set forth in subparagraph (B) of this
15 subdivision shall pay the claimant or health care provider the amount
16 of such claim plus interest at the rate of fifteen per cent per annum, in
17 addition to any other penalties which may be imposed pursuant to
18 sections 38a-11, 38a-25, 38a-41 to 38a-53, inclusive, 38a-57 to 38a-60,
19 inclusive, 38a-62 to 38a-64, inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to
20 38a-124, inclusive, 38a-129 to 38a-140, inclusive, 38a-146 to 38a-155,
21 inclusive, 38a-283, 38a-288 to 38a-290, inclusive, 38a-319, 38a-320, 38a-
22 459, 38a-464, 38a-815 to 38a-819, inclusive, 38a-824 to 38a-826,
23 inclusive, and 38a-828 to 38a-830, inclusive. Whenever the interest due
24 a claimant or health care provider pursuant to this section is less than
25 one dollar, the insurer shall deposit such amount in a separate interest-
26 bearing account in which all such amounts shall be deposited. At the
27 end of each calendar year each such insurer shall donate such amount
28 to The University of Connecticut Health Center.

29 (B) Each insurer, or other entity responsible for providing payment
30 to a health care provider pursuant to an insurance policy subject to this
31 section, shall pay claims not later than forty-five days after receipt by
32 the insurer of the claimant's proof of loss form or the health care
33 provider's request for payment filed in accordance with the insurer's
34 practices or procedures, except that when there is a deficiency in the
35 information needed for processing a claim, as determined in
36 accordance with section 38a-477, as amended by this act, the insurer
37 shall (i) send written notice to the claimant or health care provider, as
38 the case may be, of all alleged deficiencies in information needed for
39 processing a claim not later than thirty days after the insurer receives a
40 claim for payment or reimbursement under the contract, and (ii) pay
41 claims for payment or reimbursement under the contract not later than
42 thirty days after the insurer receives the information requested.

43 (C) As used in this subdivision, "health care provider" means a
44 person licensed to provide health care services under chapter 368v,
45 chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c,
46 inclusive, or chapter 400j.

47 Sec. 2. Section 38a-477 of the general statutes is repealed and the
48 following is substituted in lieu thereof (*Effective October 1, 2003*):

49 (a) Except where there is an agreement to the contrary between a
50 third-party payer and the health care provider, as defined in section
51 19a-17b, all health care providers shall submit all third-party claims for
52 payment on the current standard Health Care Financing
53 Administration Fifteen Hundred (HCFA1500) health insurance claim
54 form or its successor, or in the case of a hospital or other health care
55 institution, a [UB-82] Health Care Financing Administration UB-92
56 health insurance claim form or its successor, or in accordance with
57 other forms which may be prescribed by the Insurance Commissioner.

58 (b) For any claim submitted to an insurer on the current standard
59 Health Care Financing Administration Fifteen Hundred health
60 insurance claim form or its successor, if the following information is
61 completed and received by the insurer, the claim may not be deemed
62 to be deficient in the information needed for processing a claim
63 pursuant to subdivision (15) of section 38a-816, as amended by this act.

T1	<u>Item Number</u>	<u>Item Description</u>
T2	<u>1a</u>	<u>Insured's identification number</u>
T3	<u>2</u>	<u>Patient's name</u>
T4	<u>3</u>	<u>Patient's birth date and sex</u>
T5	<u>4</u>	<u>Insured's name</u>
T6	<u>10a</u>	<u>Patient's condition - employment</u>
T7	<u>10b</u>	<u>Patient's condition - auto accident</u>
T8	<u>10c</u>	<u>Patient's condition - other accident</u>
T9	<u>11</u>	<u>Insured's policy group number</u>
T10		<u>(if provided on identification card)</u>
T11	<u>11d</u>	<u>Is there another health benefit plan?</u>
T12	<u>17a</u>	<u>Identification number of referring physician</u>
T13		<u>(if required by insurer)</u>
T14	<u>21</u>	<u>Diagnosis</u>
T15	<u>24A</u>	<u>Dates of service</u>
T16	<u>24B</u>	<u>Place of service</u>
T17	<u>24D</u>	<u>Procedures, services or supplies</u>
T18	<u>24E</u>	<u>Diagnosis code</u>

T19	<u>24F</u>	<u>Charges</u>
T20	<u>25</u>	<u>Federal tax identification number</u>
T21	<u>28</u>	<u>Total charge</u>
T22	<u>31</u>	<u>Signature of physician or supplier with date</u>
T23	<u>33</u>	<u>Physician's, supplier's billing name,</u>
T24		<u>address, zip code & telephone number</u>

64 (c) For any claim submitted to an insurer on the current standard
65 Health Care Financing Administration UB-92 health insurance claim
66 form or its successor, if the following information is completed and
67 received by the insurer, the claim may not be deemed to be deficient in
68 the information needed for processing a claim pursuant to subdivision
69 (15) of section 38a-816, as amended by this act.

	<u>Item Number</u>	<u>Item Description</u>
T25	<u>1</u>	<u>Provider name and address</u>
T26	<u>5</u>	<u>Federal tax identification number</u>
T27	<u>6</u>	<u>Statement covers period</u>
T28	<u>12</u>	<u>Patient name</u>
T29	<u>14</u>	<u>Patient's birth date</u>
T30	<u>15</u>	<u>Patient's sex</u>
T31	<u>17</u>	<u>Admission date</u>
T32	<u>18</u>	<u>Admission hour</u>
T33	<u>19</u>	<u>Type of admission</u>
T34	<u>21</u>	<u>Discharge hour</u>
T35	<u>42</u>	<u>Revenue codes</u>
T36	<u>43</u>	<u>Revenue description</u>
T37	<u>44</u>	<u>HCPCS/CPT4 codes</u>
T38	<u>45</u>	<u>Service date</u>
T39	<u>46</u>	<u>Service units</u>
T40	<u>47</u>	<u>Total charges by revenue code</u>
T41	<u>50</u>	<u>Payer identification</u>
T42	<u>51</u>	<u>Provider number</u>
T43	<u>58</u>	<u>Insured's name</u>
T44	<u>60</u>	<u>Patient's identification number (policy</u>
T45		<u>number and/or Social Security number)</u>
T46	<u>62</u>	<u>Insurance group number (if on identification</u>
T47		<u>card)</u>
T48	<u>67</u>	<u>Principal diagnosis code</u>
T49	<u>76</u>	<u>Admitting diagnosis code</u>
T50		

T51	<u>80</u>	<u>Principle procedure code and date</u>
T52	<u>81</u>	<u>Other procedures code and date</u>
T53	<u>82</u>	<u>Attending physician's identification number</u>

70 [(b)] (d) The commissioner may adopt regulations, in accordance
71 with [the provisions of] chapter 54, to implement the provisions of
72 [subsection (a) of] this section.

This act shall take effect as follows:	
Section 1	<i>October 1, 2003</i>
Sec. 2	<i>October 1, 2003</i>

INS *Joint Favorable*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Type	FY 04 \$	FY 05 \$
Insurance Dept.	IF - None	None	None

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

The bill affects the format of filing of health insurance claims and does not result in a fiscal impact to the state.

OLR Bill Analysis

SB 351

AN ACT CONCERNING DEFICIENCIES IN INSURANCE CLAIM INFORMATION**SUMMARY:**

This bill establishes the minimum information needed for a health care provider's claim for payment to be complete for processing under the law requiring timely payment of claims and not to be considered deficient. The claim must be submitted to an insurer on the standard Health Care Financing Administration (HCFA) 1500 or UB-92 form or their successor forms.

EFFECTIVE DATE: October 1, 2003

HCFA 1500 CLAIMS FORM

<i>Item Number</i>	<i>Item Description</i>
1a	Insured's identification number
2	Patent's name
3	Patient's birth date and sex
4	Insured's name
10a	Patient's condition-employment
10b	Patient's condition-auto accident
10c	Patient's condition-other accident
11	Insured's policy group number (if provided on the identification card)
11d	Is there another health benefit plan?
17a	Identification number of referring physician (if required by insurer)
21	Diagnosis
24A	Dates of service
24B	Place of service
24D	Procedures, service or supplies
24E	Diagnosis code
24F	Charges
25	Federal tax identification number

28	Total charge
31	Signature of physician or supplier with date
33	Physician's, supplier's billing name, address, zip code and telephone number

UB-92 CLAIMS FORM

<i>Item Number</i>	<i>Item Description</i>
1	Provider name and address
5	Federal tax identification number
6	Statement covers period
12	Patient name
14	Patient's birth date
15	Patient's sex
17	Admission date
18	Admission hour
19	Type of admission
21	Discharge hour
42	Revenue codes
43	Revenue description
44	HCPCS/CPT4 codes
45	Service date
46	Service units
47	Total charges by revenue code
50	Payer identification
51	Provider number
58	Insured's name
60	Patient's identification number (policy or Social Security number)
62	Insurance group number (if on identification card)
67	Principal diagnosis code
76	Admitting diagnosis code
80	Principle procedure code and date
81	Other procedures code and date
82	Attending physician's identification number

BACKGROUND

Timely Payment and Unfair and Prohibited Insurance Practice

The law requires insurers and other entities responsible for paying health care providers under an insurance policy to pay claims within

45 days after the claimant's insurer receives the proof of loss form or the health care provider's request for payment is filed according to the insurer's practice or procedure. When there is a deficiency in the information needed to process the claim, the insurer must (1) send written notice to the claimant or health care provider of all alleged deficiencies in information needed to process the claim within 30 days after the insurer receives a claim for payment or reimbursement, and (2) pay the claim within 30 days after the insurer receives the information requested.

Insurers and others that fail to pay claims in a timely manner must pay the claim plus 15% interest in addition to other penalties that may be imposed. The failure is also an unfair and deceptive act or practice in the business of insurance. The insurance commissioner, after notice and hearing, may (1) issue a cease and desist order, (2) order the payment of a monetary penalty of up to \$1,000 for each act or practice or up to \$10,000 for egregious acts or practices, (3) suspend or revoke a license, or (4) demand restitution.

Related Bill

Substitute House Bill 6444 establishes an administrative appeal for health care providers who are aggrieved by a claim or reimbursement recoding. Recoding is changing health care service codes or group of codes by managed care organizations to lower the amount paid to providers.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Report

Yea 12 Nay 6