GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H **2**

HOUSE BILL 1066
Committee Substitute Favorable 5/1/03

Short Title: Health Plans Disclose Fee Schedules/Coding.	(Public)
Sponsors:	
Referred to:	

April 10, 2003

A BILL TO BE ENTITLED

AN ACT TO FACILITATE THE SUBMISSION OF COMPLETE CLAIMS BY PROVIDERS UNDER HEALTH BENEFIT PLANS BY REQUIRING HEALTH BENEFIT PLANS TO DISCLOSE TO CONTRACT PROVIDERS THE PLANS' SCHEDULES OF FEES AND CLAIMS SUBMISSION AND REIMBURSEMENT POLICIES, AND TO PROVIDE NOTICE TO THE PROVIDER PRIOR TO IMPLEMENTING CHANGES TO THE SCHEDULES OR POLICIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-225 is amended by adding the following new subsection to read:

"(n) In order to facilitate submission of complete claims by providers:

(1) Insurers shall make available to contracted health care providers the information listed in subdivision (2) of this subsection and shall provide to contracted health care providers advance notice of changes to the information listed in subdivision (2) of this subsection. Notice of a change in reimbursement policy shall be given at least 30 days prior to implementing the change. The notice period for a change in a schedule of fees shall be the contractual notice period, but in no event shall such notices be given less than 30 days prior to the change. If a provider contract does not include such a termination without cause provision, or if a contract requires mutual written consent prior to schedule of fees changes such notices shall be given not less than 30 days prior to the change. No advance notice must be provided for the information in subdivision (2)a. of this subsection if the change has the effect of increasing fees, expanding health benefit plan coverage, or is made for patient safety considerations, in which case such notification may be made concurrent with the change. Information may be made available in any medium selected by the insurer, including an electronic medium, and notice of change may also be provided in the

medium of the insurer's choosing. Advance notice may be made by communicating with contracted providers via an electronic mailing list or other electronic means.

(2) a. An insurer shall make available to contracted providers the following:

1. The insurer's schedule of fees associated with the top 30 services or procedures most commonly billed by that class of provider, and, upon request, the full fee schedule for services or procedures billed by that class of provider; and

2. In the case of a contract incorporating multiple classes of providers, the insurer's schedule of fees associated with the top 30 services or procedures most commonly billed for each class of provider, and, upon request, the full fee schedule for services or procedures billed for each class of provider; and

3. A description of the insurer's claim submission and reimbursement policies.

b. In a case where an insurer makes reference to source information that is the basis for fees or a reimbursement policy and that source information is outside of the control of the insurer, the insurer's clear identification of the source and information on how the provider may readily access the source information shall satisfy the requirement to make the fees or policy available.

(3) For providers offered a contract by an insurer, the insurer shall make available its schedule of fees associated with the top 30 services or procedures most commonly billed by that class of provider, and, upon request, the full fee schedule for services or procedures billed by that class of provider, or for each class of provider in the case of a contract incorporating multiple classes of providers.

(4) Nothing herein shall prevent an insurer from requiring that providers keep confidential, and not disclose to third parties, the fee information provided under this subsection.

(5) Providers shall submit claims in accordance with insurers' claim submission and reimbursement policies.

(6) As used in this subsection, the term 'schedule of fees' includes, if applicable, CPT, HCPCS, ICD-9-CM codes, modifiers, and other applicable codes for the procedures most commonly billed for that class of provider.

(7) As used in this subsection, the term reimbursement policy means information relating to payment and including the following as applicable:

a. Policies on claims bundling and other claims editing processes;

b. Policies on recognition or nonrecognition of CPT code modifiers;
c. Policies on downcoding of services or procedures;
d. Definitions of global surgery periods;
e. Policies on multiple surgical procedures; and
f. Policies related to payment based on the relationship of procedure code to diagnosis code.

(8) As used in this subsection, the term 'insurer' shall not include an insurance company, service corporation, health maintenance organization, or multiple employee welfare arrangement that writes stand alone dental insurance.

(9) Insurers' provider contracts shall indicate the availability of the information required to be provided under this subsection.

(10) Except for the notice of changes to schedules of fees in subdivision (1) and the information required to be provided in subdivision (2)a.1. of this subsection, this subsection does not apply to claims processed by an insurer on a claims adjudication system that was implemented prior to January 1, 1982, provided that the insurer:
a. Verifies with the Commissioner that its claims adjudication system qualified under this subsection; and
b. Is implementing a new claims adjudication software system as soon as possible and in any event no later than December 31, 2004. This subdivision (10) shall expire on January 1, 2005.

(11) Except for the notice of changes to schedules of fees in subdivision (1) of this subsection, this subsection does not apply to claims processed by the Teachers' and State Employees' Comprehensive Major Medical Plan until December 31, 2005. This subdivision shall expire January 1, 2006."

SECTION 2. G.S. 58-3-191(b) is amended by adding the following new subdivision to read:

"**§ 58-3-191. Managed care reporting and disclosure requirements.**

(a) Each health benefit plan shall annually, on or before the first day of March of each year, file in the office of the Commissioner the following information for the previous calendar year:

…

(6) Aggregate data on requests for schedules of fees and reimbursement policies from participating providers under G.S. 58-3-225(n) and the health benefit plans' responses to those requests."

SECTION 3. Subdivisions (2)a.1. and (2)a.2. of this subsection are effective when they become law for contracts issued, modified, or renewed after that date. The remainder of this act becomes effective January 1, 2004.