GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

HOUSE BILL 1066
RATIFIED BILL

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. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-227. Health plans fee schedules.**

(a) Definitions. – As used in this section, the following terms mean:

(1) Claim submission policy. – The procedure adopted by an insurer and used by a provider or facility to submit to the insurer claims for services rendered and to seek reimbursement for those services.

(2) Health care facility or facility. – A facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.

(3) Health care provider or provider. – An individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program.

(4) Insurer. – An entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter, except it does not include an entity that writes stand alone dental insurance.

(5) Reimbursement policy. – Information relating to payment of providers and facilities including policies on the following:

a. Claims bundling and other claims editing processes.
b. Recognition or nonrecognition of CPT code modifiers.
c. Downcoding of services or procedures.
d. The definition of global surgery periods.
e. Multiple surgical procedures.
f. Payment based on the relationship of procedure code to diagnosis code.

(6) Schedule of fees. – CPT, HCPCS, ICD-9-CM codes, ASA codes, modifiers, and other applicable codes for the procedures billed for that class of provider.

(b) Purpose. – The purpose of this section is to establish the minimum required provisions for the disclosure and notification of an insurer's schedule of fees, claims submission, and reimbursement policies to health care providers and health care

facilities. Nothing in this section shall supercede (i) the schedule of fees, claim submission, and reimbursement policy terms in an insurer's contract with a provider or facility that exceed the minimum requirements of this section nor (ii) any contractual requirement for mutual written consent of changes to reimbursement policies, claims submission policies, or fees. Nothing in this section shall prevent an insurer from requiring that providers and facilities keep confidential, and not disclose to third parties, the information that an insurer must provide under this section.

(c) Disclosure of Fee Schedules. – An insurer shall make available to contracted providers the following information:

(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 schedule of fees for services or procedures billed by that class of provider, in accordance with subdivision (3) of this subsection.

(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 schedule of fees for services or procedures billed for each class of provider, in accordance with subdivision (3) of this subsection.

(3) If a provider requests fees for more than 30 services and procedures, the insurer may require the provider to specify the additional requested services and procedures and may limit the provider's access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by the provider. The insurer may also limit the frequency of requests for the additional codes by each provider, provided that such additional codes will be made available upon request at least annually and at any time there are changes for which notification is required pursuant to subsection (f) of this section.

(d) Disclosure of Policies. – An insurer shall make available to contracted providers and facilities a description of the insurer's claim submission and reimbursement policies.

(e) Availability of Information. – Insurers shall notify contracted providers and facilities in writing of the availability of information required or authorized to be provided under this section. An insurer may satisfy this requirement by indicating in the contract with the provider the availability of this information or by providing notice in a manner authorized under subsection (f) of this section for notification of changes.

(f) Notification of Changes. – Insurers shall provide advance notice to providers and facilities of changes to the information that insurers are required to provide under this section. The notice period for a change in the schedule of fees, reimbursement policies, or submission of claims policies shall be the contractual notice period, but in no event shall the notices be given less than 30 days prior to the change. An insurer is not required to provide advance notice of changes to the information required under this section if the change has the effect of increasing fees, expanding health benefit plan coverage, or is made for patient safety considerations, in which case, notification of the changes may be made concurrent with the implementation of the changes. Information and notice of changes may be provided in the medium selected by the insurer, including an electronic medium. However, the insurer must inform the affected contracted provider or facility of the notification method to be used by the insurer and, if the insurer uses an electronic medium to provide notice of changes required under this section, the insurer shall provide clear instructions regarding how the provider or facility may access the information contained in the notice.

(g) Reference Information. – If an insurer references source information that is the basis for a schedule of fees, reimbursement policy, or claim submission policy, and

the source information is developed independently of the insurer, the insurer may satisfy the requirements of this section by providing clear instructions regarding how the provider or facility may readily access the source information or by providing for actual access if agreed to in the contract between the insurer and the provider.

(h) Contract Negotiations. – When an insurer offers a contract to a provider, the insurer shall also make available its schedule of fees associated with the top 30 services or procedures most commonly billed by that class of provider. Upon the request of a provider, the insurer shall also make available the full schedule of fees 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. If a provider requests fees for more than 30 services and procedures, the insurer may require the provider to specify the additional requested services and procedures and may limit the provider's access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by the provider.

(i) Exemptions. – Except for the information required to be provided under subsection (c) of this section, this section does not apply to:

(1) Claims processed by an insurer on a claims adjudication system that was implemented prior to January 1, 1982, provided that the insurer (i) verifies with the Commissioner that its claims adjudication system qualified under this subsection, (ii) is implementing a new claims adjudication software system, and (iii) is proceeding in good faith to move all insured claims to the new system as soon as possible and in any event no later than December 31, 2004; or

(2) Information that the insurer verifies with the Commissioner is required to be provided by the terms of a national settlement agreement between the insurer and trade associations representing certain providers, provided that the agreement is approved prior to March 1, 2004, by the court having jurisdiction over the settlement. The exemption provided in this subdivision shall be limited to those terms of the agreement that are required to be implemented no later than December 31, 2004. Nothing in this subdivision shall be construed to relieve the insurer of complying with any terms and deadlines as set out in the agreement."

SECTION 2. On or before the applicable effective dates, each insurer shall provide to the Commissioner of Insurance a written description of the policies and procedures to be used by the insurer to comply with this act.

SECTION 3. Sections 2 and 3 of this act are effective when they become law. Subsection (c) of G.S. 58-3-227, as enacted by Section 1 of this act, becomes effective January 1, 2004, and applies to the earlier of the following: (i) a contract issued, renewed, or modified on or after January 1, 2004; or (ii) any fee schedule request made on or after July 1, 2004. The remainder of this act becomes effective March 1, 2004. Subsection (i) of G.S. 58-3-227 as enacted by Section 1 of this act, expires on January 1, 2005.

In the General Assembly read three times and ratified this the 18th day of July, 2003.

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Beverly E. Perdue
President of the Senate

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Richard T. Morgan
Speaker of the House of Representatives

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Michael F. Easley
Governor

Approved _____.m. this _____ day of _____, 2003