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HOUSE BILL NO. 484

AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the House Committee on Labor and Commerce
on _____)

(Patron Prior to Substitute—Delegate Shin)

A BILL to amend and reenact § 38.2-3407.15 of the Code of Virginia, relating to health insurance; ethics and fairness in carrier business practices; downcoded claims.

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3407.15 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-3407.15. Ethics and fairness in carrier business practices.

A. As used in this section:

"Carrier," "enrollee," and "provider" shall have the meanings set forth in § 38.2-3407.10; however, a "carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.

"Clean claim" means a claim that does all of the following:

1. Identifies the provider that provided the service with industry-standard identification criteria, including billing and rendering provider names, identification numbers, and address;

2. Identifies the patient with a carrier-assigned identification number so the carrier can verify the patient was an enrollee at the time of service;

3. Identifies the service rendered using an industry-standard system of procedure or service coding, or, if applicable, a methodology required under the provider contract. The claim shall include a complete listing of all relevant diagnoses, procedures, and service codes, as well as any applicable modifiers;

4. Specifies the date and place of service;

5. If prior authorization is required for the services listed in the claim, contains verification that prior authorization was obtained in accordance with the provider contract for those services; and

6. Includes additional documentation specific to the services rendered as required by the carrier in its provider contract.

Notwithstanding the above criteria, a claim shall be considered a clean claim if a carrier has failed timely to notify the person submitting the claim of any defect or impropriety in accordance with this section.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or

certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.

"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other payments currently owed to the provider, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the provider.

B. Every provider contract entered into by a carrier shall contain specific provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific

60 information available for review by the person submitting the claim that:

61 a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or
62 dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a
63 person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of
64 the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which
65 services were accessed or provided; or

66 b. The claim was submitted fraudulently.

67 Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person
68 submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any
69 other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic
70 or facsimile confirmation of receipt of a claim.

71 2. A carrier shall, within 30 days after receipt of a claim, notify the person submitting the claim of any
72 defect or impropriety that prevents the carrier from deeming the claim a clean claim and request the
73 information that will be required to process and pay the claim. Upon receipt of the additional information
74 necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in
75 compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant
76 to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the
77 person submitting the claim of the matters identified above unless such failure was caused in material part by
78 the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a
79 retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive
80 denial of payment of the claim would violate subdivision 8. Beginning no later than January 1, 2026, all
81 notifications and information required under this subdivision shall be delivered electronically.

82 3. Any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1, under any provider
83 contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without
84 necessity of demand, at the time the claim is paid or within 60 days thereafter.

85 4. A carrier shall notify the provider in the provider contract if the carrier, or entity completing a
86 transaction on behalf of the carrier, uses a payment method that imposes a transaction or processing fee or
87 similar charge on the provider, and shall offer the provider an alternative payment method in which the
88 carrier, or entity completing a transaction on behalf of the carrier, does not impose such a fee or similar
89 charge. If the provider elects to accept the alternative payment method and has provided all required
90 information to the carrier to enroll in such alternative method, the carrier shall pay the claim using such
91 alternative payment method.

92 5. a. Every carrier shall establish and implement reasonable policies to permit any provider with which
93 there is a provider contract (i) to confirm in advance during normal business hours by free telephone or
94 electronic means if available whether the health care services to be provided are medically necessary and a
95 covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of
96 health care services which the provider has contracted to deliver under the provider contract) for (a) pre-
97 certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or
98 authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific
99 payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of
100 claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet
101 the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a
102 carrier routinely, as a matter of policy, bundles or downcodes claims submitted by a provider, the carrier shall
103 clearly disclose that practice in each provider contract. Further, such carrier shall either (1) disclose in its
104 provider contracts or on its website the specific bundling and downcoding policies that the carrier reasonably
105 expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (2)
106 disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to
107 request the specific bundling and downcoding policies that the carrier reasonably expects to be applied to that
108 provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf
109 of a provider, a carrier shall provide the requesting provider with such policies within 10 business days
110 following the date the request is received.

111 b. *No carrier or intermediary, administrator, or representative of a carrier shall downcode a claim unless
112 the decision to downcode is determined by a natural person or an electronic system that reflects correct
113 coding standards and considers all relevant patient data documented by the billing provider on the claim
114 submission in such determination. Any carrier, intermediary, administrator, or representative that
115 downcodes a claim shall notify the provider submitting the claim that such claim has been downcoded and
116 shall identify the associated claim adjustment reason codes and remittance advice remark codes on the
117 remittance device. Each carrier shall communicate to network providers the process for disputing
118 downcoded claims, including a reasonable timeline for the submission of a dispute that is at least 180 days
119 after receipt of notice of a downcoded claim and reasonable timelines for the adjudication of a dispute and
120 any subsequent appeal. All downcoding dispute decisions shall be reviewed and adjudicated by a natural
121 person. The process to initiate a dispute for a downcoding decision shall be included on the explanation of*

122 *payment of remittance device. A person disputing more than one claim that was downcoded by a carrier,*
 123 *intermediary, administrator, or representative may dispute in batches of claims for each individual patient in*
 124 *accordance with the provider contract and the federal Health Insurance Portability and Accountability Act*
 125 *(42 U.S.C. § 1320d et seq.) and any rules, regulations, or procedures adopted pursuant thereto. No provision*
 126 *of this subdivision shall apply to limited-scope benefits, including stand-alone dental plans.*

127 c. Every carrier shall make available to such providers within 10 business days of receipt of a request,
 128 copies of or reasonable electronic access to all such policies which are applicable to the particular provider or
 129 to particular health care services identified by the provider. In the event the provision of the entire policy
 130 would violate any applicable copyright law, the carrier may instead comply with this subsection by timely
 131 delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care
 132 services identified by the provider.

133 6. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has
 134 advised the provider or enrollee in advance of the provision of health care services that the health care
 135 services are medically necessary and a covered benefit, unless:

136 a. The documentation for the claim provided by the person submitting the claim clearly fails to support the
 137 claim as originally authorized;

138 b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has
 139 already been paid for the health care services identified on the claim, (iii) the claim was submitted
 140 fraudulently or the authorization was based in whole or material part on erroneous information provided to
 141 the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the
 142 health care services was not eligible to receive them on the date of service and the carrier did not know, and
 143 with the exercise of reasonable care could not have known, of the person's eligibility status; or

144 c. During the post-service claims process, it is determined that the claim was submitted fraudulently.

145 7. In the case of an invasive or surgical procedure, if the carrier has previously authorized a health care
 146 service as medically necessary and during the procedure the health care provider discovers clinical evidence
 147 prompting the provider to perform a less or more extensive or complicated procedure than was previously
 148 authorized, then the carrier shall pay the claim, provided that the additional procedures were (i) not
 149 investigative in nature, but medically necessary as a covered service under the covered person's benefit plan;
 150 (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant with a carrier's
 151 post-service claims process, including required timing for submission to carrier.

152 8. No carrier shall impose any retroactive denial of a previously paid claim or in any other way seek
 153 recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or
 154 claims for which the retroactive denial is to be imposed or the recovery or refund is sought, the carrier has
 155 provided a written explanation of why the claim is being retroactively adjusted, and (i) the original claim was
 156 submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid
 157 for the health care services identified on the claim or the health care services identified on the claim were not
 158 delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original
 159 challenged claim does not exceed 12 months. Notwithstanding the provisions of clause (iii), a provider and a
 160 carrier may agree in writing that recoupment of overpayments by withholding or offsetting against future
 161 payments may occur after such 12-month limit for the imposition of the retroactive denial. A carrier shall
 162 notify a provider at least 30 days in advance of any retroactive denial or recovery or refund of a previously
 163 paid claim.

164 Beginning no later than January 1, 2026, all written communications, explanations, notifications, and
 165 related provider responses applicable to this subdivision shall be delivered electronically. The electronic
 166 method and location for delivery shall be agreed upon by the carrier and provider and included in the
 167 provider contract.

168 9. No provider contract shall fail to include or attach at the time it is presented to the provider for
 169 execution (i) the fee schedule, reimbursement policy, or statement as to the manner in which claims will be
 170 calculated and paid that is applicable to the provider or to the range of health care services reasonably
 171 expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules,
 172 and exhibits thereto and any policies (including those referred to in subdivision 5) applicable to the provider
 173 or to the range of health care services reasonably expected to be delivered by that type of provider under the
 174 provider contract.

175 10. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new
 176 addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services
 177 reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the
 178 provider has been provided with the applicable portion of the proposed amendment (or of the proposed new
 179 addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has
 180 failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention
 181 to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

182 11. In the event that the carrier's provision of a policy required to be provided under subdivision 9 or 10
 183 would violate any applicable copyright law, the carrier may instead comply with this section by providing a

184 clear, written explanation of the policy as it applies to the provider.

185 12. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this
186 information available to providers. If a carrier's claim denial is overturned following completion of a dispute
187 review, the carrier shall, on the day the decision to overturn is made, consider the claims impacted by such
188 decision as clean claims. All applicable laws related to the payment of a clean claim shall apply to the
189 payments due.

190 13. Every carrier shall include in its provider contracts a provision that prohibits a provider from
191 discriminating against any enrollee solely due to the enrollee's status as a litigant in pending litigation or a
192 potential litigant due to being involved in a motor vehicle accident. Nothing in this subdivision shall require a
193 health care provider to treat an enrollee who has threatened to make or has made a professional liability claim
194 against the provider or the provider's employer, agents, or employees or has threatened to file or has filed a
195 complaint with a regulatory agency or board against the provider or the provider's employer, agents, or
196 employees.

197 14. Beginning July 1, 2025, every carrier shall make available through electronic means a way for
198 providers to determine whether an enrollee is covered by a health plan that is subject to the Commission's
199 jurisdiction.

200 C. A provider shall not file a complaint with the Commission for failure to pay claims in accordance with
201 subdivision B 1 unless:

202 1. Such provider has made a reasonable effort to confer with the carrier in order to resolve the issues
203 related to all claims that are under dispute. Any request to confer shall be made to the contact listed for such
204 purpose in the provider contract and shall include supporting documentation sufficient for the carrier to
205 identify the claims in question; and

206 2. At least 30 calendar days have passed from the date of the request provided that the carrier has been
207 responsive to the provider's request to confer. However, if in the judgment of the provider, the carrier has not
208 been responsive to such request, the provider shall not be required to wait at least 30 calendar days to file the
209 complaint.

210 The provider shall attest in any such complaint that it has satisfied the provisions of this subsection.

211 D. If the Commission has cause to believe that any provider has engaged in a pattern of potential
212 violations of subdivision B 13, with no corrective action, the Commission may submit information to the
213 Board of Medicine or the Commissioner of Health for action. Prior to such submission, the Commission may
214 provide the provider with an opportunity to cure the alleged violations or provide an explanation as to why
215 the actions in question were not violations. If any provider has engaged in a pattern of potential violations of
216 subdivision B 13, with no corrective action, the Board of Medicine or the Commissioner of Health may levy
217 a fine or cost recovery upon the provider and take other action as permitted under its authority. Upon
218 completion of its review of any potential violation submitted by the Commission or initiated directly by an
219 enrollee, the Board of Medicine or the Commissioner of Health shall notify the Commission of the results of
220 the review, including where the violation was substantiated, and any enforcement action taken as a result of a
221 finding of a substantiated violation.

222 E. Without limiting the foregoing, in the processing of any payment of claims for health care services
223 rendered by providers under provider contracts and in performing under its provider contracts, every carrier
224 subject to regulation by this title shall adhere to and comply with the minimum fair business standards
225 required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has
226 violated the standards set forth in subsection B by failing to include the requisite provisions in its provider
227 contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair
228 business standards set out in subdivisions B 1 and 2 in the performance of its provider contracts.

229 F. No carrier shall be in violation of this section if its failure to comply with this section is caused in
230 material part by the person submitting the claim or if the carrier's compliance is rendered impossible due to
231 matters beyond the carrier's reasonable control (such as an act of God, insurrection, strike, fire, or power
232 outages) which are not caused in material part by the carrier.

233 G. Any provider who suffers loss as the result of a carrier's violation of this section or a carrier's breach of
234 any provider contract provision required by this section shall be entitled to initiate an action to recover actual
235 damages. If the trier of fact finds that the violation or breach resulted from a carrier's gross negligence and
236 willful conduct, it may increase damages to an amount not exceeding three times the actual damages
237 sustained. Notwithstanding any other provision of law to the contrary, in addition to any damages awarded,
238 such provider also may be awarded reasonable attorney fees and court costs. Each claim for payment which is
239 paid or processed in violation of this section or with respect to which a violation of this section exists shall
240 constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this
241 subsection.

242 H. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the
243 employment or other contractual relationship with a provider, or any provider contract, or otherwise penalize
244 any provider, for invoking any of the provider's rights under this section or under the provider contract.

245 I. Except where otherwise provided in this section, beginning no later than July 1, 2025, carriers shall

246 deliver provider contracts, related amendments, and notices exclusively to providers in an electronic format
247 other than electronic facsimile. Beginning no later than January 1, 2026, the provider shall submit provider
248 contracts, amendments, and notices to carriers exclusively in an electronic format other than electronic
249 facsimile. The electronic method and location for delivery shall be agreed upon by the carrier and provider
250 and included in the provider contract.

251 J. This section shall apply only to carriers subject to regulation under this title and shall apply to the
252 carrier and provider, regardless of any vendors, subcontractors, or other entities that have been contracted by
253 the carrier or the provider to perform duties applicable to this section.

254 K. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and
255 regulations as it may deem necessary to implement this section.

256 L. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this
257 section.