

HOUSE BILL NO. 123

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Labor and Commerce

on \_\_\_\_\_)

(Patron Prior to Substitute--Delegate Sullivan)

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.

**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 ~~(i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which~~ 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;

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

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

31           4. Specifies the date and place of service;

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

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

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

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

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

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

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

58 B. Subject to subsection ~~I~~K, every provider contract entered into by a carrier shall contain specific  
59 provisions which shall require the carrier to adhere to and comply with the following minimum fair  
60 business standards in the processing and payment of claims for health care services:

61 1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation  
62 of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by  
63 specific information available for review by the person submitting the claim that:

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

69 b. The claim was submitted fraudulently.

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

74 2. A carrier shall, within 30 days after receipt of a claim, ~~request electronically or in writing from~~  
75 notify the person submitting the claim of any defect or impropriety that prevents the carrier from deeming  
76 the claim a clean claim and request the information and documentation that the carrier reasonably believes  
77 ~~will be required to process and pay the claim or to determine if the claim is a clean claim.~~ Upon receipt of  
78 the additional information ~~requested under this subsection~~ necessary to make the original claim a clean

79 claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse  
80 to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits  
81 if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters  
82 identified above unless such failure was caused in material part by the person submitting the claims;  
83 however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of  
84 such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim  
85 would violate subdivision 7. ~~Nothing in this subsection shall require a carrier to pay a claim which is not~~  
86 ~~a clean claim.~~ Beginning no later than January 1, 2026, all notifications and information required under  
87 this subdivision shall be delivered electronically.

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

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

106 telephone or facsimile number or e-mail address that a provider can use to request the specific bundling  
107 and downcoding policies that the carrier reasonably expects to be applied to that provider or provider's  
108 services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a  
109 carrier shall provide the requesting provider with such policies within 10 business days following the date  
110 the request is received.

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

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

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

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

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

130 6. In the case of an invasive or surgical procedure, if the carrier has previously authorized a health  
131 care service as medically necessary and during the procedure the health care provider discovers clinical  
132 evidence prompting the provider to perform a less or more extensive or complicated procedure than was

133 previously authorized, then the carrier shall pay the claim, provided that the additional procedures were  
134 (i) not investigative in nature, but medically necessary as a covered service under the covered person's  
135 benefit plan; (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant  
136 with a carrier's post-service claims process, including required timing for submission to carrier.

137 7. No carrier shall impose any retroactive denial of a previously paid claim or in any other way  
138 seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim  
139 or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, the carrier  
140 has provided the reason for the retroactive denial a written explanation of why the claim is being  
141 retroactively adjusted, and (i) the original claim was submitted fraudulently, (ii) the original claim  
142 payment was incorrect because the provider was already paid for the health care services identified on the  
143 claim or the health care services identified on the claim were not delivered by the provider, or (iii) the  
144 time which has elapsed since the date of the payment of the original challenged claim does not exceed ~~the~~  
145 ~~lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider~~  
146 ~~contract that a claim be submitted by the provider following the date on which a health care service is~~  
147 ~~provided. Effective July 1, 2000, a.~~ Notwithstanding the provisions of clause (iii), a provider and a carrier  
148 may agree in writing that recoupment of overpayments by withholding or offsetting against future  
149 payments may occur after such 12-month limit for the imposition of the retroactive denial. A carrier shall  
150 notify a provider at least 30 days in advance of any retroactive denial or recovery or refund of a previously  
151 paid claim.

152 8. ~~Notwithstanding subdivision 7, with respect to provider contracts entered into, amended,~~  
153 ~~extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment~~  
154 ~~or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in~~  
155 ~~writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or~~  
156 ~~refund is sought. The written communication shall also contain an explanation of why the claim is being~~  
157 ~~retroactively adjusted.~~ Beginning no later than January 1, 2026, all written communications, explanations,  
158 notifications, and related provider responses applicable to this subdivision shall be delivered

159 electronically. The electronic method and location for delivery shall be agreed upon by the carrier and  
160 provider and included in the provider contract.

161 ~~9-8.~~ No provider contract shall fail to include or attach at the time it is presented to the provider  
162 for execution (i) the fee schedule, reimbursement policy, or statement as to the manner in which claims  
163 will be calculated and paid that is applicable to the provider or to the range of health care services  
164 reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda,  
165 schedules, and exhibits thereto and any policies (including those referred to in subdivision 4) applicable  
166 to the provider or to the range of health care services reasonably expected to be delivered by that type of  
167 provider under the provider contract.

168 ~~10-9.~~ No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto  
169 (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care  
170 services reasonably expected to be delivered by that type of provider) shall be effective as to the provider,  
171 unless the provider has been provided with the applicable portion of the proposed amendment (or of the  
172 proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and  
173 the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the  
174 provider's intention to terminate the provider contract at the earliest date thereafter permitted under the  
175 provider contract.

176 ~~11-10.~~ In the event that the carrier's provision of a policy required to be provided under subdivision  
177 ~~9-8~~ or ~~10-9~~ would violate any applicable copyright law, the carrier may instead comply with this section  
178 by providing a clear, written explanation of the policy as it applies to the provider.

179 ~~12-11.~~ All carriers shall establish, in writing, their claims payment dispute mechanism and shall  
180 make this information available to providers. If a carrier's claim denial is overturned following completion  
181 of a dispute review, the carrier shall, on the day the decision to overturn is made, consider the claims  
182 impacted by such decision as clean claims. All applicable laws related to the payment of a clean claim  
183 shall apply to the payments due.

184 ~~13-12.~~ Every carrier shall include in its provider contracts a provision that prohibits a provider  
185 from discriminating against any enrollee solely due to the enrollee's status as a litigant in pending litigation

186 or a potential litigant due to being involved in a motor vehicle accident. Nothing in this subdivision shall  
187 require a health care provider to treat an enrollee who has threatened to make or has made a professional  
188 liability claim against the provider or the provider's employer, agents, or employees or has threatened to  
189 file or has filed a complaint with a regulatory agency or board against the provider or the provider's  
190 employer, agents, or employees.

191 14-13. Beginning July 1, 2025, every carrier shall make available through electronic means a way  
192 for providers to determine whether an enrollee is covered by a health plan that is subject to the  
193 Commission's jurisdiction.

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

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

200 2. At least 30 calendar days have passed from the date of the request provided that the carrier has  
201 been responsive to the providers request to confer. However, if in the judgment of the provider, the carrier  
202 has not been responsive to such request, the provider shall not be required to wait at least 30 calendar days  
203 to file the complaint.

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

205 D. If the Commission has cause to believe that any provider has engaged in a pattern of potential  
206 violations of subdivision B-13\_12, with no corrective action, the Commission may submit information to  
207 the Board of Medicine or the Commissioner of Health for action. Prior to such submission, the  
208 Commission may provide the provider with an opportunity to cure the alleged violations or provide an  
209 explanation as to why the actions in questions were not violations. If any provider has engaged in a pattern  
210 of potential violations of subdivision B-13\_12, with no corrective action, the Board of Medicine or the  
211 Commissioner of Health may levy a fine or cost recovery upon the provider and take other action as  
212 permitted under its authority. Upon completion of its review of any potential violation submitted by the

213 Commission or initiated directly by an enrollee, the Board of Medicine or the Commissioner of Health  
214 shall notify the Commission of the results of the review, including where the violation was substantiated,  
215 and any enforcement action taken as a result of a finding of a substantiated violation.

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

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

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

237 ~~G.~~H. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew  
238 the employment or other contractual relationship with a provider, or any provider contract, or otherwise

239 penalize any provider, for invoking any of the provider's rights under this section or under the provider  
240 contract.

241 H-I. Except where otherwise provided in this section, beginning no later than July 1, 2025, carriers  
242 shall deliver provider contracts, related amendments, and notices exclusively to providers in an electronic  
243 format other than electronic facsimile. Beginning no later than January 1, 2026, the provider shall submit  
244 provider contracts, amendments, and notices to carriers exclusively in an electronic format other than  
245 electronic facsimile. The electronic method and location for delivery shall be agreed upon by the carrier  
246 and provider and included in the provider contract.

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

250 I-K. This section shall apply with respect to provider contracts entered into, amended, extended  
251 or renewed on or after July 1, 1999.

252 J-L. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules  
253 and regulations as it may deem necessary to implement this section.

254 K-M. The Commission shall have no jurisdiction to adjudicate individual controversies arising  
255 out of this section.

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