
SUBSTITUTE SENATE BILL 5812

State of Washington

56th Legislature

1999 Regular Session

By Senate Committee on Health & Long-Term Care (originally sponsored by Senators Thibaudeau, Deccio, Wojahn, Winsley, Gardner, Prentice and Costa)

Read first time 03/03/99.

1 AN ACT Relating to the prompt payment of health care claims; adding
2 a new section to chapter 48.43 RCW; and creating a new section.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

4 NEW SECTION. **Sec. 1.** The legislature finds and declares that
5 there is a need for a consistent and enforceable standard for the
6 payment to Washington state health care facilities and health care
7 providers of claims submitted to health plans after health care
8 services are provided to health plan members. The legislature finds
9 that Washington state health care facilities and health care providers
10 have experienced mounting delays in reimbursement for services
11 provided.

12 NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW
13 to read as follows:

14 (1) For the purposes of this section:

15 (a) "Payer" means any group or individual disability insurance
16 policy, health care service contract, and health maintenance agreement,
17 except those contracts entered into for the provision of health care
18 services pursuant to Title XVIII of the social security act, 42 U.S.C.

1 Sec. 1395 et seq., self-insured entities subject to the jurisdiction of
2 the state of Washington, specialized health care service plans,
3 Washington state health care authority, basic health plan, and public
4 employees' benefits board, or other organizations authorized to issue
5 health benefits plans in this state. "Payer" does not include short-
6 term care, long-term care, dental, vision, accident, fixed indemnity,
7 disability income contracts, civilian health and medical program for
8 the uniform services (CHAMPUS), 10 U.S.C. 55, limited benefit or credit
9 insurance, coverage issued as a supplement to liability insurance,
10 insurance arising out of the workers' compensation or similar law,
11 automobile medical payment insurance, or insurance under which benefits
12 are payable with or without regard to fault and which is statutorily
13 required to be contained in any liability insurance policy or
14 equivalent self-insurance.

15 (b) "Claim" means a request for payment for health care services
16 that is submitted to a payer by a provider in a written, electronic, or
17 other equivalent format.

18 (c) "Clean claim" means the same as the medicare standard set forth
19 in Title XVIII of the social security act, 42 U.S.C. Sec.
20 1395u(C)(2)(A) as it exists on the effective date of this act, and
21 shall be accepted as uniform billing number 92 and health care
22 financing administration number 1500 forms that are completed
23 accurately or their electronic equivalent or other formats adopted by
24 the national uniform billing committee. The clean claim may be
25 submitted by electronic transfer. A payer may not impose as a
26 condition of payment any requirements on a provider to modify the
27 uniform billing form or its content or submit additional claims forms.
28 Denial of a claim must be communicated to the provider and must include
29 the specific reason why the claim was denied which indicates reasonable
30 compliance with this law, such as no information received from the
31 employer, provider, or enrollee. When the legitimacy or
32 appropriateness of the health care service is disputed, a payer may
33 request additional medical information that describes and summarizes
34 the diagnosis, treatment, and services rendered to the member or
35 subscriber. When necessary to determine eligibility for benefits or
36 for determination of coverage, a payer may obtain additional
37 information from the provider or its subscriber or member, the employer
38 of the subscriber or member, or any other nonprovider third party.

1 (d) "Provider" means any health care facility or professional
2 health care practitioner acting within the scope of its licensure or
3 certification.

4 (e) "All claims" means claims that are clean and claims that are
5 not clean.

6 (2)(a) For covered services rendered to members or enrollees, a
7 payer shall pay providers as soon as practical but subject to the
8 following minimum standards: (i) Ninety-five percent of the volume of
9 clean claims shall be paid within thirty days; and (ii) ninety-five
10 percent of the volume of all claims shall be paid or denied within
11 sixty days.

12 (b) The date of a claim is when the payer receives written or
13 electronic notice of the claim, in accordance with health care
14 financing administration guidelines as they exist on the effective date
15 of this act. If a payer and provider have agreed in writing to the
16 submission of claims by a specific mode of transmission, the payer
17 shall calculate the time period beginning on the date that the claim is
18 received in the agreed-upon mode of transmission.

19 (3) Any payer failing to pay a claim within the standards
20 established under subsection (2) of this section shall pay interest on
21 such claims beginning with the sixty-first day for all claims. The
22 interest shall be assessed at the rate of one percent per month, and
23 shall be calculated monthly as simple interest prorated for any portion
24 of a month. The payer shall add the interest payable to the amount of
25 the unpaid claim without the necessity for a claim for interest due to
26 be made by the provider. Any interest owed to the provider by the
27 payer shall not be applied by the payer to an enrollee's deductible,
28 copay, coinsurance, or any similar obligation of the enrollee.

29 (4) Providers or payers may seek enforcement of this section
30 through the following means, in addition to any other available to them
31 through other laws:

32 (a) Binding arbitration pursuant to the procedures in chapter 7.04
33 RCW. The arbitrating authority shall order the payment of restitution,
34 interest, and any costs incurred by the party or parties initiating the
35 investigation, including costs of arbitration and reasonable attorneys'
36 fees.

37 (c) Providers or payers who determine that any provision of this
38 section has been violated may seek enforcement by the department of
39 health who shall take action in the name of the department to enforce

1 the provisions of this section only upon the request of a provider or
2 payer. The department shall investigate the alleged violation and,
3 within thirty days, upon finding that a violation has occurred, shall
4 refer the matter to the office of administrative hearings for a hearing
5 under the provisions of chapter 34.12 RCW. The decision of the
6 administrative law judge shall be the final administrative decision.
7 The administrative law judge shall be authorized to order the payment
8 of restitution, together with interest and any costs incurred by the
9 party or parties initiating the investigation, including reasonable
10 attorneys' fees, and the payment of the reasonable costs incurred by
11 the department in investigating the violation and participating in the
12 hearing.

13 (5)(a) The department of health shall establish an oversight board
14 composed of a seven-member panel composed of three representatives from
15 payers, three representatives from providers, and one representative
16 from the department of health.

17 (b) The board shall study trends and issues and make
18 recommendations regarding future legislative, regulatory, or private
19 solutions which will promote timely and accurate payment of health
20 claims.

21 (c) The board shall consider and provide recommendations to payers
22 and providers regarding electronic billing and billing standards and
23 develop a standard and common procedure for all claims to be
24 electronically accepted by payers by January 1, 2001. The board shall
25 also monitor the activity of the federal committees charged with
26 developing and reviewing standard claims forms.

27 (6) Every payer shall be responsible for ensuring that any person
28 acting on behalf of or at the direction of the payer or acting pursuant
29 to payer standards or requirements complies with this section.

30 (7) This section does not apply to claims about which there is
31 substantial evidence of fraud or misrepresentation by providers or
32 patients, or instances where the payer has not been granted reasonable
33 access to information under the provider's control.

34 (8) Neither a provider nor a payer shall be required to comply with
35 this section if the failure to comply is occasioned by any act of God,
36 bankruptcy, act of a governmental authority responding to an act of God
37 or other emergency, or the result of a strike, lockout, or other labor
38 dispute.

1 NEW SECTION. **Sec. 3.** If any provision of this act or its
2 application to any person or circumstance is held invalid, the
3 remainder of the act or the application of the provision to other
4 persons or circumstances is not affected.

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