SENATE BILL REPORT
SHB 1183

As of March 26, 2015

Title: An act relating to radiology benefit managers.

Brief Description: Concerning radiology benefit managers.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Harris and Cody).

Brief History: Passed House: 3/09/15, 88-10.
Committee Activity: Health Care: 3/26/15.

SENATE COMMITTEE ON HEALTH CARE

Staff: Mich'l Needham (786-7442)

Background: Radiology uses medical imaging technology to diagnose and treat disease. There are two primary categories of radiology: diagnostic radiology and interventional radiology. Diagnostic radiology uses medical imaging technology to diagnose a patient's symptoms, monitor responses to treatment, and screen for illnesses. Interventional radiology uses medical imaging technology to guide procedures to treat conditions such as cancer, blockages in arteries and veins, liver problems, and kidney problems. Types of medical imaging technologies include computed tomography, magnetic resonance imaging, positron emission tomography, ultrasound, nuclear medicine, and x-rays.

Radiology benefit managers generally perform management activities related to benefits for imaging services on behalf of health carriers. These may include developing guidelines on the use of radiology services, conducting prior authorization activities, privileging certain providers to order radiology services, and profiling a provider's use of services to confirm that they meet certain benchmarks.

Summary of Bill: Radiology benefit managers are defined as persons who contract with insurers or third-party payors to provide services to: (1) process claims for services and procedures performed by radiologists or advanced diagnostic imaging services providers; and (2) pay radiology clinics, radiologists, or advanced diagnostic imaging services providers for services or procedures.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Radiology benefit managers must register with the Department of Revenue's Business Licensing Program. To register, a radiology benefit manager must submit an application and a registration fee of $200.

Auditing entities, including radiology benefit managers that audit claims and third parties that contract with radiology benefit managers to audit claims, must comply with several specified auditing standards. These standards relate to the following:

- Procedures. Auditing entities must maintain procedures for radiology clinics, radiologists, and advanced diagnostic imaging services providers to appeal findings regarding a claim or authorization request and provide notice to them about the procedure prior to conducting an audit. Appeals must be completed within 30 days of the submission of the claim that is the subject of the requested appeal. Auditing entities must audit each radiology clinic, radiologist, and advanced diagnostic imaging services provider under the same standards used for other similar providers. If an audit involves clinical or professional judgment, the auditing entity must conduct the audit in consultation with a licensed radiologist. Except in cases of fraud, an auditing entity may not conduct an audit of more than 250 unique procedures within a 12-month period for a single provider.
- Timing. Auditing entities must give at least 15 days' written notice prior to an on-site audit and may not conduct an audit during the first five days of the month without the consent of the radiology clinic, radiologist, or advanced diagnostic imaging services provider. Auditing entities may not conduct more than one on-site audit of a radiology clinic, radiologist, or advanced diagnostic imaging services provider in any 12-month period. Auditing entities may not conduct an audit of claims more than 24 months after the adjudication of the claim.
- Payments. Auditing entities may not charge a radiology clinic, radiologist, or advanced diagnostic imaging services provider for a denied or disputed claim until the audit and appeals procedures are final. Auditing entities must pay outstanding claims of a radiology clinic, radiologist, and advanced diagnostic imaging services provider within 45 days of the conclusion of all appeals or the issuance of the final report. Auditing entities may not include interest in overpayment amounts, unless the overpaid claim was based on a procedure that was not performed correctly. Auditing entities may not recoup costs related to clerical errors or errors that do not financially harm either the entity or a consumer.

An auditing entity's finding that a claim was improper must be based on identified transactions, rather than probability sampling, extrapolation, or other methods of projecting errors.

If a radiology benefits manager contracts with a third party to conduct audits, the radiology benefit manager may not base compensation on a percentage of the amount of overpayments recovered or disclose information obtained during the audit, unless specifically authorized.

When conducting an audit, an auditing entity must allow the following as evidence of validation of a claim:

- an electronic or physical copy of a referral or authorization of the procedure;
- billing data showing payment by the patient; or

- electronic records that are reasonably clear and accurate electronic documentation corresponding to a claim.

The act does not prohibit a radiology benefit manager from pursuing an action for fraud against a radiology clinic, radiologist, or advanced diagnostic imaging services provider. The auditing procedures do not apply in cases in which a physical review or review of claims indicate fraud or intentional and willful misrepresentation. The auditing procedures do not apply to state agencies conducting audits of records for services paid for by the state's medical assistance program.

Within 45 days of an audit, a radiology benefit manager must provide the audited radiology clinic, radiologist, and advanced diagnostic imaging services provider with a preliminary report of the audit. Upon receiving the preliminary report, the radiology clinic, radiologist, and advanced diagnostic imaging services provider have at least 45 days to contest the report or any of its findings and provide additional documentation in support of the claim.

The radiology benefit manager must provide the audited radiology clinic, radiologist, and advanced diagnostic imaging services provider a final report of the audit within 60 days of receipt of the preliminary report or the date that the preliminary report was contested. The final report must include all of the money to be recovered by the radiology benefit manager.

Recoupment of funds from a radiology clinic, radiologist, and advanced diagnostic imaging services provider will occur after the audit and the appeals procedures are final.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: We have agreed to narrow the focus on this bill with an amendment that brings the language to registration only and we anticipate ongoing discussions about the array of third-party benefit managers. Radiation benefit managers can have a profound impact on patient access to care. There is no way to monitor them or track how many are doing business in Washington. The registration will allow us to see how many radiation benefit managers are in the state.

OTHER: We are pleased the sponsors of this proposal have agreed to scope the focus of the bill back to registration and that will allow us all time to review benefit managers more broadly.

Persons Testifying: PRO: Tierney Edward, WA State Medical Assn.; Brad Boswell, WA State Radiological Society.

OTHER: Chris Bandoli, Regence BlueShield.

Persons Signed in to Testify But Not Testifying: No one.