(H. B. 2583)

(No. 138-2020)

(Approved September 1, 2020)

AN ACT

To amend Sections 30.020, 30.030, 30.040, and 30.050 of Act No. 77 of June 19, 1957, as amended, known as the "Insurance Code of Puerto Rico," and Section 6 of Act No. 5-2014, as amended, known as an "Act to establish the Public Policy of the Commonwealth of Puerto Rico on the Interpretation of the Provisions of the Health Insurance Code and to set forth Prohibitions," in order to streamline the process for adjudicating and paying claims submitted by healthcare providers to insurers; and for other purposes.

STATEMENT OF MOTIVES

The Government of Puerto Rico has the unavoidable responsibility to guarantee access to healthcare services and ensure the efficient rendering thereof. Consistent with the public policy of ensuring swift, accessible, and efficient healthcare services to Puerto Ricans and retaining our healthcare professionals so that our people receive quality services, the Government regulated the relationship between insurers and healthcare providers under Act No. 150-2011, known as the "Healthcare Providers' Claims Prompt Payment Act." Said Act was incorporated into Act No. 77 of June 19, 1957, as amended, known as the "Insurance Code of Puerto Rico," to promote prompt payment of claims submitted to insurance companies by healthcare providers. In accordance with said Act, an insurer shall pay a claim submitted by a healthcare provider within thirty (30) days from the receipt thereof; provided, that it is a clean claim.

After the implementation of said Act, experience shows that the intended prompt payment requirement is not met, because controversies related to the meaning and content of a clean claim frequently arise. Existing discrepancies regarding the contents of a clean claim and the interpretation of said concept by insurers have defeated the purpose of the law, since prompt payment within the established period is not promoted. In many cases the insurers deny a claim that providers believe to be clean based on deficiencies created by the rules the insurers established themselves.

Thus, this legislation seeks to provide a standard definition for the concept clean claim, thereby making it obligatory and binding under all contracts entered into between insurers and healthcare service provider, and establishing specific and clear terms on the minimum contents of a clean claim. This measure provides that, whenever a claim including the minimum content prescribed by law is submitted to an insurer, the insurer shall be required to pay it within the established timely payment period.

In order to streamline the payment to healthcare services providers by insurers, a period of thirty (30) days is herein established for the total payment of the claim which includes both clean and unprocessable claims.

Furthermore, it is important to establish the difference between the terms "payment" and "adjudication," since in their accounting process, when adjudicating a clean claim as paid, insurers validate that the claim was reviewed and found compliant with the established procedure. However, adjudication is not tantamount to prompt payment of pending claims to the provider. In most cases, insurers believe that they have complied with the "Prompt Payment Act," simply because they adjudicated the claim within the thirty (30)-day period without issuing the payment. This practice is detrimental to healthcare providers, because it substantially delays the receipt of the payment for services already rendered.

Therefore, this amendment seeks to prevent insurers from considering as paid a pending claim which has only been adjudicated, since it delays the payment to healthcare providers for the services rendered.

In order to expedite payment by insurers for services rendered by healthcare providers, Act No. 5-2014, as amended, known as "Act to establish the Public Policy of the Commonwealth of Puerto Rico on the Interpretation of the Provisions of the Health Insurance Code and to set forth Prohibitions," is hereby amended to establish clearer guidelines for the purpose of ensuring that the regulations to be adopted for medical-hospital services utilization review processes are more specific and efficient. Utilization review is a mechanism implemented in accordance with federal and state laws, which provides that public and private insurers shall only pay for medical-hospital services that are rendered according to the actual medical needs of the patient as duly documented by the physician in charge of his care. Utilization review is, therefore, an essential prerequisite for the provider to be able to bill for his services.

Furthermore, it is hereby established the insurers' unavoidable responsibility to implement the necessary means and adequate processes so that, under no circumstances, the utilization review process exceeds forty-eight (48) hours from the time service is provided to the patient. In the case of hospitals, insurers must have the appropriate staff for performing hospitalization concurrent review and provide mechanisms so that hospitalization concurrent reviews conclude with the review of the patient's record on the same date of the discharge. In no case, shall retrospective review account for more than twenty-five percent (25%) of the all hospital utilization reviews. In addition, it must be noted that clinical review guidelines used in the utilization review process shall not be replaced with the medical judgment at the time of providing healthcare services to our patients;

provided, that the services rendered meet the professionally recognized standards of acceptable medical care.

Lastly, in view of the recent approval of the "Puerto Rico Telemedicine and Telehealth Use Act," Act No. 68-2020, a telemedicine consultation shall be deemed as an in-person consultation for billing purposes. Likewise, it is hereby provided that all of the provisions of this Act shall comply with the federal laws and regulations on this subject and shall not apply in cases that have been preempted by the U.S. Congress.

This Legislative Assembly deems it imperative to adopt these provisions in order to provide the healthcare system with greater stability, expedite the timely payment to healthcare professionals, and ensure that our patients receive the best healthcare services.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF PUERTO RICO:

Section 1.- Section 30.020 of Chapter 30 of Act No. 77 June 19, 1957, as amended, known as the "Insurance Code of Puerto Rico," is hereby amended to read as follows:

"Section 30.020.- Definitions.

For the purposes...

(a) Insurer: means an entity engaged in the business of executing insurance contracts, as defined in this Code, including the entities that participate in the Healthcare Plan of the Government of Puerto Rico.

...

(g) Health Service Organization: means any person, including PBMs, PBAs, or similar entities that offer or are required to provide a healthcare plan to one or more subscribers, pursuant to Act No. 77 June 19, 1957, as amended, known as the 'Insurance Code of Puerto Rico,' including the entities that participate in the Healthcare Plan of the Government of Puerto Rico.

...

(i) Clean Claim: means a claim that has no defect, impropriety, or special circumstance such as a lack of substantiating documentation that delays timely payment. A participating provider submits a clean claim by providing the required data elements on the standard claims forms adopted for such purposes by the Centers for Medicare & Medicaid Services (CMS) along with any information, evidence of service, or revisions of which the provider has knowledge. Claims for hospitalization and hospital facility services shall be submitted on the CMS-1450 (UB-04) form and claims for medical and individual professional services shall be submitted on the CMS-1500 form. Moreover, claims for dental services shall be submitted on the J515 form approved by the American Dental Association. Likewise, an Insurer or Health Services Organization, including the participating insurers of the Healthcare Plan of the Government of Puerto Rico, shall recognize, at all times, telemedicine claims as healthcare services provided in person and pay said claims as such. In order for a claim to be considered a clean claim, it must meet all the elements required the by Centers for Medicare & Medicaid Services (CMS) or the American Dental Association (ADA), as appropriate. Only by contract, an Insurer or Health Services Organization may require additional documentation to be attached to the bill for services and said documentation shall be specific and notified in advance. Under no circumstances, an Insurer or Health Services Organization shall require documentation that hinders the purposes and intent of this Act.

Billing for healthcare services varies based on the type of service rendered, which may be hospital, medical, ancillary, or outpatient services. In view of the foregoing, the Office of the Insurance Commissioner is hereby directed to prescribe, by regulations, the minimum content criteria for each type of claim, in order to properly establish the minimum content criteria for each type of clean

claim, according to the service rendered. If a provider submits a claim that includes said minimum content, as prescribed in the aforementioned regulations, the insurer shall consider it a clean claim and proceed with the payment thereof as provided in this Act."

Section 2.- Section 30.030 of Chapter 30 of Act No. 77 June 19, 1957, as amended, known as the "Insurance Code of Puerto Rico," is hereby amended to read as follows:

"Section 30.030.- Statutory Claim Payment Period.

Participating providers shall submit their claims for payment of services rendered within ninety (90) days after having rendered the same, and the Insurer or Health Services Organization shall be required to pay in full any clean and unprocessable claim within a period of thirty (30) calendar days, from the date on which it is received by the Insurer or Health Services Organization, as provided below in Sections 30.040 and 30.050, respectively.

In the event...

After the periods above have elapsed, the provisions of this Act shall not apply to said claims. Provided, that the standard period established herein shall not be construed to render ineffective any shorter periods that may apply to claims for payment of services rendered, if other alternate payment periods are freely agreed on by contract. If a provider fails to submit his claims and/or bills within the period established in this Act, said provider shall only lose the benefits granted under this Act, but under no circumstances shall it be deemed that said provider forfeits his right to payment."

Section 3.- Section 30.040 of Chapter 30 of Act No. 77 June 19, 1957, as amended, known as the "Insurance Code of Puerto Rico," is hereby amended to read as follows:

"Section 30.040.- Payable Claims.

The participating providers...

(a) ...

(d) constitutes a clean claim.

If the Insurer or Health Services Organization fails to notify any objection to a claim for payment within a term of fifteen (15) days, pursuant to Section 30.050 of this Act, it shall be understood that said claim is a payable claim.

..."

Section 4.- Section 30.050 of Chapter 30 of Act No. 77 June 19, 1957, as amended, known as the "Insurance Code of Puerto Rico," is hereby amended to read as follows:

"Section 30.050.- Unprocessable Claims.

The Insurer or Health Services Organization shall notify the participating providers, in writing or electronically, of unprocessable claims within fifteen (15) calendar days from the receipt of the claim. The notice shall clearly state the reasons for which the Insurer or Health Services Organization deemed the claim unprocessable, and indicate the documents or additional information that must be submitted so that it may be processed. A claim notified as unprocessable to a provider shall not be classified as processed and adjudicated by the Insurer or Health Services Organization.

The participating provider must answer the notice of the Insurer or Health Services Organization within ten (10) days from the receipt thereof. Failure to do so shall be deemed to be an admission of the deficiencies notified. Once the participating provider submits the required information or documents, the Insurer or Health Services Organization shall pay the claim within five (5) days from the receipt of the information or documents. The adjudication and total payment of an unprocessable claim, under no circumstances, shall exceed thirty (30) calendar

days. A claim shall be deemed to be processed or adjudicated only when the process conducted by the Insurer or Health Services Organization has ended with the total payment of a claim, whether clean or unprocessable.

If an Insurer or Health Services Organization fails to object to a claim or portion of a claim within the aforementioned five (5)-day period, it shall be deemed to be a clean claim. Said action shall not toll the aforementioned thirty (30)-day period for the adjudication and payment of claims, whether clean or unprocessable. The erroneous notice of an unprocessable claim shall not toll the thirty (30)-day period for the adjudication and payment of any claim; thus, the Insurer or Health Services Organization shall pay the amount claimed plus interest, as provided in Section 30.070 of this Act.

No...

A claim submitted by a participating provider to an Insurer or Health Services Organization within the period agreed on between the parties shall be deemed to be duly submitted for adjudication and payment. Provided, however, that if the claim is not adjudicated and paid within the period established in this Act due to content defects or other reasons not attributable to the participating provider, and the latter is required to submit an amended claim or to resubmit the original claim submitted, none of the periods provided in the contract that may hinder the participating provider's right to payment shall run against the participating provider, since, in any case, the period for submitting, adjudicating, and paying shall be deemed to be met; provided that the original claim was submitted within the period prescribed therefor by contract."

Section 5.- Section 6 of Act No. 5-2014, as amended, known as the "Act to establish the Public Policy of the Commonwealth of Puerto Rico on the Interpretation of the Provisions of the Health Insurance Code and to set forth Prohibitions," is hereby amended to read as follows:

"Section 6.- Rulemaking Authority and Civil Fines.

The Patient Advocate...

Furthermore, the Puerto Rico Health Insurance Administration is hereby directed to prescribe through regulations the review and utilization processes in accordance with the national standards of the United States of America, including entities participating in the Healthcare Plan of the Government of Puerto Rico, using the following principles:

a) Utilization review must be completed within a period not to exceed forty-eight (48) hours after provision of service;

b) Special retrospective review remedies shall not be used to deny payments for services actually rendered to the patient.

c) Every health insurance company, health services organization, or other healthcare plan provider authorized in Puerto Rico shall be required to provide the necessary personnel trained in the review process. That is, the review process between the health insurance company, health service organization, or other healthcare plan provider authorized in Puerto Rico shall be conducted by a clinical peer of the health professional who determined the medical necessity of the service.

d) The clinical review criteria set forth in Act No. 194-2011, as amended, known as the 'Puerto Rico Health Insurance Code,' shall only constitute a reference guide for health professionals at the time of providing the patient with the necessary healthcare services. The guiding principle for determining the medical necessity and appropriateness of healthcare services provided to the patient shall be the clinical judgment; provided, that it is consistent with the reasonable standard of care required given the particular circumstances of each patient, contemporary knowledge, the generally accepted standards of medical practice, and in light of the modern communication and teaching mediums. In the

case of healthcare services associated with cancer, the entire clinical practice guidelines in oncology for each type of cancer diagnosed shall be authorized through a single evaluation. For such reason, clinical review criteria shall not replace clinical judgment in the aforementioned circumstances, to determine the actual medical necessity of the patient in the utilization review process required to bill the services rendered by a healthcare professional or provider. The regulations required to the Puerto Rico Health Insurance Administration shall not include language limiting the forum to which a provider who believes that the provisions of this Act have been violated may resort; thus, the provider shall be allowed to choose the administrative or judicial forum where he shall file his claim.''

Section 6.- Severability.

If any clause, paragraph, subparagraph, sentence, word, letter, article, provision, section, subsection, title, chapter, subchapter, heading, or part of this Act were held to be null or unconstitutional, the ruling, holding, or judgment to such effect shall not affect, impair, or invalidate the remainder of this Act. The effect of said holding shall be limited to the clause, paragraph, subparagraph, sentence, word, letter, article, provision, section, subsection, title, chapter, subchapter, heading, or part of this Act thus held to be null or unconstitutional. If the application to a person or a circumstance of any clause, paragraph, subparagraph, sentence, word, letter, article, provision, section, subsection, title, chapter, subchapter, heading, or part of this Act were held to be null or unconstitutional, the ruling, holding, or judgment to such effect shall not affect or invalidate the application of the remainder of this Act to such persons or circumstances where it may be validly applied. It is the express and unequivocal will of this Legislative Assembly that the courts enforce the provisions and application thereof, even if it renders ineffective, nullifies, invalidates, impairs, or holds to be unconstitutional any part thereof, or even if it renders ineffective,

invalidates, or holds to be unconstitutional the application thereof to any person or circumstance.

Section 7.- Supremacy.

The provisions of this Act shall prevail over any other general or specific statutory or regulatory provision of the Government of Puerto Rico that is inconsistent with this Act. This Act shall be compatible with the applicable federal laws and rules in effect. In case of conflict, the applicable federal laws and rules shall take precedence over the laws of Puerto Rico and fully apply thereto as to any of the states of the United States.

Section 8.- Prospective Application.

The provisions of this Act shall apply prospectively and shall not impair any contractual obligation entered into prior to this Act.

Section 9.- Effectiveness.

This Act shall take effect ninety (90) days after approval.