Senate File 2226 - Introduced

SENATE FILE 2226
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A BILL FOR

An Act relating to the use of automated adjudication systems by health carriers, and including civil penalties.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. NEW SECTION. **514M.1 Definitions.**

As used in this chapter, unless the context otherwise requires:

1. *"Automated adjudication system"* means any software, algorithm, artificial intelligence, machine-learning system, or rule-based automated process used by a health carrier or third-party administrator to evaluate, adjust, approve, deny, or downcode a claim submitted by a health care provider.

2. *"Claim"* means a request for payment or reimbursement submitted by a health care provider to a health carrier for health care services rendered to a covered person enrolled in a health benefit plan of the health carrier.

3. *"Clinical reviewer"* means an individual employed by a health carrier to review and decide insurance claims submitted to the health carrier.

4. *"Code"* means a current procedural terminology code, international classification of diseases code, health care common procedure coding system code, a diagnosis-related group code, or any other procedure or diagnosis code.

5. *"Commissioner"* means the commissioner of insurance.

6. *"Covered person"* means the same as defined in section 514J.102.

7. *"Deny"* means rejection of a claim, in whole or in part, submitted by a health care provider to a health carrier for reimbursement of health care services, including rejection based on alleged lack of medical necessity, incorrect coding, insufficient documentation, or policy exclusion, when such determination is made by an automated adjudication system without human oversight.

8. *"Downcode"* means the adjustment, alteration, or reassignment of a code submitted by a health care provider to a lower complexity, lower cost, or less intensive code, including a change that reduces the reimbursement rate, without individualized review by a clinical reviewer of the health care provider's documentation and the medical necessity of the

health care services provided by the health care provider. "*Downcode*" includes reassignment of a code to a lesser alternative code by an automated adjudication system.

9. "*Facility*" means the same as defined in section 514J.102.

10. "*Health care professional*" means the same as defined in section 514J.102.

11. "*Health care provider*" means a health care professional or a facility.

12. "*Health care services*" means the same as defined in section 514J.102.

13. "*Health carrier*" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services.

Sec. 2. NEW SECTION. **514M.2 Downcoding and denial of claims.**

1. A health carrier shall not use an automated adjudication system to downcode or deny a claim unless the health carrier first performs a documented individualized review, conducted by a clinical reviewer, of the claim, supporting medical documentation, and applicable clinical criteria.

2. For a claim that a health carrier intends to downcode or deny, the health carrier shall provide written notice to the health care provider of the proposed downcoding or denial, including, at a minimum, all of the following:

a. The originally billed code and health care service.

b. The proposed adjusted code or reason for the denial.

c. The clinical, contractual, or administrative justification for the downcode or denial, including a specific citation to the health carrier's applicable policy, guideline,

or contract provision that permits the downcode or denial.

d. Identification of the clinical reviewer responsible for the downcode or denial, including the clinical reviewer's name, credentials, and the date and time of the review.

e. A detailed explanation of the health care provider's right to appeal the downcode or denial. The health care provider must be given no less than thirty calendar days from the date of the health care provider's receipt of the notice under this subsection, to appeal the decision or submit additional documentation pursuant to section 514M.4, before the downcode or denial is finalized. If a health care provider does not appeal a downcode or denial within the required time period, and the health carrier finalizes the downcode or denial, the downcode or denial must be clearly identified in the explanation of benefits or remittance advice and labeled as "code adjustment", "downcoding", or "denial due to [reason]", with all associated documentation and justification.

3. An automated adjudication system shall not be used by a health carrier as the sole basis for any of the following:

a. Denying a claim based on lack of medical necessity.

b. Rejecting a claim due to missing or insufficient documentation.

c. Modifying a code without verification by a clinical reviewer.

d. Flagging or withholding payment of a claim for health care services that are routine, commonly accepted, or historically validated from the same health care provider or group of health care providers.

Sec. 3. NEW SECTION. **514M.3 Disclosure requirements.**

1. A health carrier shall disclose to the division the health carrier's use of an automated adjudication system in the processing of claims. The disclosure must include all of the following:

a. A description of the health carrier's automated adjudication system, including whether the automated

adjudication system performs downcoding or automated denials.

b. The criteria, threshold, or decision rules used by the health carrier's automated adjudication system.

c. The health carrier's oversight process by clinical reviewers, including the frequency of internal and external audits conducted of automated decisions by the automated adjudication system.

d. Measures taken by the health carrier to ensure fairness, accuracy, and prevention of unlawful bias or disparate impact on health care providers and covered persons.

2. A health carrier shall maintain documentation for each claim that is downcoded by an automated adjudication system that shows the submitted code, the adjusted code, the reason for the downcode, and whether a clinical reviewer conducted a review. The health carrier shall retain the documentation for a minimum of five years from the date of payment of the claim.

Sec. 4. NEW SECTION. **514M.4 Appeals.**

1. If a health care provider receives a notice of a proposed denial or downcode of a claim under section 514M.2, subsection 2, the health care provider may appeal the downcode or denial no later than thirty calendar days following the date the health care provider received the notice. A health care provider may appeal by submitting additional documentation to the health carrier or requesting that the health carrier's clinical reviewer review the claim. A health carrier shall respond to an appeal from a health care provider no later than forty-five calendar days from the date of receipt of the appeal.

2. After a health carrier performs a review by a clinical reviewer as required by subsection 1, if the health carrier determines that the code originally billed for the health care service is supported by proper documentation, the health carrier shall readjust the claim to the code originally billed and shall provide the health care provider with written explanation for the reversal.

3. Upon request by a health care provider, a health carrier shall provide an annual report to the health care provider that summarizes the following for the claims submitted to the health carrier by the health care provider for the immediately preceding calendar year:

a. The total number of claims the health carrier processed by an automated adjudication system.

b. The number and percentage of claims that the health carrier denied or downcoded by an automated adjudication system.

c. The number and percentage of claims that the health care provider appealed, and the number of claims that were adjusted after review by a clinical reviewer.

Sec. 5. NEW SECTION. **514M.5 Enforcement —— penalties.**

1. The commissioner may, if the commissioner finds that a health carrier has intentionally or recklessly processed claims by an automated adjudication system in violation of this chapter, impose a penalty of not more than ten thousand dollars per violation. A penalty collected under this subsection shall be deposited as provided in section 505.7.

2. A health care provider or person injured by a violation of this chapter may bring a civil action in district court against a health carrier for violation of this chapter to recover damages, to enjoin the health carrier from further violations, and to seek any other relief available by law. In addition to damages, a health care provider or person who prevails in an action against a health carrier shall be entitled to an award of court costs and reasonable attorney fees.

Sec. 6. NEW SECTION. **514M.6 Rules.**

The commissioner shall adopt rules pursuant to chapter 17A to administer this chapter, including but not limited to rules that specify all of the following:

1. The standards for the review process by a clinical reviewer.

2. The form and content of notices provided by health carriers to health care providers as required by section 514M.2, subsection 2.

3. The requirements for the appeals process pursuant to section 514M.4.

4. The recordkeeping and audit standards applicable to health carriers that use automated adjudication systems.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill relates to the use of automated adjudication systems by health carriers.

The bill prohibits a health carrier (carrier) from using an automated adjudication system (system) to downcode or deny a claim unless the carrier first performs a documented individualized review of the claim, conducted by a clinical reviewer (reviewer), including a review of the supporting medical documentation and applicable clinical criteria. "Automated adjudication system", "claim", "deny", and "downcode" are defined by the bill.

For each claim a carrier intends to downcode or deny, the carrier shall provide notice to the health care provider (provider) of the proposed downcoding or denial that includes the required information detailed in the bill, and shall allow the provider a minimum of 30 days to appeal the decision or submit additional documentation. If no appeal is submitted and the downcode or denial is finalized, the downcode or denial must be clearly identified in the explanation of benefits or remittance advice, labeled, and include all associated documentation and justification.

A system shall not be used by a carrier as the sole basis for denying a claim based on lack of medical necessity, rejecting a claim due to missing or insufficient documentation, modifying a code without verification by a reviewer, or flagging or withholding a claim for health care services that are routine,

commonly accepted, or historically validated.

A carrier shall disclose to the insurance division the use of a system in the processing of claims that includes the information detailed in the bill. A carrier shall maintain documentation for each claim for which reimbursement is decreased by a system that shows the submitted code, the adjusted code, the reason for the downcode, and whether a review by a reviewer was conducted, and shall retain the documentation for a minimum of five years.

If a provider receives a notice of a proposed denial or downcode of a claim, the provider may appeal the denial or downcode within 30 days by submitting additional documentation to a carrier or requesting the carrier to provide a review by a reviewer. A carrier shall respond to an appeal within 45 days. If, after review, it is determined that the originally billed code was supported by proper documentation, the carrier shall readjust the claim to the original code and provide the provider with a written explanation of the readjustment. Upon request by a provider, a carrier shall provide an annual report that summarizes the total number of claims processed under the carrier's system, the number and percentage of claims that were denied or downcoded by the carrier's system, the number and percentage of claims the provider appealed, and the number of claims that were adjusted after performing a review by a reviewer.

The commissioner of insurance may, upon a finding that a carrier intentionally or recklessly processed claims by a system in violation of the bill, impose a penalty of not more than $10,000 for each violation. A provider or person damaged by a violation of the bill may bring a civil action against a carrier for violation of the bill to recover damages, to enjoin the carrier from further violations, and to seek any other relief available by law. A provider or person who prevails in an action against a carrier shall be entitled to an award of court costs and reasonable attorney fees.

The commissioner of insurance shall adopt rules to administer the bill, including but not limited to rules that specify the standards for the review process by a reviewer, the form and content of notices to providers, the requirements for appeals, and recordkeeping and audit standards.