

HOUSE BILL 793

By Harwell

AN ACT to amend Tennessee Code Annotated, Title 56,
Chapter 7, Part 1, relative to responsibility for
insurance coverage.

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

SECTION 1. Tennessee Code Annotated, Section 56-7-110, is amended by deleting subdivision (f) in its entirety, by adding the following new subsections immediately preceding subsection (g), and by redesignating the subsequent subsections accordingly:

(f) Notwithstanding subsection (c), if a health insurance entity or an agent contracted to provide eligibility verification verifies that an individual is a covered person and if the health care provider provides services to the individual in reliance on the verification and submits a clean claim in good faith and in a timely manner, the health insurance entity may only deny, or retroactively deny within six (6) months of the date the claim was paid by the health insurance entity, a claim on the basis that the individual is not a covered person if the health insurance entity subsequently learns after the date of service that another health insurance entity provided coverage for the individual on that date of service. The health insurance entity is barred from making any recoupment beyond six (6) months of the date the claim was paid by the health insurance entity, unless there was fraud by the health care provider.

(g) In situations where the provider provides services based upon the health insurance entity or an agent verifying eligibility, submits a clean claim in good faith and in a timely manner and the health insurance entity denies payment, or retroactively recoups payment within six (6) months of the date of payment, for a claim on the basis that the individual is not a covered person but who was subsequently identified to be

covered by a second health insurance entity after the date of service as provided in subsection (f), the timeframe enunciated in the provider's contract with the second health insurance entity for submitting a claim shall begin not with the date of service but with the date the claim is either denied before payment is made or the date the original health insurance entity recoups payment. The health insurance entity subsequently identified to be responsible for the insurance coverage of the patient on the date of service shall not deny reimbursement for not filing timely or following its required procedures for prior authorization or pre-certification if:

(1) The provider followed all of the required procedures, if necessary, in getting a prior authorization or pre-certification from the health insurance entity thought in good faith to be responsible on the date of service;

(2) A clean claim was timely filed with the original health insurance entity;
and

(3) A clean claim and documentation from the original health insurance entity reflecting the date for denial of coverage are subsequently timely filed with the second health insurance entity as set forth in this subsection (g), unless fraud was committed by the health care provider.

(h) In situations where the provider provides services based on the health insurance entity or an agent verifying eligibility, submits a clean claim in good faith and in a timely manner, and the health insurance entity subsequently learns after the date of service that the individual was not covered on the date of service and had no other third-party coverage, the health insurance entity shall treat the claim as if the individual were covered and make appropriate payment to the health care provider. The health care entity is authorized to bill the patient directly to recoup its expenses in the absence of a responsible health insurance entity.

SECTION 2. This act shall take effect July 1, 2009, the public welfare requiring it, and shall apply to provider network contracts entered into, renewed or materially amended on or after that date.