**South Carolina General Assembly**

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**S. 977**

**STATUS INFORMATION**

General Bill

Sponsors: Senator L. Martin

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Introduced in the Senate on January 13, 2016

Currently residing in the Senate Committee on **Banking and Insurance**

Summary: Clean Claim definition

**HISTORY OF LEGISLATIVE ACTIONS**

Date Body Action Description with journal page number

1/13/2016 Senate Introduced and read first time ([Senate Journal‑page 51](file:///h:\SJ%20Archive\2016\01-13-16.docx))

1/13/2016 Senate Referred to Committee on **Banking and Insurance** ([Senate Journal‑page 51](file:///h:\SJ%20Archive\2016\01-13-16.docx))

View the latest [legislative information](http://www.scstatehouse.gov/billsearch.php?billnumbers=977&session=121&summary=B) at the website

**VERSIONS OF THIS BILL**

[1/13/2016](file:///p:\pprever\2015-16\977_20160113.docx)

**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING SECTION 38‑72‑55 SO AS TO DEFINE THE TERM “CLEAN CLAIM”, TO ESTABLISH A TIME FRAME FOR PAYMENT OF CLEAN CLAIMS FILED THROUGH PAPER AND ELECTRONIC MEANS, TO ESTABLISH THAT THE INSURER SHALL DEVELOP A SYSTEM TO ACKNOWLEDGE THE RECEIPT OF THE CLAIM, AND TO PROVIDE THAT IT IS AN UNFAIR TRADE PRACTICE FOR A BILLING SERVICE TO CONVERT ELECTRONIC CLAIMS TO PAPER CLAIMS AND TO PROVIDE PENALTIES.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Chapter 72, Title 38 of the 1976 Code is amended by adding:

“Section 38‑72‑55. (A) For purposes of this section, the term ‘clean claim’ means an eligible paper or electronic claim for reimbursement that:

(1) is received by the insurer within one hundred twenty business days of the date the long term care services at issue began;

(2) is for long term care services covered by the long term care insurance plan and rendered to an insured person by a provider eligible for reimbursement under the long term care insurance plan;

(3) has a corresponding referral that may be required for the applicable claim;

(4) is a claim for which the insurer is the primary payor, or for which the insurer’s responsibility as a secondary payor clearly has been established;

(5) has no material defect, error, or impropriety that would affect the adjudication of the claim;

(6) includes all required substantiating documentation or coding;

(7) is not subject to any particular circumstance that the insurer reasonably believes, subject to review by the Department of Insurance, would prevent accurate or timely payment from being made on the claim under the terms of the long term care insurance plan, the participating provider agreement, or the insurer’s published filing requirements; and

(8) is under a long term care insurance plan for which the insurer has been timely paid all applicable premiums.

(B) An insurer shall direct the issuance of a check or an electronic funds transfer in payment for a clean claim:

(1) submitted via paper within thirty business days following the later of the insurer’s receipt of the claim or the date on which the insurer receives all information needed;

(2) submitted in a format required for the claim to constitute a clean claim; and

(3) for which the insurer has received of all documentation which may be requested by an insurer and which is reasonably needed by the insurer to:

(a) determine that the claim does not contain any material defect, error, or impropriety; or

(b) make a payment determination.

(C) An insurer shall direct the issuance of a check or an electronic funds transfer in payment for a clean claim:

(1) submitted electronically within fifteen business days following the later of the insurer’s receipt of the claim or the date on which the insurer receives of all information needed;

(2) submitted in a format required for the claim to constitute a clean claim; and

(3) for which the insured has received all documentation which may be requested by an insurer and which is reasonably needed by the insurer to:

(a) determine that the claim does not contain any material defect, error, or impropriety; or

(b) make a payment determination.

(D) An insurer shall affix to or on paper claims, or otherwise maintain a system for determining, the date claims are received by the insurer. An insurer shall send an electronic acknowledgement of claims submitted electronically either to the provider or the provider’s designated vendor for the exchange of electronic transactions. The acknowledgement must identify the date claims are received by the insurer. If an insurer determines that there is a defect, error, or impropriety in a claim that prevents the claim from entering the insurer’s adjudication system, the insurer shall provide notice of the defect or error either to the provider or the provider’s designated vendor for the exchange of electronic transactions within fifteen business days of the submission of the claim if it was submitted electronically or within thirty business days of the claim if it was submitted via paper. Nothing contained in this section is intended or may be construed to alter an insurer’s ability to request clinical information reasonably necessary for the proper adjudication of the claim or for the purpose of investigating fraudulent or abusive billing practices.

(E) A clearinghouse, billing service, or any other vendor that contracts with a provider to deliver long term care claims to an insurer on the provider’s behalf is prohibited from converting electronic claims received from the provider into paper claims for submission to the insurer. A violation of this subsection constitutes an unfair trade practice under Chapter 5, Title 39, and individual providers and insurers injured by violations of this subsection have an action for damages as set forth in Section 39‑5‑140.”

SECTION 2. This act takes effect upon approval by the Governor.

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