2013 -- H 6287

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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2013

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Representative Robert B. Jacquard

Date Introduced: June 26, 2013

Referred To: House Corporations

It is enacted by the General Assembly as follows:

SECTION 1. Section 27-18-65 of the General Laws in Chapter 27-18 entitled "Accident and Sickness Insurance Policies" is hereby amended to read as follows:

27-18-65. Post-payment audits. -- (a)(1) Except as otherwise provided herein, any review, audit or investigation by a health insurer or health plan of a health care provider's claims which results in the recoupment or set-off of funds previously paid to the health care provider in respect to such claims shall be completed no later than ~~two (2) years~~ eighteen (18) months after the completed claims were initially paid. This section shall not restrict any review, audit or investigation regarding claims that are submitted fraudulently, are subject to a pattern of inappropriate billing, are related to coordination of benefits, are duplicate claims, or are subject to any federal law or regulation that permits claims review beyond the period provided herein.

(b) No health care provider shall seek reimbursement from a payer for underpayment of a claim later than ~~two (2) years~~ eighteen (18) months from the date the first payment on the claim was made, except if the claim is the subject of an appeal properly submitted pursuant to the payer's claims appeal policies or the claim is subject to continual claims submission.

(c) For the purposes of this section, "health care provider" means an individual clinician, either in practice independently or in a group, who provides health care services, and otherwise referred to as a non-institutional provider.

(d) Except for those contracts where the health insurer or plan has the right to unilaterally amend the terms of the contract, the parties shall be able to negotiate contract terms which allow

for different time frames than is prescribed herein.

SECTION 2. Section 27-19-56 of the General Laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" is hereby amended to read as follows:

27-19-56. Post-payment audits. -- (a)(1) Except as otherwise provided herein, any review, audit or investigation by a nonprofit hospital service corporation of a health care provider's claims which results in the recoupment or set-off of funds previously paid to the health care provider in respect to such claims shall be completed no later than ~~two (2) years~~ eighteen (18) months after the completed claims were initially paid. This section shall not restrict any review, audit or investigation regarding claims that are submitted fraudulently, are subject to a pattern of inappropriate billing, are related to coordination of benefits, are duplicate claims, or are subject to any federal law or regulation that permits claims review beyond the period provided herein.

(b) No health care provider shall seek reimbursement from a payer for underpayment of a claim later than ~~two (2) years~~ eighteen (18) months from the date the first payment on the claim was made, except if the claim is the subject of an appeal properly submitted pursuant to the payer's claims appeal policies or the claim is subject to continual claims submission.

(c) For the purposes of this section, "health care provider" means an individual clinician, either in practice independently or in a group, who provides health care services, and otherwise referred to as a non-institutional provider.

(d) Except for those contracts where the health insurer or plan has the right to unilaterally amend the terms of the contract, the parties shall be able to negotiate contract terms which allow for different time frames than is prescribed herein.

SECTION 3. Section 27-20-51 of the General Laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" is hereby amended to read as follows:

27-20-51. Post-payment audits. -- (a)(1) Except as otherwise provided herein, any review, audit or investigation by a nonprofit ~~hospital~~ medical service corporation of a health care provider's claims which results in the recoupment or set-off of funds previously paid to the health care provider in respect to such claims shall be completed no later than ~~two (2) years~~ eighteen (18) months after the completed claims were initially paid. This section shall not restrict any review, audit or investigation regarding claims that are submitted fraudulently, are subject to a pattern of inappropriate billing, are related to coordination of benefits, are duplicate claims, or are subject to any federal law or regulation that permits claims review beyond the period provided herein.

(b) No health care provider shall seek reimbursement from a payer for underpayment of

a claim later than ~~two (2) years~~ eighteen (18) months from the date the first payment on the claim was made, except if the claim is the subject of an appeal properly submitted pursuant to the payer's claims appeal policies or the claim is subject to continual claims submission.

(c) For the purposes of this section, "health care provider" means an individual clinician, either in practice independently or in a group, who provides health care services, and otherwise referred to as a non-institutional provider.

(d) Except for those contracts where the health insurer or plan has the right to unilaterally amend the terms of the contract, the parties shall be able to negotiate contract terms which allow for different time frames than is prescribed herein.

SECTION 4. Section 27-41-69 of the General Laws in Chapter 27-41 entitled "Health Maintenance Organizations" is hereby amended to read as follows:

27-41-69. Post-payment audits. -- (a)(1) Except as otherwise provided herein, any review, audit or investigation by a health maintenance organization of a health care provider's claims which results in the recoupment or set-off of funds previously paid to the health care provider in respect to such claims shall be completed no later than ~~two (2) years~~ eighteen (18) months after the completed claims were initially paid. This section shall not restrict any review, audit or investigation regarding claims that are submitted fraudulently, are subject to a pattern of inappropriate billing, are related to coordination of benefits, are duplicate claims, or are subject to any federal law or regulation that permits claims review beyond the period provided herein.

(b) No health care provider shall seek reimbursement from a payer for underpayment of a claim later than ~~two (2) years~~ eighteen (18) months from the date the first payment on the claim was made, except if the claim is the subject of an appeal properly submitted pursuant to the payer's claims appeal policies or the claim is subject to continual claims submission.

(c) For the purposes of this section, "health care provider" means an individual clinician, either in practice independently or in a group, who provides health care services, and otherwise referred to as a non-institutional provider.

(d) Except for those contracts where the health insurer or plan has the right to unilaterally amend the terms of the contract, the parties shall be able to negotiate contract terms which allow for different time frames than is prescribed herein.

SECTION 5. This act shall take effect on January 1, 2014.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

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This act would amend the amount of time permitted for a health payer to conduct a post-payment audit from two (2) years to eighteen (18) months and would establish an appeals process prior to any recoupment or set-off. It would also allow the parties to health insurance plans to negotiate different time frames than specified herein.

This act would take effect on January 1, 2014.

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