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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. 2017

A N A C T

RELATING TO INSURANCE ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Representative Scott Slater

Date Introduced: March 01, 2017

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) Except as otherwise provided herein, any review, audit or investigation by a health insurer or health plan of a health care provider's claims that 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 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~~ known by the provider to be 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 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 any healthcare facility, as defined in § 27-18-1.1 including any mental health and/or substance abuse treatment facility, physician, or other licensed practitioner as identified to the review agent as

having primary responsibility for the care, treatment, and services rendered to a patient.

(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 that 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) Except as otherwise provided herein, any review, audit or investigation by a nonprofit hospital service corporation of a health-care provider's claims that 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 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~~ known by the provider to be 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 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 any healthcare facility, as defined in § 27-18-1.1 including any mental health and/or substance abuse treatment facility, physician, or other licensed practitioner identified to the review agent as having primary responsibility for the care, treatment, and services rendered to a patient.

(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 that 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) Except as otherwise provided herein, any review, audit or investigation by a nonprofit medical service corporation of a health care provider's claims that 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 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~~ known by the provider to be 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 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 any healthcare facility, as defined in § 27-20-1 including any mental health and/or substance abuse treatment facility, physician, or other licensed practitioner identified to the review agent as having primary responsibility for the care, treatment, and services rendered to a patient.

(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) Except as otherwise provided herein, any review, audit or investigation by a health maintenance organization of a health care provider's claims that 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 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~~ known by the provider to be 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 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 any healthcare facility, as defined in § 27-41-2 including any mental health and/or substance abuse

treatment facility, physician, or other licensed practitioner identified to the review agent as having primary responsibility for the care, treatment, and services rendered to a patient.

(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. Section 27-20.1-19 of the General Laws in Chapter 27-20.1 entitled "Nonprofit Dental Service Corporations" is hereby amended to read as follows:

27-20.1-19. Post-payment audits.

(a) Except as otherwise provided herein, any review, audit or investigation by a nonprofit dental 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~~ known or should have been known by the health care provider to be a pattern of inappropriate billing according to the standards for provider billing of their respective medical or dental specialty, are related to coordination of benefits, 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.

SECTION 6. This act shall take effect upon passage.

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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 permit an audit or claims investigation for a pattern of inappropriate billing only if it is determined that the claims are known by the provider to be inappropriate.

This act would take effect upon passage.

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