HB0731

LRB09604449RPM14500b

96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

HB0731

Introduced 2/6/2009, by Rep. Frank J. Mautino

SYNOPSIS AS INTRODUCED:

215 ILCS 5/368d

Amends the Illinois Insurance Code. In the provisions regarding recoupments, removes the requirement that a remittance advice be provided to a health care provider. Provides that except in cases of fraud, all claims paid by an insurer or other specified organization shall be considered final unless adjustments are made pursuant to the Act. Provides that if an insurer or other specified organization determines that it has made an overpayment to a provider, the insurer must give the provider a written statement specifying the basis for the claim of overpayment. Sets forth recoupment provisions for situations where (i) there is a contract between the provider and the insurer and (ii) there is no contract between the provider and the insurer. Provides that an insurer or other specified organization shall not seek recoupment for payment of a claim based on any claimed lack of medical necessity if the insurer has received the provider's treatment records. Provides that an insurer or other specified organization shall not offset payment for claims for services to a patient against claims for the provider's services to any other patient. Makes other changes.

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A BILL FOR

AN ACT concerning insurance.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Insurance Code is amended by changing Section 368d as follows:

(215 ILCS 5/368d)

Sec. 368d. Recoupments.

(a) Except in cases of fraud, all claims paid by an insurer, health maintenance organization, independent practice association, or physician hospital organization shall be considered final unless adjustments are made pursuant to this Section 368d. ~~A health care professional or health care provider shall be provided a remittance advice, which must include an explanation of a recoupment or offset taken by an insurer, health maintenance organization, independent practice association, or physician hospital organization, if any. The recoupment explanation shall, at a minimum, include the name of the patient; the date of service; the service code or if no service code is available a service description; the recoupment amount; and the reason for the recoupment or offset. In addition, an insurer, health maintenance organization, independent practice association, or physician hospital organization shall provide with the remittance advice a~~

~~telephone number or mailing address to initiate an appeal of the recoupment or offset.~~

(b) If an insurer, health maintenance organization, independent practice association, or physician hospital organization determines that it has made an overpayment to a provider for services rendered to an insured, the insurer must give the provider a written statement specifying the basis for the claim of overpayment and identifying the claim or claims and the overpayment portion that is claimed. The written statement shall include the following: the name of the patient; the date or dates of service; the service code or, if no service code is available, a service description; and the amount of claimed overpayment. In addition, an insurer, health maintenance organization, independent practice association, or physician hospital organization shall provide the provider with a telephone number or mailing address to initiate an appeal of the claimed overpayment. ~~It is not a recoupment when a health care professional or health care provider is paid an amount prospectively or concurrently under a contract with an insurer, health maintenance organization, independent practice association, or physician hospital organization that requires a retrospective reconciliation based upon specific conditions outlined in the contract.~~

(c) Where there is a contract between the provider and the insurer, adjustments to claims shall be made within the time period set out in the contract between the provider and the

insurer, unless otherwise agreed to in writing by the provider and the insurer. The time period agreed to in writing shall not exceed 6 months after the date the claim was submitted.

(d) Where there is no contract between a provider and an insurer, health maintenance organization, independent practice association, or physician hospital organization, adjustments to claims shall be made within 6 months after the date the claim was submitted, unless otherwise agreed to in writing by the provider and the insurer.

(e) An insurer, health maintenance organization, independent practice association, or physician hospital organization shall not seek recoupment for payment of a claim based on claimed lack of eligibility if the insurer verified eligibility of the patient prior to payment of the claim.

(f) An insurer, health maintenance organization, independent practice association, or physician hospital organization shall not seek recoupment for payment of a claim based on any claimed lack of medical necessity if the insurer has received the provider's treatment records for the patient prior to issuing payment.

(g) An insurer, health maintenance organization, independent practice association, or physician hospital organization shall not offset payment for claims for services to a patient against claims for the provider's services to any other patient or patients.

(h) If an insurer, health maintenance organization,

independent practice association, or physician hospital organization reviews or makes a determination of medical necessity or any other medical issue, it shall be conducted by a person of identical licensure as the provider.

(i) This Section does not apply to reconciliations made under specific conditions outlined in health maintenance organization provider agreements under which health care professionals or health care providers are paid prospectively or concurrently per capita.

(Source: P.A. 93-261, eff. 1-1-04.)