SB2949

LRB09920643KTG45238b

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

SB2949

Introduced 2/18/2016, by Sen. David Koehler

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5F-32
305 ILCS 5/5F-33 new

Amends the Illinois Public Aid Code. In a provision concerning non-emergency prior approvals and appeals under the Medicare-Medicaid Alignment Initiative Demonstration Project, requires Managed Care Organizations (MCOs) to have a method of receiving prior approval requests 24 hours a day, 7 days a week, 365 days a year from (rather than for) nursing home residents, physicians, or providers (rather than nursing home residents). Provides that in a non-emergency situation, in the event a resident's physician orders a service, treatment, or test that is not approved by the MCO, the enrollee, physician, or provider may utilize an expedited appeal to the MCO (rather than the physician and the provider may utilize an expedited appeal to the MCO). Requires the MCO to notify all individuals who file an expedited appeal of the MCO's decision within 24 hours after receipt of all required information. Adds provisions concerning payment of claims submitted by a provider to a MCO, including: (i) the time period within which a claim must be reviewed and paid; (ii) MCO notification regarding the corrective action needed to permit payment of a rejected or denied claim; (iii) MCO notification on coding and documentation requirements; and (iv) the establishment of a claims mediation process to mediate rejected or denied claims.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

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

Section 5. The Illinois Public Aid Code is amended by changing Section 5F-32 and by adding Section 5F-33 as follows:

(305 ILCS 5/5F-32)

Sec. 5F-32. Non-emergency prior approval and appeal.

(a) MCOs must have a method of receiving prior approval requests 24 hours a day, 7 days a week, 365 days a year from ~~for~~ nursing home residents, physicians, or providers. If a response is not provided within 24 hours of the request and the nursing home is required by regulation to provide a service because a physician ordered it, the MCO must pay for the service if it is a covered service under the MCO's contract in the Demonstration Project, provided that the request is consistent with the policies and procedures of the MCO.

In a non-emergency situation, notwithstanding any provisions in State law to the contrary, in the event a resident's physician orders a service, treatment, or test that is not approved by the MCO, the enrollee, physician, or ~~and the~~ provider may utilize an expedited appeal to the MCO.

If an enrollee, physician, or provider requests an expedited appeal pursuant to 42 CFR 438.410, the MCO shall

notify the individual filing the appeal, whether it is the enrollee, physician, or provider, within 24 hours after the submission of the appeal of all information from the enrollee, physician, or provider that the MCO requires to evaluate the appeal. The MCO shall notify the individual filing the appeal of the MCO's ~~render a~~ decision on an expedited appeal within 24 hours after receipt of the required information.

(b) While the appeal is pending or if the ordered service, treatment, or test is denied after appeal, the Department of Public Health may not cite the nursing home for failure to provide the ordered service, treatment, or test. The nursing home shall not be liable or responsible for an injury in any regulatory proceeding for the following:

(1) failure to follow the appealed or denied order; or

(2) injury to the extent it was caused by the delay or failure to perform the appealed or denied service, treatment, or test.

Provided however, a nursing home shall continue to monitor, document, and ensure the patient's safety. Nothing in this subsection (b) is intended to otherwise change the nursing home's existing obligations under State and federal law to appropriately care for its residents.

(Source: P.A. 98-651, eff. 6-16-14.)

(305 ILCS 5/5F-33 new)

Sec. 5F-33. Payment of claims.

(a) Claims submitted by a provider to a MCO in the form and manner requested by the MCO shall be reviewed and paid within 30 days of receipt.

(b) A claim that is rejected or denied shall be accompanied with a detailed description of the corrective action needed to permit payment of the claim. A claim resubmitted in compliance with the corrective action requested shall be paid immediately.

(c) A MCO that rejects or denies a claim a second time shall notify the provider by phone and shall provide assistance to the provider to correct any deficiencies in the claim that are preventing payment.

(d) The form and manner required by each individual MCO for payment of claims along with all necessary coding and documentation requirements shall be provided in writing to each provider within 5 days of the provider entering into a contract with a MCO. Providers under contract with a MCO on the effective date of this amendatory Act of the 99th General Assembly shall be provided with a written copy of these requirements within 30 days. Any changes to these requirements shall be delivered in writing to all providers under contract with the MCO 30 days prior to the effective date of the change.

(e)(1) Within 90 days of the effective date of this amendatory Act of the 99th General Assembly, the Department shall enter into a contract with an independent body to mediate rejected or denied claims.

(2) The cost of the mediation service shall be underwritten

by an annual fee collected from each MCO under contract with the Department for either the Integrated Care Program or the Demonstration Project and shall be available to providers participating in the Integrated Care Program and Demonstration Project. The amount of the fee shall be set by rule and shall not generate an amount in excess of the cost of providing the service.

(3) The claims mediation process established pursuant to this subsection shall be available to any provider whose claim submitted pursuant to subsections (a) and (b) is rejected or denied.

(4) The Department shall publish on its website guidelines and an application form for initiating mediation.

(5) The Department shall adopt any rules necessary to implement this Section.