

**2017 -- S 0497 SUBSTITUTE A**

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LC001759/SUB A/3  
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**STATE OF RHODE ISLAND**

**IN GENERAL ASSEMBLY**

**JANUARY SESSION, A.D. 2017**

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A N A C T

RELATING TO INSURANCE ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Senators Lynch Prata, and Doyle

Date Introduced: March 02, 2017

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

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

3           **27-18-65. Post-payment audits.**

4           (a) Except as otherwise provided herein, any review, audit or investigation by a health  
5 insurer or health plan of a health care provider's claims that results in the recoupment or set-off of  
6 funds previously paid to the health care provider in respect to such claims shall be completed no  
7 later than eighteen (18) months after the completed claims were initially paid. This section shall  
8 not restrict any review, audit, or investigation regarding claims that are submitted fraudulently;  
9 are ~~subject to a pattern of inappropriate billing~~ known or should have been known by the health  
10 care provider to be a pattern of inappropriate billing according to the standards for provider  
11 billing of their respective medical or dental specialties; are related to coordination of benefits; are  
12 duplicate claims; or are subject to any federal law or regulation that permits claims review  
13 beyond the period provided herein.

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

18           (c) For the purposes of this section, "health care provider" means an individual clinician,  
19 either in practice independently, or in a group, who provides health care services, and any

1 healthcare facility, as defined in § 27-18-1.1 including any mental health and/or substance abuse  
2 treatment facility, physician, or other licensed practitioner as identified to the review agent as  
3 having primary responsibility for the care, treatment, and services rendered to a patient.

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

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

9 **27-19-56. Post-payment audits.**

10 (a) Except as otherwise provided herein, any review, audit or investigation by a nonprofit  
11 hospital service corporation of a health-care provider's claims that results in the recoupment or  
12 set-off of funds previously paid to the health-care provider in respect to such claims shall be  
13 completed no later than eighteen (18) months after the completed claims were initially paid. This  
14 section shall not restrict any review, audit, or investigation regarding claims that are submitted  
15 fraudulently; are ~~subject to a pattern of inappropriate billing~~ known or should have been known  
16 by the health care provider to be a pattern of inappropriate billing according to the standards for  
17 provider billing of their respective medical or dental specialties; are related to coordination of  
18 benefits; are duplicate claims; or are subject to any federal law or regulation that permits claims  
19 review beyond the period provided herein.

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

24 (c) For the purposes of this section, "health-care provider" means an individual clinician,  
25 either in practice independently or in a group, who provides health-care services, and any  
26 healthcare facility, as defined in § 27-18-1.1 including any mental health and/or substance abuse  
27 treatment facility, physician, or other licensed practitioner identified to the review agent as having  
28 primary responsibility for the care, treatment, and services rendered to a patient.

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

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

34 **27-20-51. Post-payment audits.**

1 (a) Except as otherwise provided herein, any review, audit or investigation by a nonprofit  
2 medical service corporation of a health care provider's claims that results in the recoupment or  
3 set-off of funds previously paid to the health care provider in respect to such claims shall be  
4 completed no later than eighteen (18) months after the completed claims were initially paid. This  
5 section shall not restrict any review, audit, or investigation regarding claims that are submitted  
6 fraudulently; are ~~subject to a pattern of inappropriate billing~~ known or should have been known  
7 by the health care provider to be a pattern of inappropriate billing according to the standards for  
8 provider billing of their respective medical or dental specialties; are related to coordination of  
9 benefits; are duplicate claims; or are subject to any federal law or regulation that permits claims  
10 review beyond the period provided herein.

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

15 (c) For the purposes of this section, "health care provider" means an individual clinician,  
16 either in practice independently or in a group, who provides health care services, and any  
17 healthcare facility, as defined in § 27-20-1 including any mental health and/or substance abuse  
18 treatment facility, physician, or other licensed practitioner identified to the review agent as having  
19 primary responsibility for the care, treatment, and services rendered to a patient.

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

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

25 **27-41-69. Post-payment audits.**

26 (a) Except as otherwise provided herein, any review, audit or investigation by a health  
27 maintenance organization of a health care provider's claims that results in the recoupment or set-  
28 off of funds previously paid to the health care provider in respect to such claims shall be  
29 completed no later than eighteen (18) months after the completed claims were initially paid. This  
30 section shall not restrict any review, audit, or investigation regarding claims that are submitted  
31 fraudulently; are ~~subject to a pattern of inappropriate billing~~ known or should have been known  
32 by the health care provider to be a pattern of inappropriate billing according to the standards for  
33 provider billing of their respective medical or dental specialties; are related to coordination of  
34 benefits; are duplicate claims; or are subject to any federal law or regulation that permits claims

1 review beyond the period provided herein.

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

6 (c) For the purposes of this section, "health care provider" means an individual clinician,  
7 either in practice independently or in a group, who provides health care services, and any  
8 healthcare facility, as defined in § 27-41-2 including any mental health and/or substance abuse  
9 treatment facility, physician, or other licensed practitioner identified to the review agent as having  
10 primary responsibility for the care, treatment, and services rendered to a patient.

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

14 SECTION 5. Section 27-20.1-19 of the General Laws in Chapter 27-20.1 entitled  
15 "Nonprofit Dental Service Corporations" is hereby amended to read as follows:

16 **27-20.1-19. Post-payment audits.**

17 (a) Except as otherwise provided herein, any review, audit or investigation by a nonprofit  
18 dental service corporation of a health care provider's claims which results in the recoupment or  
19 set-off of funds previously paid to the health care provider in respect to such claims shall be  
20 completed no later than ~~two (2) years~~ eighteen (18) months after the completed claims were  
21 initially paid. This section shall not restrict any review, audit or investigation regarding claims  
22 that are submitted fraudulently, are ~~subject to~~ known or should have been known by the health  
23 care provider to be a pattern of inappropriate billing according to the standards for provider  
24 billing of their respective medical or dental specialty, are related to coordination of benefits, or  
25 are subject to any federal law or regulation that permits claims review beyond the period provided  
26 herein.

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

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

1 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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- 1           This act would permit an audit or claims investigation for a pattern of inappropriate
- 2    billing only if it is determined that the claims are known by the provider to be inappropriate.
- 3           This act would take effect upon passage.

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