GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H **D**

HOUSE DRH50514-MH-54A (3/6)

Short Title:	Insurance/Health Care Provider Relationship.	(Public)
Sponsors:	Representatives Steen, Barnhart, Neumann, and England (Primary Sponsors).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REFORM THE PROCESS FOR RECOVERY OF OVERPAYMENTS TO PROVIDERS BY INSURERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-225 reads as rewritten:

"**§ 58-3-225. Prompt claim payments under health benefit plans.**

…

(h) Subject to the time lines required under this section, the insurer may recover overpayments made to the health care provider or health care facility by making demands for refunds ~~and~~ and, if the matter is not resolved pursuant to this subsection, by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this section. Not less than ~~30~~ 90 calendar days before an insurer seeks overpayment recovery or offsets future payments, the insurer shall give written notice to the health care provider or health care facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments may be made not more than ~~two years~~180 calendar days after the date of the original claim payment unless the insurer has reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents, or the claim involves a health care provider or health care facility receiving payment for the same service from a government payor. Recovery of overpayments pursuant to this subsection shall be limited to the actual claims for which the insurer can provide the health care provider or facility with (i) the patient's name and identification number, (ii) the service date, (iii) the payment amount received by the health care provider or facility for the claim, and (iv) an explanation of the proposed revised payment amount which includes at a minimum the change in the code used, the amount of the revised payment, and the reason for the change in code. The requirements in the preceding sentence do not apply if the insurer provides documented evidence of fraud or other intentional misconduct by the health care provider or health care facility or its agents. If a health care provider or health care facility disputes a request for an overpayment recovery by the insurer, then the provider or facility may appeal the request within 30 days of receipt of the request for recovery. The insurer shall provide an internal appeals process for adjudicating such disputes within 60 days of the health care provider or health care facility commencing an appeal. If, within 90 calendar days after an insurer provides a health care provider or health care facility written notice of a demand for recovery of overpayments, the provider or facility has not provided a refund of an overpayment

or an appeal of an alleged overpayment is still ongoing, then the insurer may seek recovery by offsetting future payments.

The health care provider or health care facility may recover underpayments or nonpayments by the insurer by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the insurer may include applicable interest under this section. The period for which such recoveries may be made may not exceed two years after the date of the original claim adjudication, unless the claim involves a health provider or health care facility receiving payment for the same service from a government payor.

(i) Every insurer shall maintain written or electronic records of its activities under this section, including records of when each claim was received, paid, denied, or pended, and the insurer's review and handling of each claim under this section, sufficient to demonstrate compliance with this section.

(j) A violation of this section by an ~~insurer~~ insurer, including a demand for recovery of overpayments under subsection (h) of this section that is made in bad faith, subjects the insurer to the sanctions in G.S. 58-2-70. The authority of the Commissioner under this subsection does not impair the right of a claimant to pursue any other action or remedy available under law. With respect to a specific claim, an insurer paying statutory interest in good faith under this section is not subject to sanctions for that claim under this subsection.

(k) An insurer is not in violation of this section nor subject to interest payments under this section if its failure to comply with this section is caused in material part by (i) the person submitting the claim, or (ii) by matters beyond the insurer's reasonable control, including an act of God, insurrection, strike, fire, or power outages. In addition, an insurer is not in violation of this section or subject to interest payments to the claimant under this section if the insurer has a reasonable basis to believe that the claim was submitted fraudulently and notifies the claimant of the alleged fraud.

(l) Expired January 1, 2003.

(m) Nothing in this section limits or impairs the patient's liability under existing law for payment of medical expenses."

SECTION 2. .The Department of Insurance shall study the advisability of and need for an independent claims review process for disputes between insurers and providers analogous to that provided for appeals by covered persons of noncertification decisions by Part 4 of Article 50 of Chapter 58 of the General Statutes. The Department shall report its findings, including proposed legislation, to the General Assembly no later than April 1, 2010.

SECTION 3. This act is effective when it becomes law. Section 1 of this act applies to reviews by insurers of claims for possible overpayment commenced on or after that date.