

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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HOUSE BILL 1485
PROPOSED COMMITTEE SUBSTITUTE H1485-PCS10955-RD-36

Short Title: Insurance/Health Care Provider Relationship.

(Public)

Sponsors:

Referred to:

April 13, 2009

1 A BILL TO BE ENTITLED
2 AN ACT TO REFORM THE PROCESS FOR RECOVERY OF OVERPAYMENTS TO
3 PROVIDERS BY INSURERS.

4 The General Assembly of North Carolina enacts:

5 SECTION 1. G.S. 58-3-225 reads as rewritten:
6 "§ 58-3-225. Prompt claim payments under health benefit plans.

7 ...
8 (h) Subject to the time lines required under this section, the insurer may recover
9 overpayments made to the health care provider or health care facility by making demands for
10 refunds ~~and~~ and, if the matter is not resolved pursuant to this subsection, by offsetting future
11 payments. Any such recoveries may also include related interest payments that were made
12 under the requirements of this section. Not less than ~~30~~90 calendar days before an insurer
13 seeks overpayment recovery or offsets future payments, the insurer shall give written notice to
14 the health care provider or health care facility, which notice shall be accompanied by adequate
15 specific information to identify the specific claim and the specific reason for the recovery. The
16 recovery of overpayments or offsetting of future payments may be made not more than two
17 years after the date of the original claim payment unless the insurer has reasonable belief of
18 fraud or other intentional misconduct by the health care provider or health care facility or its
19 agents, or the claim involves a health care provider or health care facility receiving payment for
20 the same service from a government payor. Recovery of overpayments pursuant to this
21 subsection shall be limited to the actual claims for which the insurer can provide the health care
22 provider or facility with (i) the patient's name and identification number, (ii) the service date,
23 (iii) the payment amount received by the health care provider or facility for the claim, and (iv)
24 an explanation of the proposed revised payment amount which includes at a minimum the
25 change in the code used, the amount of the revised payment, and the reason for the change in
26 code. The requirements in the preceding sentence do not apply if the insurer provides
27 documented evidence of fraud or other intentional misconduct by the health care provider or
28 health care facility or its agents. If a health care provider or health care facility disputes a
29 request for an overpayment recovery by the insurer, then the provider or facility may appeal the
30 request within 45 days of receipt of the request for recovery. The insurer shall provide an
31 internal appeals process for adjudicating such disputes within 90 days of the health care
32 provider or health care facility commencing an appeal. If, within 120 calendar days after an
33 insurer provides a health care provider or health care facility written notice of a demand for
34 recovery of overpayments, the provider or facility has not provided a refund of an overpayment



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

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

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

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

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

27 (l) Expired January 1, 2003.

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

30 **SECTION 2.** The Department of Insurance shall study the advisability of and need
31 for an independent claims review process for disputes between insurers and providers
32 analogous to that provided for appeals by covered persons of noncertification decisions by Part
33 4 of Article 50 of Chapter 58 of the General Statutes. The Department shall report its findings,
34 including proposed legislation, to the General Assembly no later than April 1, 2010.

35 **SECTION 3.** This act is effective when it becomes law. Section 1 of this act
36 applies to reviews by insurers of claims for possible overpayment of claim payments made on
37 or after that date and to health care provider or health care facility demands for refunds from
38 insurers for claims originally adjudicated on or after that date.