

House Bill 2455

Sponsored by Representative NOSSE; Representative SANCHEZ (Pre-session filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced**.

Imposes requirements and restrictions on insurer and coordinated care organization audits of claims for reimbursement submitted by behavioral health treatment providers.

Takes effect on 91st day following adjournment sine die.

A BILL FOR AN ACT

1
2 Relating to audits of claims for reimbursement of the costs of behavioral health treatment; creating
3 new provisions; amending ORS 414.592; and prescribing an effective date.

4 **Be It Enacted by the People of the State of Oregon:**

5 **SECTION 1. Section 2 of this 2023 Act is added to and made a part of the Insurance Code.**

6 **SECTION 2. (1) As used in this section:**

7 (a) **“Audit” means an on-site or remote review of records of or claims made by a provider**
8 **by or on behalf of an insurer.**

9 (b) **“Behavioral health treatment” includes:**

10 (A) **Mental health treatment and services as defined in ORS 743B.427; and**

11 (B) **Substance use disorder treatment and services as defined in ORS 743B.427.**

12 (c) **“Claim” means a request made by a provider to an insurer to reimburse the cost of**
13 **behavioral health treatment provided to a beneficiary of a policy or certificate of health in-**
14 **urance offered by the insurer.**

15 (d) **“Clerical error” means a minor error in the keeping, recording or transcribing of re-**
16 **ords or documents or in the handling of electronic or hard copies of correspondence that**
17 **does not result in financial harm to an insurer or to a patient.**

18 (e) **“Provider” means a person who is licensed, certified or otherwise authorized to pro-**
19 **vide behavioral health treatment in this state.**

20 (2) **An insurer that offers a policy or certificate of health insurance that reimburses the**
21 **cost of behavioral health treatment must make available to all providers who submit claims**
22 **a separate document or brochure containing a detailed written description of all audit re-**
23 **quirements. The description must:**

24 (a) **Be written in plain language that is easy to understand and that does not rely on**
25 **references to other sources such as statutes or contract provisions;**

26 (b) **Provide examples of documentation requirements for the submission of claims;**

27 (c) **Identify which requirements may result in recoupment for failure to comply;**

28 (d) **Explain which requirements apply to in-network providers and which apply to out-of-**
29 **network providers; and**

30 (e) **If the requirements differentiate between types of providers, explain the requirements**
31 **applicable to each type of provider.**

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

1 (3) An insurer may not recoup from a provider a payment on a claim if the insurer has
2 failed to comply with subsection (2) of this section.

3 (4) An insurer must notify providers no later than 30 days before the effective date of
4 any changes to the insurer's audit requirements as described by the insurer in accordance
5 with subsection (2) of this section. An insurer may not demand recoupment of a payment
6 made on a claim based on new audit requirements if the insurer has failed to comply with
7 this subsection.

8 (5) An insurer's audit of a claim:

9 (a) May not be conducted on any paid claim submitted by a provider on a date more than
10 12 months earlier;

11 (b) Must be completed no later than 180 days from the date an audit is initiated on a
12 claim;

13 (c) Must be conducted by a behavioral health professional;

14 (d) May not result in reversing or overturning a medical necessity determination made
15 by the insurer when the claim was submitted or prior authorization of the service approved;
16 and

17 (e) May not be based on probability sampling, extrapolation or other means that project
18 an error using the number of claims submitted by a provider.

19 (6) In the course of an audit, an insurer must respond to a provider with findings no later
20 than 30 days after the date the provider responds to the insurer's request for additional in-
21 formation regarding the claim.

22 (7) An insurer may not demand recoupment of a payment made on a claim based on a
23 clerical error.

24 (8) If an insurer identifies an error during an audit of a claim that results in the
25 insurer's demand for recoupment of the insurer's payment on the claim, the insurer:

26 (a) Must provide a detailed description of the error and allow a provider a reasonable
27 opportunity of not less than 30 days to rectify the error; and

28 (b) Must allow the provider to use a repayment plan of up to three years to repay the
29 claim unless the recoupment is based on an insurer's duplicate payment on a claim.

30 (9) An insurer may not begin a new audit of any claim submitted by a provider while
31 another audit is in process. A subsequent audit may not be initiated until the provider has
32 been given the opportunity to correct mistakes identified in the previous audit and complete
33 any corrective action plan resulting from the previous audit.

34 (10) An insurer conducting an audit may not compensate an individual conducting an
35 audit based on a percentage of the overpayments recouped or in any other way that creates
36 a financial incentive to identify errors that result in recoupment.

37 (11) The provisions of this section apply to audits conducted by an insurer and to audits
38 conducted by a third party on behalf of an insurer.

39 **SECTION 3.** Section 4 of this 2023 Act is added to and made a part of ORS chapter 414.

40 **SECTION 4.** (1) As used in this section:

41 (a) "Audit" means an on-site or remote review of records of or claims made by a provider
42 by or on behalf of a coordinated care organization.

43 (b) "Behavioral health treatment" includes:

44 (A) Mental health treatment and services as defined in ORS 743B.427; and

45 (B) Substance use disorder treatment and services as defined in ORS 743B.427.

1 (c) “Claim” means a request made by a provider to a coordinated care organization to
 2 reimburse the cost of behavioral health treatment provided to a member of the coordinated
 3 care organization.

4 (d) “Clerical error” means a minor error in the keeping, recording or transcribing of re-
 5 cords or documents or in the handling of electronic or hard copies of correspondence that
 6 does not result in financial harm to a coordinated care organization or to a patient.

7 (e) “Provider” means a person who is licensed, certified or otherwise authorized to pro-
 8 vide behavioral health treatment in this state.

9 (2) A coordinated care organization must make available to all providers who submit
 10 claims to the coordinated care organization a separate document or brochure containing a
 11 detailed written description of all audit requirements. The description must:

12 (a) Be written in plain language that is easy to understand and that does not rely on
 13 references to other sources such as statutes or contract provisions;

14 (b) Provide examples of documentation requirements for the submission of claims;

15 (c) Identify which requirements may result in recoupment for failure to comply;

16 (d) Explain which requirements apply to in-network providers and which apply to out-of-
 17 network providers; and

18 (e) If the requirements differentiate between types of providers, explain the requirements
 19 applicable to each type of provider.

20 (3) A coordinated care organization may not recoup from a provider a payment on a
 21 claim if the coordinated care organization has failed to comply with subsection (2) of this
 22 section.

23 (4) A coordinated care organization must notify providers no later than 30 days before
 24 the effective date of any changes to the coordinated care organization’s audit requirements
 25 as described by the coordinated care organization in accordance with subsection (2) of this
 26 section. A coordinated care organization may not demand recoupment of a payment made
 27 on a claim based on new audit requirements if the coordinated care organization has failed
 28 to comply with this subsection.

29 (5) A coordinated care organization’s audit of a claim:

30 (a) May not be conducted on any paid claim submitted by a provider on a date more than
 31 12 months earlier;

32 (b) Must be completed no later than 180 days from the date an audit is initiated on a
 33 claim;

34 (c) Must be conducted by a behavioral health professional;

35 (d) May not result in reversing or overturning a medical necessity determination made
 36 by the coordinated care organization when the claim was submitted or prior authorization
 37 of the service approved; and

38 (e) May not be based on probability sampling, extrapolation or other means that project
 39 an error using the number of claims submitted by a provider.

40 (6) In the course of an audit, a coordinated care organization must respond to a provider
 41 with findings no later than 30 days after the date the provider responds to the coordinated
 42 care organization’s request for additional information regarding the claim.

43 (7) A coordinated care organization may not demand recoupment of a payment made on
 44 a claim based on a clerical error.

45 (8) If a coordinated care organization identifies an error during an audit of a claim that

1 results in the coordinated care organization's demand for recoupment of the coordinated
2 care organization's payment on the claim, the coordinated care organization:

3 (a) Must provide a detailed description of the error and allow a provider a reasonable
4 opportunity of not less than 30 days to rectify the error; and

5 (b) Must allow the provider to use a repayment plan of up to three years to repay the
6 claim unless the recoupment is based on a coordinated care organization's duplicate payment
7 on a claim.

8 (9) A coordinated care organization may not begin a new audit of any claim submitted
9 by a provider while another audit is in process. A subsequent audit may not be initiated until
10 the provider has been given the opportunity to correct mistakes identified in the previous
11 audit and complete any corrective action plan resulting from the previous audit.

12 (10) A coordinated care organization conducting an audit may not compensate an indi-
13 vidual conducting an audit based on a percentage of the overpayments recouped or in any
14 other way that creates a financial incentive to identify errors that result in recoupment.

15 (11) The provisions of this section apply to audits conducted by a coordinated care or-
16 ganization and to audits conducted by a third party on behalf of a coordinated care organ-
17 ization.

18 **SECTION 5.** ORS 414.592 is amended to read:

19 414.592. Notwithstanding ORS 414.590:

20 (1) Contracts between the Oregon Health Authority and coordinated care organizations or indi-
21 vidual providers for the provision of behavioral health services must align with the quality metrics
22 and incentives developed by the Behavioral Health Committee under ORS 413.017 and contain pro-
23 visions that ensure that:

24 (a) Individuals have easy access to needed care;

25 (b) Services are responsive to individual and community needs; [*and*]

26 (c) Services will lead to meaningful improvement in individuals' lives[.]; **and**

27 **(d) Coordinated care organizations comply with section 4 of this 2023 Act.**

28 (2) The authority must provide at least 90 days' notice of changes needed to contracts that are
29 necessary to comply with subsection (1) of this section.

30 **SECTION 6. This 2023 Act takes effect on the 91st day after the date on which the 2023**
31 **regular session of the Eighty-second Legislative Assembly adjourns sine die.**

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