HB1075

LRB095 04857 MJR 24919 b

95TH GENERAL ASSEMBLY

State of Illinois

2007 and 2008

HB1075

Introduced 2/8/2007, by Rep. Kurt M. Granberg

SYNOPSIS AS INTRODUCED:

215 ILCS 5/368b

Amends the Illinois Insurance Code. Requires a third party payer (i) to adopt and implement policies related to bundling of physician services submitted for reimbursement that conform with the American Medical Association's Current Procedural Terminology coding guidelines, (ii) to reimburse a physician for office visits and consultations and therapeutic or diagnostic procedures performed on the same day that the services are medically indicated, and (iii) to provide written notice to the physician of any change to its policy related to bundling at least 90 days prior to the effective date of the change. Makes related changes.

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A BILL FOR

AN ACT concerning regulation.

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

Section 5. The Illinois Insurance Code is amended by changing Section 368b as follows:

(215 ILCS 5/368b)

Sec. 368b. Contracting procedures.

(a) The General Assembly hereby finds and declares the following:

(1) In an effort to reduce payments, some third party payers are arbitrarily and inappropriately bundling services such that participating physicians are being denied payment for legitimate multiple services.

(2) This practice also has the effect of denying payment for physician office visits and consultations rendered on the same day that a medically necessary therapeutic or diagnostic procedure is performed.

(3) The Centers for Medicare and Medicaid Services recognized the impropriety of denying payment for office visits and consultations rendered on the same day as a medically necessary therapeutic or diagnostic procedure and changed its Medicare reimbursement policy so that both services are reimbursed when medically indicated.

(4) Third party payers often change their policies relating to bundling without providing advance notice to the physician of such changes.

(b) For the purpose of this Section, "third party payer" means any insurer, health maintenance organization, independent practice association, or physician hospital organization.

(c) A third party payer shall adopt and implement policies related to bundling of physician services submitted for reimbursement that conform with the American Medical Association's (AMA's) Current Procedural Terminology (CPT) coding guidelines.

A third party payer must reimburse a physician for office visits and consultations and therapeutic or diagnostic procedures performed on the same day that the services are medically indicated.

A third party payer shall not combine any individually coded services submitted by the provider for reimbursement, unless such action conforms to the AMA's Current Procedural Terminology (CPT) coding guidelines, including, but not limited to, the use of CPT modifiers, add-on codes, and 51-exempt codes, and is in accordance with the third party payer's policies regarding bundling, as agreed to in the contract between the physician and third party payer.

A third party payer must provide written notice to the physician of any change to its policy related to bundling at

least 90 days prior to the effective date of the change.

(d) ~~(a)~~ A health care professional or health care provider offered a contract by an insurer, health maintenance organization, independent practice association, or physician hospital organization for signature after the effective date of this amendatory Act of the 93rd General Assembly shall be provided with a proposed health care professional or health care provider services contract including, if any, exhibits and attachments that the contract indicates are to be attached. Within 35 days after a written request, the health care professional or health care provider offered a contract shall be given the opportunity to review and obtain a copy of the following: a specialty-specific fee schedule sample based on a minimum of the 50 highest volume fee schedule codes with the rates applicable to the health care professional or health care provider to whom the contract is offered, the network provider administration manual, and a summary capitation schedule, if payment is made on a capitation basis. If 50 codes do not exist for a particular specialty, the health care professional or health care provider offered a contract shall be given the opportunity to review or obtain a copy of a fee schedule sample with the codes applicable to that particular specialty. This information may be provided electronically. An insurer, health maintenance organization, independent practice association, or physician hospital organization may substitute the fee schedule sample with a document providing reference to the

information needed to calculate the fee schedule that is available to the public at no charge and the percentage or conversion factor at which the insurer, health maintenance organization, preferred provider organization, independent practice association, or physician hospital organization sets its rates.

(e) ~~(b)~~ The fee schedule, the capitation schedule, and the network provider administration manual constitute confidential, proprietary, and trade secret information and are subject to the provisions of the Illinois Trade Secrets Act. The health care professional or health care provider receiving such protected information may disclose the information on a need to know basis and only to individuals and entities that provide services directly related to the health care professional's or health care provider's decision to enter into the contract or keep the contract in force. Any person or entity receiving or reviewing such protected information pursuant to this Section shall not disclose the information to any other person, organization, or entity, unless the disclosure is requested pursuant to a valid court order or required by a state or federal government agency. Individuals or entities receiving such information from a health care professional or health care provider as delineated in this subsection are subject to the provisions of the Illinois Trade Secrets Act.

(f) ~~(c)~~ The health care professional or health care

provider shall be allowed at least 30 days to review the health care professional or health care provider services contract, including exhibits and attachments, if any, before signing. The 30-day review period begins upon receipt of the health care professional or health care provider services contract, unless the information available upon request in subsection (d) ~~(a)~~ is not included. If information is not included in the professional services contract and is requested pursuant to subsection (d) ~~(a)~~, the 30-day review period begins on the date of receipt of the information. Nothing in this subsection shall prohibit a health care professional or health care provider from signing a contract prior to the expiration of the 30-day review period.

(g) ~~(d)~~ The insurer, health maintenance organization, independent practice association, or physician hospital organization shall provide all contracted health care professionals or health care providers with any changes to the fee schedule provided under subsection (d) ~~(a)~~ not later than 35 days after the effective date of the changes, unless such changes are specified in the contract and the health care professional or health care provider is able to calculate the changed rates based on information in the contract and information available to the public at no charge. For the purposes of this subsection, "changes" means an increase or decrease in the fee schedule referred to in subsection (d) ~~(a)~~. This information may be made available by mail, e-mail,

newsletter, website listing, or other reasonable method. Upon request, a health care professional or health care provider may request an updated copy of the fee schedule referred to in subsection (d) ~~(a)~~ every calendar quarter.

(h) ~~(e)~~ Upon termination of a contract with an insurer, health maintenance organization, independent practice association, or physician hospital organization and at the request of the patient, a health care professional or health care provider shall transfer copies of the patient's medical records. Any other provision of law notwithstanding, the costs for copying and transferring copies of medical records shall be assigned per the arrangements agreed upon, if any, in the health care professional or health care provider services contract.

(Source: P.A. 93-261, eff. 1-1-04.)