HOUSE BILL 2076
By Martin B

SENATE BILL 2328

By Yager

AN ACT to amend Tennessee Code Annotated, Title 56; Title 63 and Title 68, relative to payment for health care.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-7-110, is amended by deleting the section and substituting:

(a) As used in this part:

(1) "Covered person" means a person on whose behalf a health insurance entity offering health insurance coverage is obligated to pay benefits or provide services;

(2) "Healthcare provider" means a person or entity performing services regulated pursuant to title 63 or title 68, chapter 11;

(3) "Health insurance coverage" has the same meaning as in § 56-7-109;

(4) "Health insurance entity" has the same meaning as in § 56-7-109; and

(5) "Recoupment" or "recoup" means the action by a health insurance entity to recover amounts previously paid to a healthcare provider by withholding or offsetting the amounts against current payments to the healthcare provider.

(b) A health insurance entity is not required to correct a payment error to a healthcare provider if the provider's request for a payment correction is filed more than six (6) months after the date that the healthcare provider received payment for the claim from the health insurance entity.

(c) Except in cases of fraud committed by the healthcare provider, a health insurance entity may only recoup reimbursements from the provider during the six-month

period after the date that the health insurance entity paid the claim submitted by the healthcare provider;

(d) Notwithstanding subsection (c), if a health insurance entity or an agent that contracted to provide eligibility verification verifies that an individual is a covered person, and if the healthcare provider provides services to the individual in reliance on the verification, the health insurance entity shall not thereafter recoup a claim on the basis that the individual is not a covered person unless the recoupment occurs within six (6) months of the date that the health insurance entity paid the claim; otherwise, the health insurance entity is barred from making the recoupment unless there was fraud by the healthcare provider.

(e) If a healthcare provider reports an overpayment by a health insurance entity to the health insurance entity in accordance with the process identified by the health insurance entity, then the health insurance entity shall not recoup any additional overpayment amount that is discovered more than sixty (60) days from the date of the healthcare provider's report to the health insurance entity that arose from the same claim or claims subject to the report.

(f) A health insurance entity that intends to recoup a previously paid claim shall give the healthcare provider sixty (60) days' advance written or electronic notice specifying the basis for the recoupment, and the notice must contain, at a minimum, the following information:

(1) The CPT codes in the claims subject to the recoupment, or, if no CPT code is available, a description of the healthcare items or services for which the health insurance entity overpaid;

(2) A detailed explanation of why the previously made payment is being recouped, including, but not limited to:

(A) Identification of the billing codes and modifiers that the health insurance entity believes should have been billed;

(B) The health insurance entity's policies supporting the billing codes and modifiers that the health insurance entity believes should have been billed; and

(C) The amount that should have been paid;

(3) The claims subject to the recoupment, including applicable claim numbers;

(4) The covered person's full legal name and any identification numbers;

(5) The dates on which the healthcare provider provided the healthcare items or services, the costs of which are being recouped by the health insurance entity;

(6) The amount of recoupment;

(7) Each claim's date of payment and how it was issued to the healthcare provider, including by mail or electronically, and, if applicable, the number of the check containing the recoupment or electronic payment identifying information; and

(8) The process by which the healthcare provider may appeal the recoupment, including the instructions for the appeal process.

(g) Payment must not be withheld from the healthcare provider until all appeals are exhausted, unless the healthcare provider notifies the health insurance entity that the provider is not appealing the recoupment or withdraws the appeal in accordance with the appeal process provided to the provider under subdivision (f)(8).

(h) If the healthcare provider chooses to appeal the recoupment, both entities must follow the dispute resolution process as set forth in chapter 61 of this title.

(i) Once all appeals are exhausted, if it is determined that a health insurance entity is entitled to a recoupment, the health insurance entity shall give written notice to the healthcare provider of the amount the health insurance entity is entitled to recoup from the previously paid claim and may:

(1) Request a refund from the healthcare provider; or

(2) Recoup by reducing payments currently owed to the healthcare provider by clearly identifying the pending claims from which the health insurance entity intends to recoup the overpayment.

(j) The notice required by subsection (f) may be included with the results of an audit submitted to a healthcare provider.

(k)

(1) If the commissioner finds that a health insurance entity has failed to comply with this section, the commissioner may impose a penalty of two (2) times the amount of the claim or one thousand five hundred dollars ($1,500), whichever amount is less.

(2) In the alternative, the healthcare provider may seek injunctive or other appropriate relief in the chancery or circuit court in the county where the provider resides or practices.

(l) This section must not be waived, voided, or nullified by contract.

(m) The amount of a recoupment must equal the difference between the actual amount paid to a healthcare provider and the amount that should have been paid as specified in the notice provided to the healthcare provider under subsection (i).

(n)

(1) This section must not interfere with or otherwise repeal the following:

(A) The prompt payment appeals process described in § 56-32-126;

(B) After January 1, 2025, the Prior Authorization Fairness Act, codified in part 37 of this chapter;

(C) The authority of a receiver appointed by the commissioner pursuant to chapter 9 of this title to audit or collect overpayment made to providers more than eighteen (18) months from the date that a managed care organization (MCO) paid the claim;

(D) The authority of the bureau of TennCare to collect overpayments made to providers more than eighteen (18) months from the date that the MCO paid the claim if discovered and verified by the bureau pursuant to an audit of an MCO; or

(E) The subrogation rights or authority of the bureau of TennCare.

(2) Health insurance entities that contract directly with the bureau of TennCare in the provision of services for TennCare recipients are specifically excluded from this section only for the products and services made by the health insurance entities on behalf of the bureau of TennCare.

(o) Only a health insurance entity or a health insurance entity's agent that contracts with healthcare providers or is responsible for paying contracted or noncontracted healthcare providers may seek to recover payments made to those healthcare providers. No other entity may pursue recoupments governed by this section.

(p) A health insurance entity may not impose a monetary penalty on the healthcare provider with respect to an overpayment, including, but not limited to, an interest charge or a late fee.

(q) A health insurance entity shall not base a recoupment on the extrapolation of other claims from an audit.

(r) The commissioner is authorized to promulgate rules to effectuate this section in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 2. This act takes effect July 1, 2024, the public welfare requiring it.