



Sen. David Koehler

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10400SB3114sam001

LRB104 19668 BAB 35623 a

1 AMENDMENT TO SENATE BILL 3114

2 AMENDMENT NO. _____. Amend Senate Bill 3114 by replacing
3 everything after the enacting clause with the following:

4 "Section 1. Short title. This Act may be cited as the
5 Transparency in Downcoding Act.

6 Section 2. Findings. The General Assembly finds that:

7 (1) Downcoding of medical claims, when done without
8 clear justification or transparency, undermines fair
9 payment of health care providers and threatens the
10 stability of physician practices.

11 (2) Improper downcoding may result in harm to patients
12 by disincentivizing care for individuals with complex
13 medical conditions.

14 (3) It is in the public interest to ensure that all
15 coding adjustments are clinically supported, transparent,
16 appealable, and free from discriminatory targeting.

1 Section 5. Definitions. As used in this Act:

2 "CARC" means Claim Adjustment Reason Codes, which provide
3 the reason for a financial adjustment specific to a particular
4 claim or service referenced in the transmitted Accredited
5 Standards Committee (ASC) X12 835 standard transaction adopted
6 by the United States Department of Health and Human Services
7 under 45 CFR 162.1602.

8 "Downcoding" means the unilateral alteration by a health
9 care payor of the level of evaluation and management service
10 code or other service code submitted on a claim, resulting in a
11 lower payment.

12 "Excepted benefits" has the meaning given to that term in
13 42 U.S.C. 300gg-91(c) and implementing regulations.

14 "Group health plan" has the meaning given to that term in
15 Section 5 of the Illinois Health Insurance Portability and
16 Accountability Act.

17 "Group health plan sponsor" means the plan sponsor of a
18 group health plan.

19 "Health care payor" means a group health plan sponsor,
20 health insurance issuer, or Medicaid managed care
21 organization.

22 "Health insurance issuer" has the meaning given to that
23 term in Section 5 of the Illinois Health Insurance Portability
24 and Accountability Act.

25 "Medicaid managed care organization" has the meaning given

1 to that term in Section 5H-1 of the Illinois Public Aid Code.

2 "Plan sponsor" has the meaning given to that term in 29
3 U.S.C. 1002(16) (B).

4 "RARC" means Remittance Advice Remark Codes, which provide
5 supplemental information about a financial adjustment
6 indicated by a CARC or information about remittance
7 processing.

8 Section 10. Applicability; scope.

9 (a) This Act applies to the following if they are issued,
10 amended, delivered, or renewed on or after the effective date
11 of this Act:

12 (1) a policy or contract for health insurance coverage
13 as defined in the Illinois Health Insurance Portability
14 and Accountability Act;

15 (2) State, employee, county, municipality, or school
16 district group health plans; and

17 (3) policies issued or delivered in this State to the
18 Department of Healthcare and Family Services and providing
19 coverage to persons who are enrolled under Article V of
20 the Illinois Public Aid Code or under the Children's
21 Health Insurance Program Act.

22 This Act does not apply to employee or employer
23 self-insured health benefit plans under the federal Employee
24 Retirement Income Security Act of 1974 and health care
25 provided pursuant to the Workers' Compensation Act or the

1 Workers' Occupational Diseases Act, and excepted benefits,
2 including stand-alone dental plans.

3 (b) This Act does not diminish a health care payor's
4 duties and responsibilities under other federal or State law
5 or the rules adopted thereunder.

6 (c) This Act is not intended to alter or impede the
7 provisions of any consent decree or judicial order to which
8 the State or any of its agencies is a party.

9 (d) The requirement that group health plans and group
10 health plan sponsors must comply with this Act is an exclusive
11 power and function of the State and is a denial and limitation
12 under subsection (h) of Section 6 of Article VII of the
13 Illinois Constitution. A home rule jurisdiction to which this
14 Act applies must comply with every provision of this Act.

15 Section 15. Prohibition of automatic downcoding.

16 (a) A health care payor shall not implement any policy or
17 use any algorithm or other automated process, system, or tool
18 that bypasses the evaluation of all information included by
19 the billing physician to downcode a claim.

20 (b) A health care payor may use an automated process to
21 identify claims that may justify a downcoding determination
22 using the most recently released American Medical Association
23 Current Procedural Terminology (CPT) coding guidelines and
24 considering all information included by the billing physician
25 on the claim submission. All downcoding determinations must be

1 made or reviewed by a natural person using the most recently
2 released American Medical Association Current Procedural
3 Terminology (CPT) coding guidelines and considering all
4 information included by the billing physician on the claim
5 submission in such determination.

6 Section 20. Prohibition on diagnosis-based downcoding. A
7 health care payor shall not downcode a claim based solely on
8 the reported diagnosis codes.

9 Section 25. Notification requirements for downcoded
10 claims. When a claim is downcoded, the health care payor shall
11 notify the billing physician using the appropriate CARC and
12 RARC to clearly indicate that the claim has been downcoded and
13 provide:

14 (1) the specific reason for the downcoding, including
15 reference to the clinical information and coding guidance
16 used to justify the downcoding;

17 (2) the original and revised service codes and payment
18 amounts; and

19 (3) the process to initiate a dispute for a downcoding
20 decision.

21 Section 30. Dispute process for downcoded claims.

22 (a) A health care payor shall provide physicians with a
23 clear and accessible process for disputing downcoded claims,

1 including a written or electronic notice detailing how to
2 initiate a dispute, contact information for the natural person
3 managing the dispute, reasonable timelines for submission by
4 the billing physician of a dispute that are no less than 180
5 days, and timelines for adjudication of the dispute consistent
6 with applicable State law or regulations governing utilization
7 review.

8 Each health care payor shall communicate to physicians the
9 process for disputing downcoded claims, including a reasonable
10 timeline for the submission of a dispute that is at least 180
11 days after the receipt of notice of a downcoded claim.

12 (b) A person disputing more than one claim that was
13 downcoded by a health care payor, intermediary, administrator,
14 or representative may dispute in batches of claims for each
15 individual patient in accordance with the provider contract
16 and the federal Health Insurance Portability and
17 Accountability Act (42 U.S.C. 1320d et seq.) and any rules,
18 regulations, or procedures adopted pursuant thereto. A batch
19 of claims may be submitted no later than 180 days after the
20 receipt of the oldest notice of a downcoded claim in a batch.

21 (c) A health care payor must ensure that all downcoding
22 disputes are reviewed by a natural person. The reviewing
23 natural person must:

24 (1) be knowledgeable of, and have experience
25 providing, the health care services under appeal;

26 (2) not have been directly involved in making the

1 decision to downcode the claim;

2 (3) perform a document review of the clinical
3 information supporting the billed service, including, but
4 not limited to, a review of all pertinent medical records
5 provided to the health care payor and any medical
6 literature provided to the health care payor from the
7 billing physician; and

8 (4) follow the most recently released American Medical
9 Association Current Procedural Terminology (CPT) coding
10 guidelines.

11 (d) Use of a dispute process for downcoded claims does not
12 preclude the physician's or enrollee's right to appeal any
13 adverse determination under applicable State and federal law,
14 rules, or regulations governing utilization review.

15 Section 35. Protections for patients with chronic
16 conditions. A health care payor shall not use downcoding
17 practices in a targeted or discriminatory manner against
18 physicians who routinely treat patients with complex or
19 chronic conditions.

20 Section 40. Administration and enforcement.

21 (a) The Department of Insurance shall enforce the
22 provisions of this Act pursuant to the enforcement powers
23 granted to it by law, including, but not limited to, any powers
24 granted to enforce the Illinois Insurance Code. Such

1 enforcement shall extend to health care payors' compliance
2 with this Act's procedural requirements and restrictions,
3 compliance with this Act's standards for personnel and
4 automated processes, and any pattern or practice of violating
5 Section 20 of this Act. Nothing in this Act shall authorize the
6 Department of Insurance to conduct any process under which a
7 health care provider may submit an appeal for the purpose of
8 receiving a determination from the Department of Insurance
9 about the correctness of any particular downcoding decision
10 under applicable coding guidelines, except to ensure that
11 downcoding determinations are being made in accordance with
12 subsection (b) of Section 15.

13 (b) A health care payor shall be responsible for the
14 compliance with this Act by any third party to whom the health
15 care payor delegates any functions related to downcoding.

16 (c) The Department of Healthcare and Family Services shall
17 enforce the provisions of this Act as it applies to all
18 Medicaid managed care organizations serving persons enrolled
19 under Article V of the Illinois Public Aid Code or under the
20 Children's Health Insurance Program Act.

21 Section 97. Severability. The provisions of this Act are
22 severable under Section 1.31 of the Statute on Statutes.

23 Section 500. The Illinois Public Aid Code is amended by
24 adding Section 5-5.12g as follows:

1 (305 ILCS 5/5-5.12g new)

2 Sec. 5-5.12g. Compliance with the Transparency in
3 Downcoding Act. Notwithstanding any other provision of law to
4 the contrary, all managed care organizations shall comply with
5 the requirements of the Transparency in Downcoding Act.

6 Section 999. Effective date. This Act takes effect January
7 1, 2028."