HOUSE BILL 1505

C3 8lr3182

By: **Delegates Oaks, Costa, Donoghue, Elliott, Hubbard, Morhaim, Pena–Melnyk, Riley, Tarrant, and Weldon**
Introduced and read first time: February 20, 2008
Assigned to: Rules and Executive Nominations

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance – Reimbursement for Preauthorized or**
3 **Approved Health Care Services**

4 FOR the purpose of prohibiting certain health insurance carriers from altering the
5 amount of reimbursement to health care providers for preauthorized or
6 approved health care services delivered to a patient except under certain
7 circumstances; requiring certain carriers to establish a mechanism for providers
8 to submit certain fees to the carriers; requiring certain carriers or the carriers'
9 private review agents to provide certain notification to providers or patients at a
10 certain time; and generally relating to reimbursement for preauthorized or
11 approved health care services under health insurance.

12 BY repealing and reenacting, with amendments,
13 Article – Insurance
14 Section 15–1009
15 Annotated Code of Maryland
16 (2006 Replacement Volume and 2007 Supplement)

17 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF
18 MARYLAND, That the Laws of Maryland read as follows:

19 **Article – Insurance**

20 15–1009.

21 (a) In this section, "carrier" means:

22 (1) an insurer;

23 (2) a nonprofit health service plan;

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW**.
[Brackets] indicate matter deleted from existing law.

(3) a health maintenance organization;

(4) a dental plan organization; or

(5) any other person that provides health benefit plans subject to regulation by the State.

(b) If a health care service for a patient has been preauthorized or approved by a carrier or the carrier's private review agent, the carrier may not deny**, OR ALTER THE AMOUNT OF,** reimbursement to a health care provider for the preauthorized or approved service delivered to that patient unless:

(1) the information submitted to the carrier regarding the service to be delivered to the patient was fraudulent or intentionally misrepresentative;

(2) critical information requested by the carrier regarding the service to be delivered to the patient was omitted such that the carrier's determination would have been different had it known the critical information;

(3) a planned course of treatment for the patient that was approved by the carrier was not substantially followed by the health care provider; or

(4) on the date the preauthorized or approved service was delivered:

(i) the patient was not covered by the carrier;

(ii) the carrier maintained an automated eligibility verification system that was available to the contracting provider by telephone or via the Internet; and

(iii) according to the verification system, the patient was not covered by the carrier.

(C) (1) EACH CARRIER SHALL ESTABLISH A MECHANISM FOR A HEALTH CARE PROVIDER TO SUBMIT TO THE CARRIER THE PROVIDER'S FEE FOR A PROPOSED HEALTH CARE SERVICE FOR A PATIENT.

(2) AT THE TIME A CARRIER OR THE CARRIER'S PRIVATE REVIEW AGENT PREAUTHORIZES OR APPROVES A PROPOSED HEALTH CARE SERVICE FOR A PATIENT, THE CARRIER SHALL NOTIFY THE PROVIDER OR THE PATIENT OF THE AMOUNT OF REIMBURSEMENT THAT THE CARRIER WILL PAY FOR THE PREAUTHORIZED OR APPROVED HEALTH CARE SERVICE.

[(c)**] (D)** A carrier shall pay a claim for a preauthorized or approved covered health care service in accordance with §§ 15–1005 and 15–1008 of this subtitle.

1 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect
2 October 1, 2008.