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Introduced and read first time: January 31, 1997
Assigned to: Economic Matters

Committee Report: Favorable with amendments
House action: Adopted
Read second time: March 21, 1997

CHAPTER ____

AN ACT concerning

Health Insurance - ~~Health Care Practitioners - Retroactive Denials of~~ Reimbursement of Service Providers

FOR the purpose of ~~restricting the time period during which certain health insurance carriers may retroactively deny reimbursement to health care practitioners under certain circumstances; requiring certain health insurance carriers to provide a certain statement; prohibiting certain health insurance carriers from retroactively denying reimbursement or attempting to retroactively collect reimbursement already paid to health care practitioners under certain circumstances; and generally relating to retroactive denials of reimbursement to health care practitioners~~ requiring a health maintenance organization, insurer, or nonprofit health service plan to permit a provider a certain minimum number of months to submit a claim for reimbursement; requiring a health maintenance organization, insurer, or nonprofit health service plan to reimburse a provider within a certain time, under certain circumstances, after receiving certain documentation; and generally relating to reimbursement of health care service providers.

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-712.1
Annotated Code of Maryland
(1996 Replacement Volume and 1996 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section ~~15-113~~ 15-1005

Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter _____ (H.B. 11) of the Acts of the General Assembly of 1997)

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

Article - Health - General

19-712.1.

(a) For covered services rendered to its members, a health maintenance organization shall reimburse any provider within 30 days after receipt of a claim that is accompanied by all reasonable and necessary documentation.

(b) (1) If a health maintenance organization fails to comply with subsection (a) of this section, the health maintenance organization shall pay interest beginning with the 31st day on the amount of the claim that remains unpaid after 30 days following the receipt of the claim.

(2) The interest payable shall be at the rate of 1.5 percent per month simple interest prorated for any portion of a month.

(3) Except as provided in subsection (c) of this section, when paying a claim more than 30 days after its receipt, the health maintenance organization shall add the interest payable to the amount of the unpaid claim without the necessity for any claim for that interest to be made by the provider filing the original claim.

(c) The provisions of this section do not apply to claims where:

(1) There is a good faith dispute regarding:

(i) The legitimacy of the claim; or

(ii) The appropriate amount of reimbursement; and

(2) The health maintenance organization:

(i) Notifies the provider within 2 weeks of the receipt of the claim that the legitimacy of the claim or the appropriate amount of reimbursement is in dispute;

(ii) Supplies in writing to the provider the specific reasons why the legitimacy of the claim, or a portion of the claim, or the appropriate amount of reimbursement is in dispute;

(iii) Pays any undisputed portion of the claim within 30 days of the receipt of the claim; and

(iv) Makes a good faith, timely effort to resolve the dispute.

(D) A HEALTH MAINTENANCE ORGANIZATION SHALL PERMIT A PROVIDER A MINIMUM OF 6 MONTHS FROM THE DATE A COVERED SERVICE IS RENDERED TO SUBMIT A CLAIM FOR REIMBURSEMENT FOR THE SERVICE.

(E) (1) IF A HEALTH MAINTENANCE ORGANIZATION NOTIFIES A PROVIDER THAT ADDITIONAL DOCUMENTATION IS NECESSARY TO ADJUDICATE A CLAIM, THE HEALTH MAINTENANCE ORGANIZATION SHALL REIMBURSE THE PROVIDER FOR COVERED SERVICES WITHIN 30 DAYS AFTER RECEIPT OF ALL REASONABLE AND NECESSARY DOCUMENTATION.

(2) IF A HEALTH MAINTENANCE ORGANIZATION FAILS TO COMPLY WITH THE REQUIREMENTS OF PARAGRAPH (1) OF THIS SUBSECTION, THE HEALTH MAINTENANCE ORGANIZATION SHALL PAY INTEREST IN ACCORDANCE WITH THE REQUIREMENTS OF SUBSECTION (B) OF THIS SECTION.

Article - Insurance

~~15-113.~~

~~(a) (1) In this section the following words have the meanings indicated.~~

~~(2) "Carrier" means:~~

~~(i) an insurer;~~

~~(ii) a nonprofit health service plan;~~

~~(iii) a health maintenance organization;~~

~~(iv) a dental plan organization; or~~

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

~~(3) "Health care practitioner" means an individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.~~

~~(b) A carrier may not reimburse a health care practitioner in an amount less than the sum or rate negotiated in the carrier's provider contract with the health care practitioner.~~

~~(C) (1) IF A CARRIER RETROACTIVELY DENIES REIMBURSEMENT TO A HEALTH CARE PRACTITIONER, THE CARRIER:~~

~~(I) MAY ONLY RETROACTIVELY DENY REIMBURSEMENT DURING THE 6 MONTH PERIOD AFTER THE DATE THAT THE HEALTH CARE PRACTITIONER SUBMITTED THE CLAIM TO THE CARRIER FOR REIMBURSEMENT; AND~~

~~(II) SHALL PROVIDE THE HEALTH CARE PRACTITIONER WITH A WRITTEN STATEMENT SPECIFYING THE BASIS FOR THE RETROACTIVE DENIAL.~~

~~(2) EXCEPT IN CASES OF FRAUD OR IMPROPER CODING BY A HEALTH CARE PRACTITIONER, A CARRIER THAT DOES NOT COMPLY WITH THE PROVISIONS OF PARAGRAPH (1) OF THIS SUBSECTION MAY NOT RETROACTIVELY DENY REIMBURSEMENT OR ATTEMPT IN ANY MANNER TO RETROACTIVELY COLLECT REIMBURSEMENT ALREADY PAID TO A HEALTH CARE PRACTITIONER BY REDUCING REIMBURSEMENTS CURRENTLY OWED TO THE HEALTH CARE PRACTITIONER,~~

~~WITHHOLDING FUTURE REIMBURSEMENT, OR IN ANY OTHER MANNER AFFECTING THE FUTURE REIMBURSEMENT TO THE HEALTH CARE PRACTITIONER.~~

~~[(c)] (D) This section does not prohibit a carrier from providing bonuses or other incentive-based compensation to a health care practitioner if the bonus or other incentive-based compensation does not:~~

~~(1) violate § 19-705.1 of the Health - General Article; or~~

~~(2) deter the delivery of medically appropriate care to an enrollee.~~

15-1005.

(a) This section does not apply when there is a good faith dispute about the legitimacy of a claim or the appropriate amount of reimbursement.

(b) To the extent consistent with the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001, et seq., this section applies to an insurer or nonprofit health service plan that acts as a third party administrator.

(c) Within 30 days after receipt of a claim for reimbursement from a person entitled to reimbursement under § 15-701(a) of this title or from a hospital or related institution, as those terms are defined in § 19-301 of the Health - General Article, an insurer or nonprofit health service plan shall:

(1) pay the claim in accordance with this section; or

(2) send a notice of receipt and status of the claim that states:

(i) that the insurer or nonprofit health service plan refuses to reimburse all or part of the claim and the reason for the refusal; or

(ii) that additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary.

(D) AN INSURER OR A NONPROFIT HEALTH SERVICE PLAN SHALL PERMIT A PROVIDER A MINIMUM OF 6 MONTHS FROM THE DATE A COVERED SERVICE IS RENDERED TO SUBMIT A CLAIM FOR REIMBURSEMENT FOR THE SERVICE.

(E) (1) IF AN INSURER OR NONPROFIT HEALTH SERVICE PLAN NOTIFIES A PROVIDER THAT ADDITIONAL DOCUMENTATION IS NECESSARY TO ADJUDICATE A CLAIM, THE INSURER OR NONPROFIT HEALTH SERVICE PLAN SHALL REIMBURSE THE PROVIDER FOR COVERED SERVICES WITHIN 30 DAYS AFTER RECEIPT OF ALL REASONABLE AND NECESSARY DOCUMENTATION.

(2) IF AN INSURER OR NONPROFIT HEALTH SERVICE PLAN FAILS TO COMPLY WITH THE REQUIREMENTS OF PARAGRAPH (1) OF THIS SUBSECTION, THE INSURER OR NONPROFIT HEALTH SERVICE PLAN SHALL PAY INTEREST IN ACCORDANCE WITH THE REQUIREMENTS OF SUBSECTION (F) OF THIS SECTION.

[(d)] (F) (1) If an insurer or nonprofit health service plan fails to comply with subsection (c) of this section, the insurer or nonprofit health service plan shall pay interest on the amount of the claim that remains unpaid 30 days after the claim is filed at the monthly rate of:

(i) 1.5% from the 31st day through the 60th day;

(ii) 2% from the 61st day through the 120th day; and

(iii) 2.5% after the 120th day.

(2) The interest paid under this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 1997.