HOUSE BILL 346

Unofficial Copy 1999 Regular Session
C3 (9lr1792)

ENROLLED BILL
-- *Economic Matters/Finance* --

Introduced by **Delegate Donoghue**

Read and Examined by Proofreaders:

_____
Proofreader.

_____
Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this _____ day of _____ at _____ o'clock, _____M.

_____
Speaker.

CHAPTER_____

AN ACT concerning

Health Insurance - Retroactive Denial of Reimbursement - Improper Coding

FOR the purpose of ~~defining what constitutes improper coding for the purposes of~~ *clarifying the circumstances under which* the limitation of retroactive denial of reimbursement *is effective*; providing for the application of this Act; *providing for a delayed effective date; defining certain terms;* and generally relating to retroactive denial of reimbursement.

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-1008
Annotated Code of Maryland
(1997 Volume and 1998 Supplement)

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

Article - Insurance

15-1008.

(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) *"CODE" MEANS:*

(I) *THE APPLICABLE CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE, AS ADOPTED BY THE AMERICAN MEDICAL ASSOCIATION;*

(II) *IF FOR A DENTAL SERVICE, THE APPLICABLE CODE ADOPTED BY THE AMERICAN DENTAL ASSOCIATION; OR*

(III) *ANOTHER APPLICABLE CODE UNDER AN APPROPRIATE UNIFORM CODING SCHEME USED BY A CARRIER IN ACCORDANCE WITH THIS SECTION.*

(4) *"CODING GUIDELINES" MEANS THOSE STANDARDS OR PROCEDURES USED OR APPLIED BY A PAYOR TO DETERMINE THE MOST ACCURATE AND APPROPRIATE CODE OR CODES FOR PAYMENT BY THE PAYOR FOR A SERVICE OR SERVICES.*

~~(3)~~ *(5)* "Health care provider" means a person or entity licensed, certified or otherwise authorized under the Health Occupations Article or the Health - General Article to provide health care services.

~~(4)~~ ~~"IMPROPER CODING" MEANS THE USE OF A PROCEDURAL CODE FOR A PROCEDURE OR SERVICE DELIVERED, IN A SUBMISSION OF CLAIM INFORMATION, THAT DOES NOT CONFORM WITH:~~

~~(I)~~ ~~THE VERSION OF THE AMERICAN MEDICAL ASSOCIATION'S CLINICAL PROCEDURAL TERMINOLOGY CODE BOOK IN EFFECT ON THE DATE A CLAIM WAS SUBMITTED TO A CARRIER FOR REIMBURSEMENT; OR~~

~~(II)~~ ~~THE CODING GUIDELINES THAT A CARRIER HAS PROVIDED IN WRITING TO THE HEALTH CARE PROVIDER THAT ARE IN EFFECT ON THE DATE THAT THE CLAIM WAS SUBMITTED TO THE CARRIER FOR REIMBURSEMENT.~~

~~(4)~~ ~~"IMPROPER CODING" MEANS THE INACCURATE OR INAPPROPRIATE DESCRIPTION OF A SERVICE OR GROUP OF SERVICES BY A HEALTH CARE PROVIDER FOR PAYMENT BY A CARRIER THAT USES PROCEDURAL CODES FOR THE SERVICE OR GROUP OF SERVICES DELIVERED, WHERE THE DESCRIPTION DOES NOT CONFORM WITH:~~

~~(I)~~ ~~THE APPLICABLE CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE IN EFFECT ON THE DATE THE SERVICE OR GROUP OF SERVICES WERE RENDERED:~~

~~1.~~ ~~AS ADOPTED BY THE AMERICAN MEDICAL ASSOCIATION FOR MEDICAL SERVICES; OR~~

~~2.~~ ~~AS ADOPTED BY THE AMERICAN DENTAL ASSOCIATION FOR DENTAL SERVICES;~~

~~(II)~~ ~~OTHER APPLICABLE CODES UNDER A UNIFORM CODING SCHEME REQUIRED BY THE CARRIER, IN EFFECT ON THE DATE THE SERVICE OR GROUP OF SERVICES WERE RENDERED, IN INSTANCES WHERE A CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE IS NOT THE APPLICABLE CODE FOR THE SERVICE PROVIDED; OR~~

~~(III)~~ ~~THE PROVISIONS OF THE HEALTH CARE PROVIDER'S CONTRACT WITH THE CARRIER IN EFFECT ON THE DATE THE SERVICE OR GROUP OR SERVICES WERE RENDERED.~~

(b) (1) If a carrier retroactively denies reimbursement to a health care provider, the carrier:

(i) may only retroactively deny reimbursement for services subject to coordination of benefits with another carrier, the Maryland Medical Assistance Program, or the Medicare Program during the 18-month period after the date that the carrier paid the claim submitted by the health care provider; and

(ii) except as provided in item (i) of this paragraph, may only retroactively deny reimbursement during the 6-month period after the date that the carrier paid the claim submitted by the health care provider.

(2) (i) A carrier that retroactively denies reimbursement to a health care provider under paragraph (1) of this subsection shall provide the health care provider with a written statement specifying the basis for the retroactive denial.

(ii) If the retroactive denial of reimbursement results from coordination of benefits, the written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denied claim.

(c) Except as provided in subsection (d) of this section, a carrier that does not comply with the provisions of subsection (b) of this section may not retroactively deny reimbursement or attempt in any manner to retroactively collect reimbursement already paid to a health care provider by reducing reimbursements currently owed to

the health care provider, withholding future reimbursement, or in any other manner affecting the future reimbursement to the health care provider.

(d) *(1)* The provisions of subsection (b)(1) of this section do not apply if*:*

(I) a carrier retroactively denies reimbursement to a health care provider because ~~OF IMPROPER CODING OR~~ the information submitted to the carrier was fraudulent ~~or improperly coded~~ *OR IMPROPERLY CODED; AND*

(II) IN THE CASE OF IMPROPER CODING, THE CARRIER HAS PROVIDED TO THE HEALTH CARE PROVIDER SUFFICIENT INFORMATION REGARDING THE CODING GUIDELINES USED BY THE CARRIER AT LEAST 30 DAYS PRIOR TO THE DATE THE SERVICES SUBJECT TO THE RETROACTIVE DENIAL WERE RENDERED.

(2) INFORMATION SUBMITTED TO A CARRIER MAY BE CONSIDERED TO BE IMPROPERLY CODED UNDER PARAGRAPH (1) OF THIS SUBSECTION IF THE INFORMATION SUBMITTED TO THE CARRIER BY THE HEALTH CARE PROVIDER:

(I) USES CODES THAT DO NOT CONFORM WITH THE CODING GUIDELINES USED BY THE CARRIER APPLICABLE AS OF THE DATE THE SERVICE OR SERVICES WERE RENDERED; OR

(II) DOES NOT OTHERWISE CONFORM WITH THE CONTRACTUAL OBLIGATIONS OF THE HEALTH CARE PROVIDER TO THE CARRIER APPLICABLE AS OF THE DATE THE SERVICE OR SERVICES WERE RENDERED.

(e) If a carrier retroactively denies reimbursement for services as a result of coordination of benefits under provisions of subsection (b)(1)(i) of this section, the health care provider shall have 6 months from the date of denial, unless a carrier permits a longer time period, to submit a claim for reimbursement for the service to the carrier, Maryland Medical Assistance Program, or Medicare Program responsible for payment.

SECTION 2. AND IT BE FURTHER ENACTED, That this Act shall apply to a retroactive denial based on improper coding issued on or after ~~October 1, 1999~~ *January 1, 2000*, regardless of the date of the service subject to the retroactive denial.

SECTION ~~2.~~ 3. AND BE IT FURTHER ENACTED, That this Act shall take effect ~~October 1, 1999~~ *January 1, 2000*.