Unofficial Copy 1999 Regular Session
C3 9lr1792
CF 9lr1631

By: **Delegate Donoghue**
Introduced and read first time: February 5, 1999
Assigned to: Economic Matters

Committee Report: Favorable with amendments
House action: Adopted
Read second time: March 16, 1999

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 the limitation of retroactive denial of reimbursement; providing for the application of this Act; 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) "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) The provisions of subsection (b)(1) of this section do not apply if 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~~.

(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, 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.