HOUSE BILL 762

Unofficial Copy 2000 Regular Session
C3 (0lr2443)

ENROLLED BILL
-- Economic Matters/Finance --

Introduced by **Delegates Hammen ~~and McHale~~, McHale, Donoghue, Fulton, Goldwater, Love, Moe, and Pendergrass**

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 - Uniform Claims Forms ~~- Clean Claims~~

FOR the purpose of consolidating certain provisions relating to acceptance of uniform claims forms for reimbursement by insurers, nonprofit health service plans, and health maintenance organizations; requiring the Insurance Commissioner to adopt certain regulations relating to certain uniform claims forms for reimbursement of hospitals and health care practitioners by insurers, nonprofit health service plans, and health maintenance organizations; specifying certain contents of certain regulations; requiring certain uniform claims forms to be properly completed in accordance with certain regulations; altering a certain penalty for certain violations ~~relating to uniform claims forms~~; establishing certain penalties; providing that insurers, nonprofit health service plans, and health maintenance organizations shall pay or refuse to reimburse certain clean claims, and otherwise respond on receipt of a claim, in a certain manner and within certain time periods under certain circumstances; requiring insurers, nonprofit health service plans, and health maintenance organizations to provide

certain providers with a manual or other document containing certain information; specifying certain requirements and limitations of certain delegation agreements between insurers, nonprofit health service plans, and health maintenance organizations and certain entities; defining a certain term; providing that certain regulations shall be ~~adopted~~ published for proposal on or before a certain date; and generally relating to uniform claims forms for reimbursement under health insurance.

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-706(kk)
Annotated Code of Maryland
(1996 Replacement Volume and 1999 Supplement)

BY repealing
Article - Health - General
Section 19-712.3
Annotated Code of Maryland
(1996 Replacement Volume and 1999 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-1003, 15-1004, and 15-1005
Annotated Code of Maryland
(1997 Volume and 1999 Supplement)

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

Article - Health - General

19-706.

(kk) The provisions of [§ 15-1005] §§ 15-1003, 15-1004, AND 15-1005 of the Insurance Article apply to health maintenance organizations.

[19-712.3.

(a) Except as provided in subsection (d) of this section, for services rendered to its members or subscribers, a health maintenance organization shall accept as a properly filed claim and the sole instrument for reimbursement the uniform claims form submitted by a hospital or health care practitioner in accordance with § 15-1003 of the Insurance Article.

(b) The uniform claims form submitted under this section:

(1) Shall be properly completed; and

(2) May be submitted by electronic transfer.

(c) A health maintenance organization may not impose as a condition of payment any requirements on a hospital or health care practitioner to:

(1) Modify the uniform claims form or its content; or

(2) Submit additional claims forms.

(d) When the legitimacy or appropriateness of the health care service is disputed, a health maintenance organization may request additional medical information that describes and summarizes the diagnosis, treatment, and services rendered to the member or subscriber.

(e) When necessary to determine eligibility for benefits or for determination of coverage, a health maintenance organization may obtain additional information from its subscriber or member, the employer of the subscriber or member, or any other non-provider third party, provided that any delays in paying a uniform claim resulting from obtaining this information are subject to the provisions of § 19-712.1(b) of this subtitle.

(f) The Commissioner may impose a penalty not to exceed $500 on any health maintenance organization that violates the provisions of this section.]

Article - Insurance

15-1003.

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

(2) (i) "Health care practitioner" means a person that is licensed or certified under the Health Occupations Article and reimbursed by a third party payor.

(ii) "Health care practitioner" does not include a physician or other person licensed or certified under this article when the physician or other person is rendering care to a member or subscriber of a health maintenance organization and is compensated by the health maintenance organization for that care on a salaried or capitated basis.

(3) "Hospital" has the meaning stated in § 19-301 of the Health - General Article.

(b) The Commissioner shall adopt by regulation as the uniform claims form for reimbursement of hospital services in the State the uniform claims form adopted by the National Uniform Billing Committee and approved by the Health Care Financing Administration for Hospital Payments under Title XVIII of the Social Security Act.

(c) The Commissioner shall adopt by regulation a uniform claims form for reimbursement of health care practitioners' services.

(D) (1) THE COMMISSIONER SHALL ADOPT BY REGULATION:

(I) A DEFINITION OF A CLEAN CLAIM, INCLUDING:

1. THE ESSENTIAL DATA ELEMENTS THAT MUST BE COMPLETED ON THE UNIFORM CLAIMS FORM; AND

2. UNIFORM STANDARDS FOR ATTACHMENTS TO THE UNIFORM CLAIMS FORM;

(II) PERMISSIBLE CATEGORIES OF DISPUTED CLAIMS FOR WHICH ADDITIONAL INFORMATION MAY BE REQUESTED UNDER §§ 15-1004(C) AND 15-1005(C) OF THIS SUBTITLE; AND

(III) STANDARDS FOR DETERMINING WHEN A CLAIM IS CONSIDERED RECEIVED FOR REIMBURSEMENT.

(2) IN ADOPTING THE REGULATIONS REQUIRED UNDER PARAGRAPH (1)(I) OF THIS SUBSECTION, THE COMMISSIONER SHALL CONSIDER:

(I) STANDARDS FOR ATTACHMENTS REQUIRED BY THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION FOR THE MEDICARE PROGRAM;

(II) STANDARDS USED BY INSURANCE CARRIERS, NONPROFIT HEALTH SERVICE PLANS, AND HEALTH MAINTENANCE ORGANIZATIONS IN THE STATE; AND

(III) FEDERAL REGULATIONS ADOPTED UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

15-1004.

~~(A) IN THIS SECTION, "CLEAN CLAIM" MEANS A CLAIM FOR REIMBURSEMENT AS DEFINED IN REGULATIONS ADOPTED BY THE COMMISSIONER UNDER SUBSECTION (D) OF THIS SECTION.~~

~~[~~(a)~~]~~ ~~(B)~~ For services rendered by a person entitled to reimbursement under § 15-701(a) of this title or by a hospital, as defined in § 19-301 of the Health - General Article, an insurer, [or] nonprofit health service plan, OR HEALTH MAINTENANCE ORGANIZATION:

(1) [except as provided in subsection (c) of this section,] shall accept the uniform claims form AND ANY ATTACHMENTS APPROVED OR adopted by the Commissioner under § 15-1003 of this subtitle:

(i) as a properly filed claim with all necessary documentation; and

(ii) as the sole instrument for reimbursement; and

(2) may not impose as a condition of reimbursement a requirement to:

(i) modify the uniform claims form or its content; or

(ii) submit additional claims forms.

~~[~~(b)~~]~~ ~~(C)~~ (1) A uniform claims form submitted under this section shall be completed properly ~~IN ACCORDANCE WITH SUBSECTION (D) OF THIS SECTION~~ and may be submitted by electronic transfer.

(2) If the health care practitioner rendering the service is a certified registered nurse anesthetist or certified nurse midwife, the uniform claims form shall include identification modifiers for the certified registered nurse anesthetist or certified nurse midwife that indicate whether the service is provided with or without medical direction by a physician.

~~[~~(c) ~~If~~ IN ACCORDANCE WITH §§ 15-1003(D)(1)(II) AND 15-1005(C) OF THIS SUBTITLE, IF the legitimacy or appropriateness of a health care service is disputed, an insurer ~~or,~~ nonprofit health service plan, OR HEALTH MAINTENANCE ORGANIZATION may request additional medical information that describes and summarizes the diagnosis, treatment, and services rendered to the insured.~~]~~

(D) (1) ~~THE COMMISSIONER SHALL ADOPT REGULATIONS DEFINING A CLEAN CLAIM FOR PURPOSES OF THIS SECTION.~~

~~(2) THE REGULATIONS SHALL SPECIFY:~~

~~(I) THE ESSENTIAL DATA ELEMENTS THAT MUST BE COMPLETED ON THE UNIFORM CLAIMS FORM FOR THE CLAIM TO BE CONSIDERED A CLEAN CLAIM;~~

~~(II) WHEN A CLAIM IS CONSIDERED RECEIVED BY THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION;~~

~~(III) THAT, EXCEPT AS PROVIDED IN PARAGRAPH (3) OF THIS SUBSECTION, REQUESTS FOR ATTACHMENTS SHALL COMPLY WITH THE STANDARDS FOR ATTACHMENTS REQUIRED BY THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION FOR THE MEDICARE PROGRAM;~~

~~(IV)~~ ~~THAT~~ INSURERS, NONPROFIT HEALTH SERVICE PLANS, AND HEALTH MAINTENANCE ORGANIZATIONS SHALL PROVIDE AND UPDATE, AS APPROPRIATE, ALL ~~AFFECTED PROVIDERS~~ CONTRACTING PROVIDERS AND ANY OTHER PROVIDER ON REQUEST, WITH A MANUAL OR OTHER DOCUMENT THAT SETS FORTH THE CLAIMS FILING PROCEDURES, INCLUDING:

~~1.~~ (I) THE ADDRESS WHERE THE CLAIMS SHOULD BE SENT FOR PROCESSING;

~~2.~~ (II) THE TELEPHONE NUMBER AT WHICH PROVIDERS' QUESTIONS AND CONCERNS REGARDING CLAIMS MAY BE ADDRESSED;

~~3.~~ (III) THE NAME, ADDRESS, AND TELEPHONE NUMBER OF ANY ENTITY TO WHICH THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION HAS DELEGATED THE CLAIMS PAYMENT FUNCTION, IF APPLICABLE; AND

~~4.~~ (IV) THE ADDRESS AND TELEPHONE NUMBER OF ANY SEPARATE CLAIMS PROCESSING CENTER FOR SPECIFIC TYPES OF APPLICABLE SERVICES~~, IF APPLICABLE; AND~~.

~~(V)~~ (2) ~~THAT~~ IF AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION HAS DELEGATED ITS CLAIMS PROCESSING FUNCTION TO A THIRD PARTY, THE DELEGATION AGREEMENT:

~~1.~~ (I) SHALL REQUIRE THE CLAIMS PROCESSING ENTITY TO COMPLY WITH THE REQUIREMENTS OF THIS SUBTITLE; AND

~~2.~~ (II) MAY NOT BE CONSTRUED TO LIMIT THE RESPONSIBILITY OF THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION TO COMPLY WITH THE REQUIREMENTS OF THIS SUBTITLE.

~~(3) ADDITIONAL DATA ELEMENTS OR ATTACHMENTS MAY NOT BE REQUIRED UNLESS:~~

~~(I) APPROVED BY THE COMMISSIONER;~~

~~(II) MADE APPLICABLE TO ALL INSURERS, NONPROFIT HEALTH SERVICE PLANS, AND HEALTH MAINTENANCE ORGANIZATIONS; AND~~

~~(III) AFTER APPROVAL BY THE COMMISSIONER:~~

~~1. WRITTEN NOTICE OF ANY CHANGE IS RECEIVED BY THE PROVIDER AT LEAST 60 DAYS BEFORE THE CHANGE TAKES EFFECT; AND~~

~~2. THE MANUAL OR OTHER DOCUMENT THAT SETS FORTH THE CLAIMS FILING PROCEDURES IS UPDATED TO REFLECT THE CHANGE AND IS SENT TO THE PROVIDER AT LEAST 60 DAYS BEFORE THE CHANGE TAKES EFFECT.~~

[(d)] (E) (1) If necessary to determine eligibility for benefits or to determine coverage, an insurer, [or] nonprofit health service plan, OR HEALTH MAINTENANCE ORGANIZATION may obtain additional information from its insured, MEMBER, OR SUBSCRIBER, the [insured's] employer OF THE INSURED, MEMBER OR SUBSCRIBER, or any other nonprovider third party.

(2) If obtaining additional information results in a delay in paying a claim, the insurer, [or] nonprofit health service plan, OR HEALTH MAINTENANCE ORGANIZATION shall pay interest in accordance with the provisions of ~~§ 15-1005(d)~~ § 15-1005(F) of this subtitle.

[(e)] (F) The Commissioner may impose a penalty not exceeding [$500] $5,000 on an insurer, [or] nonprofit health service plan, OR HEALTH MAINTENANCE ORGANIZATION that violates this section.

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.] IN THIS SECTION, "CLEAN CLAIM" MEANS A CLAIM FOR REIMBURSEMENT, AS DEFINED IN REGULATIONS ADOPTED BY THE COMMISSIONER UNDER ~~§ 15-1004~~ § 15-1003 OF THIS SUBTITLE.

(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, nonprofit health service plan, or health maintenance organization that acts as a third party administrator.

(c) ~~[~~Within 30 days after~~]~~ ~~AFTER~~ receipt of a ~~CLEAN~~ 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, nonprofit health service plan, or health maintenance organization shall:

(1) ~~WITHIN 30 DAYS,~~ pay the claim in accordance with this section; or

(2) ~~WITHIN 15 DAYS,~~ send a notice of receipt and status of the claim that states:

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

(ii) that, IN ACCORDANCE WITH § 15-1003(D)(1)(II) OF THIS SUBTITLE, THE LEGITIMACY OF THE CLAIM OR THE APPROPRIATE AMOUNT OF REIMBURSEMENT IS IN DISPUTE AND additional information is necessary ~~[~~to determine if all or part of the claim will be reimbursed~~]~~ ~~FOR THE CLAIM TO BE CONSIDERED A CLEAN CLAIM~~ and what specific additional information is necessary; OR

(III) THAT THE CLAIM IS NOT CLEAN AND THE SPECIFIC ADDITIONAL INFORMATION NECESSARY FOR THE CLAIM TO BE CONSIDERED A CLEAN CLAIM.

(d) An insurer, nonprofit health service plan, or 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 an insurer, nonprofit health service plan, or health maintenance organization notifies a provider that additional documentation is necessary [to adjudicate a claim] FOR THE CLAIM TO BE CONSIDERED A CLEAN CLAIM, the insurer,~~

~~nonprofit health service plan, or health maintenance organization shall reimburse the provider for covered services within 30 days after receipt of all reasonable and necessary documentation.~~

~~(2) If an insurer, nonprofit health service plan, or health maintenance organization fails to comply with the requirements of paragraph (1) of this subsection, the insurer, nonprofit health service plan, or health maintenance organization shall pay interest in accordance with the requirements of subsection (f) of this section.~~

(E) (1) IF AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION PROVIDES NOTICE UNDER SUBSECTION (C)(2)(I) OF THIS SECTION, THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION SHALL PAY ANY UNDISPUTED PORTION OF THE CLAIM WITHIN 30 DAYS OF RECEIPT OF THE CLAIM, IN ACCORDANCE WITH THIS SECTION.

(2) IF AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION PROVIDES NOTICE UNDER SUBSECTION (C)(2)(II) OF THIS SECTION, THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION SHALL:

(I) PAY ANY UNDISPUTED PORTION OF THE CLAIM IN ACCORDANCE WITH THIS SECTION; AND

(II) COMPLY WITH SUBSECTION (C)(1) OR (2)(I) OF THIS SECTION WITHIN 30 DAYS AFTER RECEIPT OF THE REQUESTED ADDITIONAL INFORMATION.

(3) IF AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION PROVIDES NOTICE UNDER SUBSECTION (C)(2)(III) OF THIS SECTION, THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION SHALL COMPLY WITH SUBSECTION (C)(1) OR (2)(I) OF THIS SECTION WITHIN 30 DAYS AFTER RECEIPT OF THE REQUESTED ADDITIONAL INFORMATION.

(f) (1) If an insurer, nonprofit health service plan, or health maintenance organization fails to comply with subsection (c) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall pay interest on the amount of the claim that remains unpaid 30 days after the claim is ~~filed~~ RECEIVED 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.

(G) AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION THAT VIOLATES A PROVISION OF THIS SECTION IS SUBJECT TO:

(1) A FINE NOT EXCEEDING $500 FOR EACH VIOLATION THAT IS ARBITRARY AND CAPRICIOUS, BASED ON ALL AVAILABLE INFORMATION; AND

(2) THE PENALTIES PRESCRIBED UNDER § 4-113(D) OF THIS ARTICLE FOR VIOLATIONS COMMITTED WITH A FREQUENCY THAT INDICATES A GENERAL BUSINESS PRACTICE.

SECTION 2. AND BE IT FURTHER ENACTED, That the regulations required under Section 1 of this Act shall be ~~adopted~~ published for proposal on or before ~~October 1, 2000~~ January 1, 2001. To facilitate implementation of the requirements of this Act, the Insurance Commissioner shall convene a State Uniform Billing Committee comprised of representatives of the affected parties to advise and assist in the development of the regulations. The regulations required under Section 1 of this Act shall include standards for clean claims for services rendered in a hospital emergency facility.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2000.