

HOUSE BILL 762

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2000 Regular Session
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CF 0lr2349

By: ~~Delegates Hammen and McHale, McHale, Donoghue, Fulton, Goldwater,~~
Love, Moe, and Pendergrass

Introduced and read first time: February 10, 2000

Assigned to: Economic Matters

Committee Report: Favorable with amendments

House action: Adopted

Read second time: March 25, 2000

CHAPTER _____

1 AN ACT concerning

2 **Health Insurance - Uniform Claims Forms ~~-Clean Claims~~**

3 FOR the purpose of consolidating certain provisions relating to acceptance of uniform
4 claims forms for reimbursement by insurers, nonprofit health service plans, and
5 health maintenance organizations; requiring the Insurance Commissioner to
6 adopt certain regulations relating to certain uniform claims forms for
7 reimbursement of hospitals and health care practitioners by insurers, nonprofit
8 health service plans, and health maintenance organizations; specifying certain
9 contents of certain regulations; requiring certain uniform claims forms to be
10 properly completed in accordance with certain regulations; altering a certain
11 penalty for certain violations ~~relating to uniform claims forms~~; establishing
12 certain penalties; providing that insurers, nonprofit health service plans, and
13 health maintenance organizations shall pay or refuse to reimburse certain clean
14 claims, ~~and otherwise respond on receipt of a claim~~, in a certain manner and
15 within certain time periods under certain circumstances; requiring insurers,
16 nonprofit health service plans, and health maintenance organizations to provide
17 certain providers with a manual or other document containing certain
18 information; specifying certain requirements and limitations of certain
19 delegation agreements between insurers, nonprofit health service plans, and
20 health maintenance organizations and certain entities; defining a certain term;
21 providing that certain regulations shall be ~~adopted~~ published for proposal on or
22 before a certain date; and generally relating to uniform claims forms for
23 reimbursement under health insurance.

24 BY repealing

25 Article - Health - General

26 Section 19-712.3

1 Annotated Code of Maryland
2 (1996 Replacement Volume and 1999 Supplement)

3 BY repealing and reenacting, with amendments,
4 Article - Insurance
5 Section 15-1003, 15-1004, and 15-1005
6 Annotated Code of Maryland
7 (1997 Volume and 1999 Supplement)

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

10 **Article - Health - General**

11 [19-712.3.

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

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

18 (1) Shall be properly completed; and

19 (2) May be submitted by electronic transfer.

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

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

23 (2) Submit additional claims forms.

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

28 (e) When necessary to determine eligibility for benefits or for determination of
29 coverage, a health maintenance organization may obtain additional information from
30 its subscriber or member, the employer of the subscriber or member, or any other
31 non-provider third party, provided that any delays in paying a uniform claim
32 resulting from obtaining this information are subject to the provisions of §
33 19-712.1(b) of this subtitle.

34 (f) The Commissioner may impose a penalty not to exceed \$500 on any health
35 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;

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

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

6 15-1004.

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

10 ~~{a}~~ ~~(B)~~ For services rendered by a person entitled to reimbursement under §
 11 15-701(a) of this title or by a hospital, as defined in § 19-301 of the Health - General
 12 Article, an insurer, [or] nonprofit health service plan, OR HEALTH MAINTENANCE
 13 ORGANIZATION:

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

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

18 (ii) as the sole instrument for reimbursement; and

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

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

21 (ii) submit additional claims forms.

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

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

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

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

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

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

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

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

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

16 1- (I) ~~THE ADDRESS WHERE THE CLAIMS SHOULD BE~~
17 ~~SENT FOR PROCESSING;~~

18 2- (II) ~~THE TELEPHONE NUMBER AT WHICH PROVIDERS'~~
19 ~~QUESTIONS AND CONCERNS REGARDING CLAIMS MAY BE ADDRESSED;~~

20 3- (III) ~~THE NAME, ADDRESS, AND TELEPHONE NUMBER OF~~
21 ~~ANY ENTITY TO WHICH THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR~~
22 ~~HEALTH MAINTENANCE ORGANIZATION HAS DELEGATED THE CLAIMS PAYMENT~~
23 ~~FUNCTION, IF APPLICABLE; AND~~

24 4- (IV) ~~THE ADDRESS AND TELEPHONE NUMBER OF ANY~~
25 ~~SEPARATE CLAIMS PROCESSING CENTER FOR SPECIFIC TYPES OF APPLICABLE~~
26 ~~SERVICES, IF APPLICABLE; AND.~~

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

30 1- (I) ~~SHALL REQUIRE THE CLAIMS PROCESSING ENTITY~~
31 ~~TO COMPLY WITH THE REQUIREMENTS OF THIS SUBTITLE; AND~~

32 2- (II) ~~MAY NOT BE CONSTRUED TO LIMIT THE~~
33 ~~RESPONSIBILITY OF THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH~~
34 ~~MAINTENANCE ORGANIZATION TO COMPLY WITH THE REQUIREMENTS OF THIS~~
35 ~~SUBTITLE.~~

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

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

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

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

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

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

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

15 (2) If obtaining additional information results in a delay in paying a
16 claim, the insurer, [or] nonprofit health service plan, OR HEALTH MAINTENANCE
17 ORGANIZATION shall pay interest in accordance with the provisions of ~~§ 15-1005(d)~~ §
18 15-1005(F) of this subtitle.

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

22 15-1005.

23 (a) [This section does not apply when there is a good faith dispute about the
24 legitimacy of a claim or the appropriate amount of reimbursement.] IN THIS SECTION,
25 "CLEAN CLAIM" MEANS A CLAIM FOR REIMBURSEMENT, AS DEFINED IN
26 REGULATIONS ADOPTED BY THE COMMISSIONER UNDER ~~§ 15-1004~~ § 15-1003 OF THIS
27 SUBTITLE.

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

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

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

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

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

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

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

15 (d) An insurer, nonprofit health service plan, or health maintenance
16 organization shall permit a provider a minimum of 6 months from the date a covered
17 service is rendered to submit a claim for reimbursement for the service.

18 (e) (1) ~~If an insurer, nonprofit health service plan, or health maintenance~~
19 ~~organization notifies a provider that additional documentation is necessary {to~~
20 ~~adjudicate a claim} FOR THE CLAIM TO BE CONSIDERED A CLEAN CLAIM, the insurer,~~
21 ~~nonprofit health service plan, or health maintenance organization shall reimburse~~
22 ~~the provider for covered services within 30 days after receipt of all reasonable and~~
23 ~~necessary documentation.~~

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

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

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

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

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

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

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

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

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

16 (iii) 2.5% after the 120th day.

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

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

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

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

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

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

