HOUSE BILL 934

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By: **Delegates Love, Kach, Donoghue, Harrison, Pendergrass, Goldwater, Mitchell, McClenahan, Moe, McHale, Eckardt, Kirk, Hurson, Doory, Krysiak, Hill, Walkup, Barve, Sophocleus, and Nathan-Pulliam**
Introduced and read first time: February 11, 2000
Assigned to: Economic Matters

A BILL ENTITLED

AN ACT concerning

Emergency Room Services - Reimbursement Required

FOR the purpose of requiring certain uniform claims forms to include certain information under certain circumstances; altering the circumstances under which certain additional medical information may be requested by health maintenance organizations, insurers, and nonprofit health service plans; requiring health maintenance organizations, insurers, and nonprofit health service plans to reimburse a hospital emergency facility or health care practitioner under certain circumstances in a certain amount and within a certain time frame for certain services rendered; requiring health maintenance organizations to collect or attempt to collect certain payments from members or subscribers under certain circumstances; requiring the payment of interest on certain unpaid claims under certain circumstances; providing for the application of this Act; and generally relating to claims for reimbursement of emergency room services.

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-712.3 and 19-712.5
Annotated Code of Maryland
(1996 Replacement Volume and 1999 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 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

19-712.3.

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

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

[(2)] (II) Submit additional claims forms.

(2) NOTWITHSTANDING PARAGRAPH (1) OF THIS SUBSECTION, A UNIFORM CLAIMS FORM SUBMITTED BY A HOSPITAL OR HEALTH CARE PRACTITIONER FOR REIMBURSEMENT OF SERVICES RENDERED IN A HOSPITAL EMERGENCY FACILITY, SHALL INCLUDE THE PRESENTING SYMPTOMS OF THE MEMBER OR SUBSCRIBER.

(d) [When] EXCEPT FOR SERVICES RENDERED IN A HOSPITAL EMERGENCY FACILITY, 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] § 15-1005 OF THE INSURANCE ARTICLE.

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

19-712.5.

[(a) A health maintenance organization shall reimburse a hospital emergency facility and provider, less any applicable co-payments, for medically necessary services provided to a member or subscriber of the health maintenance organization if

the health maintenance organization authorized, directed, referred, or otherwise allowed the member or subscriber to use the emergency facility and the medically necessary services are related to the condition for which the member was allowed to use the emergency facility.

(b) A health maintenance organization shall reimburse a hospital emergency facility and provider, less any applicable co-payments, for medically necessary services that relate to the condition presented and that are provided by the provider in the emergency facility to a member or subscriber of the health maintenance organization if the health maintenance organization fails to provide 24-hour access in accordance with the standards of quality of care required under § 19-705.1(b)(2) of this subtitle.]

(A) WITHIN 30 DAYS AFTER RECEIPT OF A CLAIM FOR REIMBURSEMENT, A HEALTH MAINTENANCE ORGANIZATION SHALL REIMBURSE A HOSPITAL EMERGENCY FACILITY OR HEALTH CARE PRACTITIONER THE FULL AMOUNT OF THE CLAIM AS SUBMITTED, LESS ANY APPLICABLE CO-PAYMENTS, FOR:

(1) SERVICES RENDERED TO A MEMBER OR SUBSCRIBER OF THE HEALTH MAINTENANCE ORGANIZATION IF THE HEALTH MAINTENANCE ORGANIZATION AUTHORIZED, DIRECTED, REFERRED, OR OTHERWISE ALLOWED THE MEMBER OR SUBSCRIBER TO USE THE HOSPITAL EMERGENCY FACILITY AND THE SERVICES RELATE TO THE CONDITION FOR WHICH THE MEMBER WAS ALLOWED TO USE THE HOSPITAL EMERGENCY FACILITY;

(2) SERVICES RENDERED TO A MEMBER OR SUBSCRIBER OF THE HEALTH MAINTENANCE ORGANIZATION IF THE HEALTH MAINTENANCE ORGANIZATION FAILS TO PROVIDE 24-HOUR ACCESS IN ACCORDANCE WITH THE STANDARDS OF QUALITY OF CARE REQUIRED UNDER § 19-705.1(B)(2) OF THIS SUBTITLE;

(3) EMERGENCY SERVICES RENDERED TO A MEMBER OR SUBSCRIBER OF THE HEALTH MAINTENANCE ORGANIZATION; AND

(4) MEDICAL SCREENING, ASSESSMENT, AND STABILIZATION SERVICES RENDERED TO A MEMBER OR SUBSCRIBER OF THE HEALTH MAINTENANCE ORGANIZATION TO MEET THE REQUIREMENTS OF THE FEDERAL EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT.

[(c) A health maintenance organization shall reimburse a hospital emergency facility and provider, less any applicable co-payments, for medical screening, assessment, and stabilization services rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act.

(d)] (B) Notwithstanding any other provision of this subtitle, a provider may not be required to obtain prior authorization or approval for payment from a health maintenance organization in order to obtain reimbursement under [subsection (a), (b), or (c)] SUBSECTION (A) of this section.

[(e)] (C) Notwithstanding any other provision of this article, [a hospital emergency facility or provider or] a health maintenance organization that has reimbursed a provider [may] SHALL collect or attempt to collect payment from a member or subscriber for health care services provided for a medical condition that is determined not to be an emergency as defined in § 19-701(d) of this subtitle.

[(f)] (D) If a health maintenance organization authorizes, directs, refers, or otherwise allows a member or subscriber to access a hospital emergency facility or other urgent care facility for a medical condition that requires emergency surgery, the health maintenance organization:

(1) Shall reimburse the physician, oral surgeon, periodontist, or podiatrist, who performed the surgical procedure, for follow-up care that is:

(i) Medically necessary;

(ii) Directly related to the condition for which the surgical procedure was performed; and

(iii) Provided in consultation with the member's or subscriber's primary care physician; and

(2) May not impose on the member or subscriber any co-payment or other cost-sharing requirement for any follow-up care that exceeds what a member or subscriber is required to pay for services rendered by a physician, oral surgeon, periodontist, or podiatrist who is a member of the provider panel of the health maintenance organization.

Article - Insurance

15-1004.

(a) 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:

(1) except as provided in subsection (c) of this section, shall accept the uniform claims form 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) NOTWITHSTANDING SUBSECTION (A)(2) OF THIS SECTION, A UNIFORM CLAIMS FORM SUBMITTED BY A HOSPITAL OR HEALTH CARE PRACTITIONER FOR REIMBURSEMENT OF SERVICES RENDERED IN A HOSPITAL EMERGENCY FACILITY, SHALL INCLUDE THE PRESENTING SYMPTOMS OF THE INSURED.

[(b)] (C) (1) A uniform claims form submitted under this section shall be completed properly 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)] (D) [If] EXCEPT FOR SERVICES RENDERED IN A HOSPITAL EMERGENCY FACILITY, IF the legitimacy or appropriateness of a health care service is disputed, an insurer or nonprofit health service plan may request additional medical information that describes and summarizes the diagnosis, treatment, and services rendered to the insured.

[(d)] (E) (1) If necessary to determine eligibility for benefits or to determine coverage, an insurer or nonprofit health service plan may obtain additional information from its insured, the insured's employer, 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 shall pay interest in accordance with the provisions of § 15-1005(d) of this subtitle.

[(e)] (F) The Commissioner may impose a penalty not exceeding $500 on an insurer or nonprofit health service plan 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.

(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 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, nonprofit health service plan, or health maintenance organization shall:

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

(2) EXCEPT AS PROVIDED IN SUBSECTION (F) OF THIS SECTION, 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 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, 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, 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)] (G) of this section.

(F) (1) WITHIN 30 DAYS AFTER RECEIPT OF A CLAIM FOR REIMBURSEMENT, AN INSURER OR NONPROFIT HEALTH SERVICE PLAN SHALL REIMBURSE A HOSPITAL EMERGENCY FACILITY OR HEALTH CARE PRACTITIONER THE FULL AMOUNT OF THE CLAIM AS SUBMITTED, LESS ANY APPLICABLE CO-PAYMENTS, FOR:

(I) SERVICES RENDERED TO AN INSURED IF THE INSURER OR NONPROFIT HEALTH SERVICE PLAN AUTHORIZED, DIRECTED, REFERRED, OR OTHERWISE ALLOWED THE INSURED TO USE THE HOSPITAL EMERGENCY FACILITY AND THE SERVICES RELATE TO THE CONDITION FOR WHICH THE INSURED WAS ALLOWED TO USE THE HOSPITAL EMERGENCY FACILITY;

(II) EMERGENCY SERVICES AS DEFINED UNDER § 19-701(D) OF THE HEALTH - GENERAL ARTICLE RENDERED TO AN INSURED; AND

(III) MEDICAL SCREENING, ASSESSMENT, AND STABILIZATION SERVICES RENDERED TO AN INSURED TO MEET THE REQUIREMENTS OF THE FEDERAL EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT.

(2) A HEALTH MAINTENANCE ORGANIZATION SHALL REIMBURSE A HOSPITAL EMERGENCY FACILITY OR HEALTH CARE PRACTITIONER FOR SERVICES RENDERED IN ACCORDANCE WITH § 19-712.5 OF THE HEALTH - GENERAL ARTICLE.

[(f)] (G) (1) If an insurer, nonprofit health service plan, or health maintenance organization fails to comply with subsection (c) OR (F) 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 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 apply to claims for services rendered on or after October 1, 2000.

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