SENATE BILL 275

Unofficial Copy 2000 Regular Session
C3 0lr1655
CF 0lr1805

By: **Senator Dorman**
Introduced and read first time: January 31, 2000
Assigned to: Finance

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: March 24, 2000

CHAPTER_____

AN ACT concerning

Health Insurance - Preauthorized Health Care Services - Denials of Reimbursement by Carriers

FOR the purpose of prohibiting certain health insurance carriers from denying reimbursement to a health care provider for preauthorized or approved services delivered to a patient if a ~~course of treatment~~ health care service has been preauthorized or approved for the patient; providing certain exceptions; providing that a carrier must pay certain claims in accordance with certain provisions of law; defining a certain term; making a stylistic change; providing for the application of this Act; and generally relating to denials of reimbursement by carriers for preauthorized or approved services delivered to a patient.

~~BY repealing and reenacting, with amendments,~~
~~Article - Insurance~~
~~Section 15-1008~~
~~Annotated Code of Maryland~~
~~(1997 Volume and 1999 Supplement)~~

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

BY adding to
Article - Insurance

Section 15-1009
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 - 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.~~

~~(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.~~

~~(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 the information submitted to the carrier was fraudulent 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 the 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.~~

Article - Health - General

19-706.

(o) The provisions of [§ 15-1008] §§ 15-1008 AND 15-1009 of the Insurance Article [shall] apply to health maintenance organizations.

Article - Insurance

15-1009.

(A) IN THIS SECTION, "CARRIER" MEANS:

(1) AN INSURER;

(2) A NONPROFIT HEALTH SERVICE PLAN;

(3) A HEALTH MAINTENANCE ORGANIZATION;

(4) A DENTAL PLAN ORGANIZATION; OR

(5) ANY OTHER PERSON THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO REGULATION BY THE STATE.

~~(F)~~ (B) IF A ~~COURSE OF TREATMENT~~ HEALTH CARE SERVICE FOR A PATIENT HAS BEEN PREAUTHORIZED OR APPROVED BY A CARRIER, THE CARRIER MAY NOT DENY REIMBURSEMENT TO A HEALTH CARE PROVIDER FOR THE PREAUTHORIZED OR APPROVED ~~SERVICES~~ SERVICE DELIVERED TO THAT PATIENT UNLESS:

(1) THE INFORMATION SUBMITTED TO THE CARRIER REGARDING THE ~~SERVICES~~ SERVICE TO BE DELIVERED TO THE PATIENT WAS FRAUDULENT OR INTENTIONALLY MISREPRESENTATIVE ~~OR~~;

(2) CRITICAL INFORMATION REQUESTED BY THE CARRIER REGARDING ~~SERVICES~~ THE SERVICE TO BE DELIVERED TO THE PATIENT WAS OMITTED SUCH THAT THE CARRIER'S DETERMINATION WOULD HAVE BEEN DIFFERENT HAD IT KNOWN THE CRITICAL INFORMATION; OR

~~(2)~~ (3) ~~THE~~ A PLANNED COURSE OF TREATMENT FOR THE PATIENT THAT WAS APPROVED BY THE CARRIER WAS NOT SUBSTANTIALLY FOLLOWED BY THE HEALTH CARE PROVIDER.

(C) A CARRIER SHALL PAY A CLAIM FOR A PREAUTHORIZED OR APPROVED COVERED HEALTH CARE SERVICE IN ACCORDANCE WITH §§ 15-1005 AND 15-1008 OF THIS SUBTITLE.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act applies to reimbursements for health care services that are preauthorized or approved on or after June 1, 2000.

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