Department of Legislative Services

Maryland General Assembly
2000 Session

FISCAL NOTE
Revised

Senate Bill 800 (Senator Bromwell)
Finance

Health Insurance - Uniform Claims Forms

This bill clarifies the requirements for a health care provider's submission of claims for reimbursement to a health insurer, nonprofit health service plan, or HMO (carrier) and the carrier's timely payment of the claims.

The bill takes effect June 1, 2000.

Fiscal Summary

State Effect: Costs associated with the development and adoption of a clean claim form and regulations could be handled with existing Maryland Insurance Administration resources.

Local Effect: None.

Small Business Effect: Potential minimal. Claims payments will be uniform, providing some administrative efficiencies for health care providers who submit claims to insurance carriers.

Analysis

Bill Summary: The bill requires the Insurance Commissioner to adopt regulations defining a "clean claim" as it relates to information submitted on a uniform claims form by a health care provider to a carrier. The regulations must specify: (1) the definition of a clean claim, including the essential data elements that must be completed on the uniform claims form and uniform standards for attachments to the uniform claims form; (2) permissible categories of disputed claims for which additional information may be requested; and (3) standards for determining when a claim is considered received for reimbursement. When adopting

regulations, the Commissioner must consider: (1) standards for attachments required by the federal Health Care Financing Administration for the Medicare Program; (2) standards used by insurance carriers, nonprofit health service plans, and HMOs; and (3) federal regulations adopted under the Health Insurance Portability and Accountability Act. The regulations also must include standards for clean claims for services rendered in a hospital emergency facility. The regulations must be published for proposal on or before January 1, 2001.

A carrier must accept the uniform claims form and any attachments approved or adopted by the Commissioner as a properly filed claim and as the sole instrument for reimbursement.

Carriers must provide and update, as appropriate, contracting providers and any other provider on request, with a manual or other document that sets forth the claims filing procedures.

Within 30 days after receiving a uniform claims form from a provider, a carrier must either pay the claim or send a notice of receipt and status of the claim that states: (1) the carrier refuses to reimburse all or part of the claim and the reasons why; (2) the legitimacy of the claim is in dispute and additional information is necessary to process the claim; or (3) the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim. Within 30 days after receipt of a uniform claims form, the carrier must pay any undisputed portion of the claim. If a carrier requests additional information to process the claim, the carrier must pay any undisputed portion of the claim within 30 of receiving the additional information.

A carrier that violates claims payment provisions is subject to a fine not exceeding $500 for each violation that is arbitrary and capricious and the penalties applicable to violations committed with a frequency that indicates a general business practice (a fine of not less than $100 and not more than $125,000 for each general business practice violation).

The Insurance Commissioner must convene a State Uniform Billing Committee comprised of representatives of the affected parties to advise and assist in the development of the regulations.

Current Law: Carriers are required to accept claims information on the uniform claims form. There are no provisions for specified essential data elements or a requirement for carriers to provide claims procedure manuals to health care providers. In addition, HMOs are prohibited from requiring any additional claims data with the provider's uniform claims submission. Carriers also have 30 days after receipt of claims before notifying health care providers that the carrier is unable to pay the claim.

Additional Information

Prior Introductions: None.

Cross File: HB 762 (Delegate Hammen, *et al.*) - Economic Matters.

Information Source(s): Maryland Insurance Administration, Department of Health and Mental Hygiene (Developmental Disabilities Administration), Department of Legislative Services

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