Unofficial Copy 2002 Regular Session
C3 2lr2047

By: **Delegate Rosenberg**
Introduced and read first time: February 8, 2002
Assigned to: Economic Matters

A BILL ENTITLED

AN ACT concerning

Managed Care Organizations - Claim Payments and Late Fines

FOR the purpose of increasing the time that a managed care organization has to pay or respond to certain claims; making the late fine that a managed care organization must pay equal to the amount of the clean claim due; defining a certain term; and generally relating to claim payments and late fines for managed care organizations.

BY repealing and reenacting, without amendments,
Article - Health - General
Section 15-101(a) and (f)
Annotated Code of Maryland
(2000 Replacement Volume and 2001 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 15-102.3(b)
Annotated Code of Maryland
(2000 Replacement Volume and 2001 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-1005
Annotated Code of Maryland
(1997 Volume and 2001 Supplement)

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

Article - Health - General

15-101.

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

(f) "Managed care organization" means:

(1) A certified health maintenance organization that is authorized to receive medical assistance prepaid capitation payments; or

(2) A corporation that:

(i) Is a managed care system that is authorized to receive medical assistance prepaid capitation payments;

(ii) Enrolls only program recipients or individuals or families served under the Maryland Children's Health Program; and

(iii) Is subject to the requirements of § 15-102.4 of this title.

15-102.3.

(b) The provisions of § 15-1005 of the Insurance Article shall apply to managed care organizations [in the same manner they apply to health maintenance organizations].

Article - Insurance

15-1005.

(a) (1) In this section[,] THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) ["clean claim"] "CLEAN CLAIM" means a claim for reimbursement, as defined in regulations adopted by the Commissioner under § 15-1003 of this subtitle.

(3) "MANAGED CARE ORGANIZATION" HAS THE MEANING STATED IN § 15-101 OF THE HEALTH - GENERAL ARTICLE.

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

[(2)] (II) send a notice of receipt and status of the claim that states:

[(i)] 1. 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;

[(ii)] 2. 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 and what specific additional information is necessary; or

[(iii)] 3. that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.

(2) 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, A MANAGED CARE ORGANIZATION SHALL:

(I) PAY THE CLAIM IN ACCORDANCE WITH THIS SECTION; OR

(II) SEND A NOTICE OF RECEIPT AND STATUS OF THE CLAIM THAT STATES:

1. THAT THE MANAGED CARE ORGANIZATION REFUSES TO REIMBURSE ALL OR PART OF THE CLAIM AND THE REASON FOR THE REFUSAL;

2. 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 AND WHAT SPECIFIC ADDITIONAL INFORMATION IS NECESSARY; OR

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

(d) (1) An insurer, nonprofit health service plan, MANAGED CARE ORGANIZATION, or health maintenance organization shall permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement for the service.

(2) If an insurer, nonprofit health service plan, MANAGED CARE ORGANIZATION, or health maintenance organization wholly or partially denies a claim for reimbursement, the insurer, nonprofit health service plan, MANAGED CARE ORGANIZATION, or health maintenance organization shall permit a provider a minimum of 90 working days after the date of denial of the claim to appeal the denial.

(e) (1) (I) If an insurer, nonprofit health service plan, or health maintenance organization provides notice under subsection [(c)(2)(i)] (C)(1)(II)1 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.

(II) IF A MANAGED CARE ORGANIZATION PROVIDES NOTICE UNDER SUBSECTION (C)(2)(II)1 OF THIS SECTION, THE MANAGED CARE ORGANIZATION SHALL PAY ANY UNDISPUTED PORTION OF THE CLAIM WITHIN 45 DAYS OF RECEIPT OF THE CLAIM, IN ACCORDANCE WITH THIS SECTION.

(2) If an insurer, nonprofit health service plan, MANAGED CARE ORGANIZATION, or health maintenance organization provides notice under subsection [(c)(2)(ii)] (C)(1)(II)2 OR (C)(2)(II)2 of this section, the insurer, nonprofit health service plan, MANAGED CARE ORGANIZATION, 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)] (C)(1)(I), (C)(1)(II)1, (C)(2)(I) OR (C)(2)(II)1 of this section within 30 days after receipt of the requested additional information.

(3) If an insurer, nonprofit health service plan, MANAGED CARE ORGANIZATION, or health maintenance organization provides notice under subsection [(c)(2)(iii)] (C)(1)(II)3 OR (C)(2)(II)3 of this section, the insurer, nonprofit health service plan, MANAGED CARE ORGANIZATION, or health maintenance organization shall comply with subsection [(c)(1) or (2)(i)] (C)(1)(I), (C)(1)(II)1, (C)(2)(I), OR (C)(2)(II)1 of this section within 30 days after receipt of the requested additional information.

(f) (1) (I) 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 received at the monthly rate of:

[(i)] 1. 1.5% from the 31st day through the 60th day;

[(ii)] 2. 2% from the 61st day through the 120th day; and

[(iii)] 3. 2.5% after the 120th day.

(II) IF A MANAGED CARE ORGANIZATION FAILS TO COMPLY WITH SUBSECTION (C) OF THIS SECTION, THE MANAGED CARE ORGANIZATION SHALL PAY INTEREST ON THE AMOUNT OF THE CLAIM THAT REMAINS UNPAID 45 DAYS AFTER THE CLAIM IS RECEIVED AT THE MONTHLY RATE OF:

1. 1.5% FROM THE 46TH DAY THROUGH THE 60TH DAY;

2. 2% FROM THE 61ST DAY THROUGH THE 120TH DAY; AND

3. 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) (1) An insurer, nonprofit health service plan, or health maintenance organization that violates a provision of this section is subject to:

[(1)] (I) a fine not exceeding $500 for each violation that is arbitrary and capricious, based on all available information; and

[(2)] (II) the penalties prescribed under § 4-113(d) of this article for violations committed with a frequency that indicates a general business practice.

(2) A MANAGED CARE ORGANIZATION THAT VIOLATES A PROVISION OF THIS SECTION IS SUBJECT TO:

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

(II) A FINE EQUAL TO THE AMOUNT OF THE CLEAN CLAIM DUE FOR EACH VIOLATION THAT IS ARBITRARY AND CAPRICIOUS, BASED ON ALL AVAILABLE INFORMATION; AND

(III) 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 this Act shall take effect October 1, 2002.