HOUSE BILL 1082

C3, J1 7lr2522

By: **Delegate Hubbard**
Introduced and read first time: February 9, 2007
Assigned to: Health and Government Operations

Committee Report: Favorable with amendments
House action: Adopted
Read second time: March 20, 2007

CHAPTER ______

AN ACT concerning

Managed Care Organizations – Retroactive Denial of Claims and Applicability of State Laws

FOR the purpose of making certain provisions of law relating to ~~retroactive denial of claims by health insurance carriers~~ health insurance applicable to managed care organizations under the Maryland Medical Assistance Program; providing that a managed care organization is not subject to certain State laws, with a certain exception; providing that certain provisions of law relating to the retroactive denial of claims do not apply under certain circumstances; providing for the application of this Act; altering a certain definition; and generally relating to retroactive denial of claims by and applicability of State laws to managed care organizations.

BY adding to
Article – Health – General
Section 15–101.1
Annotated Code of Maryland
(2005 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets] indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

Section 15–102.3
Annotated Code of Maryland
(2005 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–1008
Annotated Code of Maryland
(2006 Replacement Volume and 2006 Supplement)

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

Article – Health – General

15–101.1.

EXCEPT AS OTHERWISE PROVIDED IN THIS SUBTITLE, A MANAGED CARE ORGANIZATION IS NOT SUBJECT TO THE INSURANCE LAWS OF THE STATE OR TO THE PROVISIONS OF TITLE 19 OF THIS ARTICLE.

15–102.3.

(a) The provisions of § 15–112 of the Insurance Article (Provider panels) shall apply to managed care organizations in the same manner they apply to carriers.

(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.

(C) THE PROVISIONS OF ~~§ 15–1008~~ §§ 4–311, 15–604, 15–605, AND 15–1008 OF THE INSURANCE ARTICLE SHALL APPLY TO MANAGED CARE ORGANIZATIONS IN THE SAME MANNER THEY APPLY TO CARRIERS.

[(c)**] (D)** (1) The provisions of §§ 19–712(b), (c), and (d), 19–713.2, and 19–713.3 of this article apply to managed care organizations in the same manner they apply to health maintenance organizations.

(2) The Insurance Commissioner shall consult with the Secretary before taking any action against a managed care organization under this subsection.

1 **[**(d)**] (E)** The Insurance Commissioner or an agent of the Commissioner
2 shall examine the financial affairs and status of each managed care organization at
3 least once every 5 years.

4 **Article – Insurance**

5 15–1008.

6 (a) (1) In this section the following words have the meanings indicated.

7 (2) "Carrier" means:

8 (i) an insurer;

9 (ii) a nonprofit health service plan;

10 (iii) a health maintenance organization;

11 (iv) a dental plan organization; **[**or**]**

12 **(V) A MANAGED CARE ORGANIZATION, AS DEFINED IN §**
13 **15–101 OF THE HEALTH – GENERAL ARTICLE; OR**

14 **[**(v)**] (VI)** any other person that provides health benefit plans
15 subject to regulation by the State.

16 (3) "Code" means:

17 (i) the applicable current procedural terminology (CPT) code, as
18 adopted by the American Medical Association;

19 (ii) if for a dental service, the applicable code adopted by the
20 American Dental Association; or

21 (iii) another applicable code under an appropriate uniform
22 coding scheme used by a carrier in accordance with this section.

23 (4) "Coding guidelines" means those standards or procedures used or
24 applied by a payor to determine the most accurate and appropriate code or codes for
25 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.

(6) "Reimbursement" means payments made to a health care provider by a carrier on either a fee–for–service, capitated, or premium basis.

(b) This section does not apply to an adjustment to reimbursement made as part of an annual contracted reconciliation of a risk sharing arrangement under an administrative service provider contract.

(c) (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 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 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.

(d) Except as provided in subsection (e) of this section, a carrier that does not comply with the provisions of subsection (c) of this section may not retroactively deny reimbursement or attempt in any manner to retroactively collect reimbursement already paid to a health care provider.

(e) (1) The provisions of subsection (c)(1) of this section do not apply if a carrier retroactively denies reimbursement to a health care provider because:

(i) the information submitted to the carrier was fraudulent;

(ii) the information submitted to the carrier was improperly coded and the carrier has provided to the health care provider sufficient information

1 regarding the coding guidelines used by the carrier at least 30 days prior to the date
2 the services subject to the retroactive denial were rendered; ~~or~~

3 (iii) the claim submitted to the carrier was a duplicate claim**; OR**

4 **(IV) FOR A CLAIM SUBMITTED TO A MANAGED CARE**
5 **ORGANIZATION, THE CLAIM WAS FOR SERVICES PROVIDED TO A MARYLAND**
6 **MEDICAL ASSISTANCE PROGRAM RECIPIENT DURING A TIME PERIOD FOR**
7 **WHICH THE PROGRAM HAS PERMANENTLY RETRACTED THE CAPITATION**
8 **PAYMENT FOR THE PROGRAM RECIPIENT FROM THE MANAGED CARE**
9 **ORGANIZATION**.

10 (2) Information submitted to the carrier may be considered to be
11 improperly coded under paragraph (1) of this subsection if the information submitted
12 to the carrier by the health care provider:

13 (i) uses codes that do not conform with the coding guidelines
14 used by the carrier applicable as of the date the service or services were rendered; or

15 (ii) does not otherwise conform with the contractual obligations
16 of the health care provider to the carrier applicable as of the date the service or
17 services were rendered.

18 (f) If a carrier retroactively denies reimbursement for services as a result of
19 coordination of benefits under provisions of subsection (c)(1)(i) of this section, the
20 health care provider shall have 6 months from the date of denial, unless a carrier
21 permits a longer time period, to submit a claim for reimbursement for the service to
22 the carrier, Maryland Medical Assistance Program, or Medicare Program responsible
23 for payment.

24 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to
25 claims paid by Maryland Medical Assistance Program managed care organizations on
26 or after July 1, 2007.

27 SECTION ~~2.~~ 3. AND BE IT FURTHER ENACTED, That this Act shall take
28 effect July 1, 2007.