HOUSE BILL 1081

C3, J1 8lr2167

By: **Delegates Love, Costa, Kipke, Morhaim, and Weldon**
Introduced and read first time: February 7, 2008
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Reimbursement of Providers of Health Care Services – Claims

FOR the purpose of prohibiting certain managed care organizations from downcoding claims for reimbursement for certain services rendered in compliance with certain federal law based on a certain diagnosis code list; requiring that an audit by certain managed care organizations of certain services rendered in compliance with certain federal law be conducted based on certain guidelines; and generally relating to reimbursement of claims of providers of health care services.

BY adding to
Article – Health – General
Section 15–102.4
Annotated Code of Maryland
(2005 Replacement Volume and 2007 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–1005
Annotated Code of Maryland
(2006 Replacement Volume and 2007 Supplement)

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

Article – Health – General

15–102.4.

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

(A) A MANAGED CARE ORGANIZATION MAY NOT DOWNCODE A CLAIM FOR REIMBURSEMENT FOR A SERVICE RENDERED TO A PROGRAM RECIPIENT IN COMPLIANCE WITH THE FEDERAL EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) AND REGULATIONS ADOPTED UNDER EMTALA BASED ON AN AUTO–PAY DIAGNOSIS CODE LIST.

(B) AN AUDIT BY A MANAGED CARE ORGANIZATION OF SERVICES RENDERED TO A PROGRAM RECIPIENT IN COMPLIANCE WITH EMTALA AND REGULATIONS ADOPTED UNDER EMTALA SHALL BE CONDUCTED BASED ON THE GUIDELINES FOLLOWED BY AUDITORS AT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES.

Article – Insurance

15–1005.

(a) In this section, "clean claim" means a claim for reimbursement, as defined in regulations adopted by the Commissioner under § 15–1003 of this subtitle.

(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) mail or otherwise transmit payment for the claim in accordance with this section; or

(2) 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;

(ii) 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) that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.

(D) (1) A MANAGED CARE ORGANIZATION MAY NOT DOWNCODE A CLAIM FOR REIMBURSEMENT FOR A SERVICE RENDERED IN COMPLIANCE WITH THE FEDERAL EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) AND REGULATIONS ADOPTED UNDER EMTALA BASED ON AN AUTO–PAY DIAGNOSIS CODE LIST.

(2) AN AUDIT BY A MANAGED CARE ORGANIZATION OF SERVICES RENDERED IN COMPLIANCE WITH EMTALA AND REGULATIONS ADOPTED UNDER EMTALA SHALL BE CONDUCTED BASED ON THE GUIDELINES FOLLOWED BY AUDITORS AT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES.

[(d)**] (E)** (1) An insurer, nonprofit health service plan, 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, or health maintenance organization wholly or partially denies a claim for reimbursement, the insurer, nonprofit health service plan, 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.

(3) If an insurer, nonprofit health service plan, or health maintenance organization erroneously denies a provider's claim for reimbursement submitted within the time period specified in paragraph (1) of this subsection because of a claims processing error, and the provider notifies the insurer, nonprofit health service plan, or health maintenance organization of the potential error within 1 year of the claim denial, the insurer, nonprofit health service plan, or health maintenance organization, on discovery of the error, shall reprocess the provider's claim without the necessity for the provider to resubmit the claim, and without regard to timely submission deadlines.

[(e)**] (F)** (1) If an insurer, nonprofit health service plan, or health maintenance organization provides notice under subsection (c)(2)(i) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall mail or otherwise transmit payment for any undisputed portion of the claim within 30 days of receipt of the claim, in accordance with this section.

(2) If an insurer, nonprofit health service plan, or health maintenance organization provides notice under subsection (c)(2)(ii) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall:

(i) mail or otherwise transmit payment for any undisputed portion of the claim in accordance with this section; and

(ii) comply with subsection (c)(1) or (2)(i) of this section within 30 days after receipt of the requested additional information.

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

[(f)**] (G)** (1) 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) 1.5% 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.

[(g)**] (H)** An insurer, nonprofit health service plan, or health maintenance organization that violates a provision of this section is subject to:

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

(2) 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 June 1, 2008.