Department of Legislative Services

Maryland General Assembly
2008 Session

FISCAL AND POLICY NOTE

House Bill 1081 (Delegate Love, *et al.*)
Health and Government Operations

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

This bill prohibits a Medicaid managed care organization from downcoding a claim for reimbursement for a service rendered in compliance with the federal Emergency Medical Treatment and Active Labor Act based on an auto-pay diagnosis code list. MCOs must conduct an audit of services rendered under EMTALA in accordance with Centers for Medicare and Medicaid Services guidelines.

The bill takes effect June 1, 2008.

Fiscal Summary

State Effect: To the extent that the Maryland Insurance Administration receives additional complaints from providers, MIA special fund expenditures could increase beginning in FY 2009. Medicaid expenditures (50% general funds, 50% federal funds) could potentially increase beginning in FY 2011 due to increased MCO rates. No effect on revenues.

Local Effect: None.

Small Business Effect: Small business emergency room physician practices could receive additional reimbursement under the bill.

Analysis

Current Law: A carrier must permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim. Within 30 days of receipt, a carrier must

pay the claim or send a notice of receipt with the status of the claim. If a carrier denies a claim, it must permit a provider at least 90 working days to appeal. If a carrier erroneously denies a claim and the provider notifies the carrier within one year, the carrier must reprocess the claim. If a carrier disputes a portion of a claim, it must provide payment for any undisputed portion within 30 days of receipt of the claim. Carriers that do not pay clean claims must pay interest on the amount of the claim that remains unpaid 30 days after the claim is received. Carriers in violation of clean claims regulations are subject to a fine of up to $500 per violation and additional penalties for violations committed with a frequency that indicates a general business practice.

A carrier may retroactively deny reimbursement if information submitted was fraudulent or improperly coded or if the claim was duplicative. A claim may be considered improperly coded if it uses codes that do not conform to the coding guidelines used by the carrier or if it does not conform to the contractual obligations of the provider. If a carrier retroactively denies reimbursement, the carrier must specify in writing the basis for the denial. A carrier may only retroactively deny reimbursement for services within six months after the date that the carrier paid the provider, with the exception of services subject to coordination of benefits with another carrier, Medicaid, or Medicare, in which case a claim may be denied for up to 18 months. If a carrier retroactively denies reimbursement as a result of coordination of benefits, the provider has at least six months from the date of denial to submit a claim to the carrier, Medicaid, or Medicare.

Background: EMTALA requires a hospital that receives Medicare funds to treat an individual who comes to the hospital with an emergency medical condition regardless of the ability to pay. If a hospital is capable of providing the necessary emergency care to a patient and an emergency medical condition is found to exist, the hospital is prohibited from refusing to provide treatment to the individual or from transferring the patient to another medical facility without good cause.

"Downcoding" of a claim occurs when a health insurer reduces a service level. A provider submits a claim based on a certain CPT code or diagnosis and the insurer automatically "downcodes" the claim for a lower level CPT code or diagnosis and then reimburses at a lower rate. One MCO is currently downgrading all emergency room claims and requiring additional information before paying at a higher level.

State Expenditures: MIA special fund expenditures could increase beginning in fiscal 2009 to the extent that additional complaints are received from providers. This amount cannot be reliably estimated but is not expected to be significant.

Medicaid expenditures (50% general funds, 50% federal funds) could potentially increase beginning in fiscal 2011 to increase reimbursement rates to the one MCO that currently

downgrades emergency room claims. This amount cannot be reliably estimated but is not anticipated to be significant.

The fiscal impact on Medicaid would be delayed because MCO rates are set on a calendar year basis using actual expenditures from prior years along with other factors. While the MCO would potentially incur additional expenditures beginning in fiscal 2009 under the bill, those expenses would not be reflected in higher reimbursement rates from Medicaid until fiscal 2011.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): American Medical Association, Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Budget and Management, Department of Legislative Services

Fiscal Note History: First Reader - February 27, 2008
mam/ljm

Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510