Department of Legislative Services

Maryland General Assembly
2008 Session

FISCAL AND POLICY NOTE

House Bill 709 (Delegates Costa and Kipke)
Health and Government Operations

Health Insurance - Special Services, Procedures, or Reports - Reimbursement

This bill prohibits a carrier from denying reimbursement for or bundling into another procedure code any special service, procedure, or report related to a covered service or provided at the request of the carrier. A carrier must pay a claim for a special service, procedure, or report in accordance with clean claim and retroactive denial of reimbursement guidelines.

The bill takes effect July 1, 2008.

Fiscal Summary

State Effect: Potential significant increase in expenditures for the State Employee and Retiree Health and Welfare Benefit Plan (State plan) beginning in FY 2009. Potential minimal increase in special fund expenditures for the Maryland Insurance Administration to review HMO provider contracts and handle additional consumer and provider complaints. No effect on revenues.

Local Effect: To the extent that carriers incur additional costs and increase premiums, expenditures for local jurisdiction employee health benefits could increase.

Small Business Effect: Potential meaningful. Small business health care providers could receive additional reimbursement for services under the bill.

Analysis

Bill Summary: "Special service, procedure, or report" means any service, procedure, or report with a special service, procedure, or report code in the *Current Procedural and Terminology Code Book*.

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: Special services, procedures, and reports CPT codes provide the reporting health care provider with a means for identifying the completion of special reports and services that are adjunct to the basic services rendered. The specific number assigned indicates the special circumstances under which a basic procedure is performed. These codes may be used to account for such variables as services provided in the office at times other than regularly scheduled office hours or administrative functions.

Anecdotal evidence suggests that health care providers are not receiving reimbursement for special services, procedures, and reports or are having these services bundled for payment with other services provided. The State plan currently bundles reimbursement for administrative functions with the payment for the associated procedure.

State Expenditures: State plan expenditures could increase beginning in fiscal 2009 due to increased claims costs to "unbundle" administrative functions and pay additional reimbursement for such functions on a line-by-line basis. Such an increase cannot be reliably estimated at this time, but could be significant.

State plan expenditures assume a fund mix of 60% general funds, 20% federal funds, and 20% special funds; also, 20% of expenditures are reimbursable through employee contributions.

MIA special fund expenditures could increase in fiscal 2009 to review HMO provider contracts and handle additional consumer and provider complaints. The amount of expenditures will depend on the amount of contract revisions and complaints submitted but are expected to be minimal.

Additional Information

Prior Introductions: None.

Cross File: SB 469 (Senator Della) – Finance.

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

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