Department of Legislative Services

Maryland General Assembly
2009 Session

FISCAL AND POLICY NOTE
Revised

House Bill 440 (Delegate Bromwell)
Health and Government Operations Finance

Health Insurance - Prompt Pay - Clarifications

This bill clarifies that if an insurer, nonprofit health service plan, or health maintenance organization (carrier) fails to pay a clean claim for reimbursement or otherwise violates clean claims requirements, the carrier must pay interest on the amount of the claim that remains unpaid 30 days after the receipt of the initial clean claim for reimbursement.

Fiscal Summary

State Effect: None. The bill clarifies current law.

Local Effect: None.

Small Business Effect: None.

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. A carrier that does not pay clean claims must pay interest on the amount of the claim that remains unpaid 30 days after the claim is received. Interest must be paid at a monthly rate of:

- 1.5% from the thirty-first through sixtieth day;
- 2.0% from the sixty-first through one hundred-twentieth day; and
- 2.5% after the one hundred-twentieth day.

A carrier in violation of these regulations is subject to a fine of up to $500 per violation and additional penalties for frequent violations that indicate a general business practice. Interest must be included in any late reimbursement to the provider.

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: Errors may occur during the electronic processing of claims (*i.e.*, failure to reconcile the claim with a prior authorization number) that result in the initial denial of a clean claim. The claim must then be resubmitted by the provider. This bill clarifies that clean claims requirements continue to apply when claims are resubmitted. This reflects the Maryland Insurance Administration's interpretation of current law.

Additional Information

Prior Introductions: None.

Cross File: SB 439 (Senator Middleton) - Finance.

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

Fiscal Note History: First Reader - February 11, 2009
mcp/mwc Revised - House Third Reader - March 20, 2009

Analysis by: Jennifer B. Chasse

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