# SENATE BILL 561

C3 1lr2285
CF 1lr2250

By: **Senator Pugh**
Introduced and read first time: February 4, 2011
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

**Health Insurance – Health Care Providers – Payment of Claims for Reimbursement by Carriers**

FOR the purpose of altering the scope of certain provisions of law governing the prompt payment of provider claims for reimbursement, the retroactive denial of health care provider claims for reimbursement, and the denial of reimbursement for preauthorized or approved health care services delivered by health care providers, by expanding the carriers and providers of health care services that are subject to the provisions of law; defining certain terms; altering certain definitions; making certain conforming and stylistic changes; and generally relating to payment of health care provider claims for reimbursement by carriers.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–1005, 15–1008, and 15–1009
Annotated Code of Maryland
(2006 Replacement Volume and 2010 Supplement)

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

**Article – Insurance**

15–1005.

(a) **(1)** In this section**[**, "clean**]** **THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.**

**(2) "CARRIER" MEANS AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION THAT:**

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

**(I) ISSUES OR DELIVERS A POLICY, CONTRACT, OR CERTIFICATE OF HEALTH INSURANCE IN THE STATE; OR**

**(II) RECEIVES, PROCESSES, ADJUDICATES, PAYS, OR DENIES CLAIMS FOR REIMBURSEMENT FOR HEALTH CARE SERVICES RENDERED IN THE STATE BY A PROVIDER.**

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

**(4) "PROVIDER" MEANS A PERSON THAT IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED TO PROVIDE HEALTH CARE SERVICES IN THE JURISDICTION IN WHICH A HEALTH CARE SERVICE IS RENDERED.**

(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**]** **A CARRIER** 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**]** **PROVIDER**, **[**an insurer, nonprofit health service plan, or health maintenance organization**]** **A CARRIER** 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**]** **CARRIER** 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) **[**An insurer, nonprofit health service plan, or health maintenance organization**]** **A CARRIER** shall permit a provider a minimum of 180 days **[**from**]**

**AFTER** the date a covered **HEALTH CARE** service is rendered to submit a claim for reimbursement for the service.

(2) If **[**an insurer, nonprofit health service plan, or health maintenance organization**]** **A CARRIER** wholly or partially denies a claim for reimbursement, the **[**insurer, nonprofit health service plan, or health maintenance organization**]** **CARRIER** 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**]** **A CARRIER** 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**]** **CARRIER** of the potential error within 1 year of the claim denial, the **[**insurer, nonprofit health service plan, or health maintenance organization**]** **CARRIER**, 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) (1) If **[**an insurer, nonprofit health service plan, or health maintenance organization**]** **A CARRIER** provides notice under subsection (c)(2)(i) of this section, the **[**insurer, nonprofit health service plan, or health maintenance organization**]** **CARRIER** shall mail or otherwise transmit payment for any undisputed portion of the claim within 30 days **[**of**]** **AFTER** receipt of the claim, in accordance with this section.

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

(f) (1) If **[**an insurer, nonprofit health service plan, or health maintenance organization**]** **A CARRIER** fails to pay a clean claim for reimbursement or otherwise violates any provision of this section, the **[**insurer, nonprofit health service plan, or

health maintenance organization**]** **CARRIER** shall pay interest on the amount of the claim that remains unpaid 30 days after receipt of the initial clean claim for reimbursement 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) **[**An insurer, nonprofit health service plan, or health maintenance organization**]** **A CARRIER** 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.

15–1008.

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

(2) **(I)** "Carrier" means:

**[**(i)**]** **1.** an insurer;

**[**(ii)**]** **2.** a nonprofit health service plan;

**[**(iii)**]** **3.** a health maintenance organization;

**[**(iv)**]** **4.** a dental plan organization;

**[**(v)**]** **5.** a managed care organization, as defined in § 15–101 of the Health – General Article; or

**[**(vi)**]** **6.** any other person that provides health benefit plans **[**subject to regulation by**]** **THAT COVER RESIDENTS OF** the State.

**(II) "CARRIER" INCLUDES AN ENTITY LISTED IN SUBPARAGRAPH (I)1 THROUGH 5 OF THIS PARAGRAPH THAT RECEIVES, PROCESSES, ADJUDICATES, PAYS, OR DENIES CLAIMS FOR REIMBURSEMENT**

**FOR HEALTH CARE SERVICES RENDERED IN THE STATE BY A HEALTH CARE PROVIDER.**

(3) "Code" means:

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

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

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

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

(5) "Health care provider" means a person **[**or entity**]** **THAT IS** licensed, certified**,** or otherwise authorized **[**under the Health Occupations Article or the Health – General Article**]** to provide health care services **IN THE JURISDICTION IN WHICH A HEALTH CARE SERVICE IS RENDERED**.

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

(iii) the claim submitted to the carrier was a duplicate claim; or

(iv) for a claim submitted to a managed care organization, the claim was for services provided to a Maryland Medical Assistance Program recipient during a time period for which the Program has permanently retracted the capitation payment for the Program recipient from the managed care organization.

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

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

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

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

15–1009.

(a) **(1)** In this section**[**, "carrier"**]** **THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.**

**(2) (I) "CARRIER"** means:

**[**(1)**]** **1.** an insurer;

**[**(2)**]** **2.** a nonprofit health service plan;

**[**(3)**]** **3.** a health maintenance organization;

**[**(4)**]** **4.** a dental plan organization; or

**[**(5)**]** **5.** any other person that provides health benefit plans **[**subject to regulation by**]** **THAT COVER RESIDENTS OF** the State.

**(II) "CARRIER" INCLUDES AN ENTITY LISTED IN SUBPARAGRAPH (I)1 THROUGH 4 OF THIS PARAGRAPH THAT RECEIVES, PROCESSES, ADJUDICATES, PAYS, OR DENIES CLAIMS FOR REIMBURSEMENT FOR HEALTH CARE SERVICES RENDERED IN THE STATE BY A HEALTH CARE PROVIDER.**

**(3) "HEALTH CARE PROVIDER" MEANS A PERSON THAT IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED TO PROVIDE HEALTH CARE SERVICES IN THE JURISDICTION IN WHICH A HEALTH CARE SERVICE IS DELIVERED.**

(b) If a health care service for a patient has been preauthorized or approved by a carrier or the carrier's private review agent, the carrier may not deny reimbursement to a health care provider for the preauthorized or approved service delivered to that patient unless:

(1) the information submitted to the carrier regarding the service to be delivered to the patient was fraudulent or intentionally misrepresentative;

(2) critical information requested by the carrier regarding the service to be delivered to the patient was omitted such that the carrier's determination would have been different had it known the critical information;

(3) a planned course of treatment for the patient that was approved by the carrier was not substantially followed by the health care provider; or

(4) on the date the preauthorized or approved service was delivered:

(i) the patient was not covered by the carrier;

(ii) the carrier maintained an automated eligibility verification system that was available to the contracting **HEALTH CARE** provider by telephone or via the Internet; and

(iii) according to the verification system, the patient was not covered by the carrier.

(c) A carrier shall pay a claim for a preauthorized or approved covered health care service in accordance with §§ 15–1005 and 15–1008 of this subtitle.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2011.