Chapter 163

(Senate Bill 416)

AN ACT concerning

Health Maintenance Organizations – Payments to Nonparticipating Providers – Repeal of Termination Date

FOR the purpose of repealing the termination date of certain provisions of law requiring health maintenance organizations to pay certain providers for certain services at certain rates; and generally relating to payments by health maintenance organizations to nonparticipating providers.

BY repealing and reenacting, without amendments,
Article – Health – General
Section 19–710.1
Annotated Code of Maryland
(2009 Replacement Volume and 2013 Supplement)

BY repealing and reenacting, with amendments,
Chapter 664 of the Acts of the General Assembly of 2009
Section 2

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

Article – Health – General

19–710.1.

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

(2) "Adjunct claims documentation" means an abstract of an enrollee's medical record which describes and summarizes the diagnosis and treatment of, and services rendered to, the enrollee, including, in the case of trauma rendered in a trauma center, an operative report, a discharge summary, a Maryland Ambulance Information Systems form, or a medical record.

(3) "Berenson–Eggers Type of Service Code" means a code in a classification system developed by the Centers for Medicare and Medicaid Services that groups Current Procedural Terminology codes together based on clinical consistency.

(4) "Enrollee" means a subscriber or member of a health maintenance organization.

(5) "Evaluation and management service" means any service with a Berenson–Eggers Type of Service Code in the category of evaluation and management.

(6) "Institute" means the Maryland Institute for Emergency Medical Services Systems.

(7) "Medicare Economic Index" means the fixed–weight input price index that:

(i) Measures the weighted average annual price change for various inputs needed to produce physician services; and

(ii) Is used by the Centers for Medicare and Medicaid Services in the calculation of reimbursement of physician services under Title XVIII of the federal Social Security Act.

(8) "Similarly licensed provider" means:

(i) For a physician:

1. A physician who is board certified or eligible in the same practice specialty; or

2. A group physician practice that contains board certified or eligible physicians in the same practice specialty;

(ii) For a health care provider that is not a physician, a health care provider that holds the same type of license.

(9) (i) "Trauma center" means a primary adult resource center, level I trauma center, level II trauma center, level III trauma center, or pediatric trauma center that has been designated by the institute to provide care to trauma patients.

(ii) "Trauma center" includes an out–of–state pediatric facility that has entered into an agreement with the institute to provide care to trauma patients.

(10) "Trauma patient" means a patient that is evaluated or treated in a trauma center and is entered into the State trauma registry as a trauma patient.

(11) "Trauma physician" means a licensed physician who has been credentialed or designated by a trauma center to provide care to a trauma patient at a trauma center.

(b) In addition to any other provisions of this subtitle, for a covered service rendered to an enrollee of a health maintenance organization by a health care provider not under written contract with the health maintenance organization, the health maintenance organization or its agent:

(1) Shall pay the health care provider within 30 days after the receipt of a claim in accordance with the applicable provisions of this subtitle; and

(2) Shall pay the claim submitted by:

(i) A hospital at the rate approved by the Health Services Cost Review Commission;

(ii) A trauma physician for trauma care rendered to a trauma patient in a trauma center, at the greater of:

1. 140% of the rate paid by the Medicare program, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; or

2. The rate as of January 1, 2001 that the health maintenance organization paid in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; and

(iii) Any other health care provider:

1. For an evaluation and management service, no less than the greater of:

A. 125% of the average rate the health maintenance organization paid as of January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service, to similarly licensed providers under written contract with the health maintenance organization; or

B. 140% of the rate paid by Medicare, as published by the Centers for Medicare and Medicaid Services, for the same covered service to a similarly licensed provider in the same geographic area as of August 1, 2008, inflated by the change in the Medicare Economic Index from 2008 to the current year; and

2. For a service that is not an evaluation and management service, no less than 125% of the average rate the health maintenance organization paid as of January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, to a similarly licensed provider under written contract with the health maintenance organization for the same covered service.

(c) For the purposes of subsection (b)(2)(iii) of this section, a health maintenance organization shall calculate the average rate paid to similarly licensed providers under written contract with the health maintenance organization for the same covered service by summing the contracted rate for all occurrences of the Current Procedural Terminology Code for that service and then dividing by the total number of occurrences of the Current Procedural Terminology Code.

(d) A health maintenance organization shall disclose, on request of a health care provider not under written contract with the health maintenance organization, the reimbursement rate required under subsection (b)(2)(ii) and (iii) of this section.

(e) (1) Subject to paragraph (2) of this subsection, a health maintenance organization may require a trauma physician not under contract with the health maintenance organization to submit appropriate adjunct claims documentation and to include on the uniform claim form a provider number assigned to the trauma physician by the health maintenance organization.

(2) If a health maintenance organization requires a trauma physician to include a provider number on the uniform claim form in accordance with paragraph (1) of this subsection, the health maintenance organization shall assign a provider number to a trauma physician not under contract with the health maintenance organization at the request of the physician.

(3) A trauma center, on request from a health maintenance organization, shall verify that a licensed physician is credentialed or otherwise designated by the trauma center to provide trauma care.

(4) Notwithstanding the provisions of § 19–701(d) of this subtitle, for trauma care rendered to a trauma patient in a trauma center by a trauma physician, a health maintenance organization may not require a referral or preauthorization for a service to be covered.

(f) (1) A health maintenance organization may seek reimbursement from an enrollee for any payment under subsection (b) of this section for a claim or portion of a claim submitted by a health care provider and paid by the health maintenance organization that the health maintenance organization determines is the responsibility of the enrollee.

(2) The health maintenance organization may request and the health care provider shall provide adjunct claims documentation to assist in making the determination under paragraph (1) of this subsection or under subsection (b) of this section.

(g) (1) A health care provider may enforce the provisions of this section by filing a complaint against a health maintenance organization with the Maryland Insurance Administration or by filing a civil action in a court of competent jurisdiction under § 1–501 or § 4–201 of the Courts Article.

(2) The Maryland Insurance Administration or a court shall award reasonable attorney fees if the complaint of the health care provider is sustained.

(h) The Maryland Health Care Commission annually shall review payments to health care providers to determine the compliance of health maintenance organizations with the requirements of this section and report its findings to the Maryland Insurance Administration.

(i) The Maryland Insurance Administration may take any action authorized under this subtitle or the Insurance Article, including conducting an examination under Title 2, Subtitle 2 of the Insurance Article, to investigate and enforce a violation of the provisions of this section.

(j) In addition to any other penalties under this subtitle, the Commissioner may impose a penalty not to exceed $5,000 on any health maintenance organization which violates the provisions of this section if the violation is committed with such frequency as to indicate a general business practice of the health maintenance organization.

(k) The Maryland Insurance Administration, in consultation with the Maryland Health Care Commission, shall adopt regulations to implement this section.

Chapter 664 of the Acts of 2009

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 2010. **[**It shall remain in effect for a period of 5 years and, at the end of December 31, 2014, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.**]**

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2014.

Approved by the Governor, April 14, 2014.