SENATE BILL 797

J5, J4, J1 6lr2011
CF 6lr1913

By: **Senator Lam**
Introduced and read first time: February 6, 2026
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Maryland Medical Assistance Program and Health Insurance – Claims for Reimbursement – Downcoding

FOR the purpose of prohibiting insurers, nonprofit health service plans, health maintenance organizations, and managed care organizations from downcoding a claim for reimbursement under certain circumstances; establishing certain procedures that insurers, nonprofit health service plans, health maintenance organizations, and managed care organizations are required to follow if the insurer, nonprofit health service plan, or health maintenance organization intends or makes a final decision to downcode a claim; providing that a decision to downcode a claim leading to nonpayment constitutes a coverage decision and may be appealed under certain provisions of law; and generally relating to health insurance claims and downcoding.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 15–102.3(b) and 19–712(b)
Annotated Code of Maryland
(2023 Replacement Volume and 2025 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–113(b), 15–10A–06(a)(1), and 15–10D–02(d)
Annotated Code of Maryland
(2017 Replacement Volume and 2025 Supplement)

BY adding to
Article – Insurance
Section 15–1005.1
Annotated Code of Maryland
(2017 Replacement Volume and 2025 Supplement)

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

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

Article – Health – General

15–102.3.

(b) The provisions of **[**§ 15–1005**] §§ 15–113(B), 15–1005, AND 15–1005.1** of the Insurance Article shall apply to managed care organizations in the same manner they apply to health maintenance organizations.

19–712.

(b) (1) A person who holds a certificate of authority to operate a health maintenance organization under this subtitle and who enters into any administrative service provider contract, as defined in § 19–713.2 of this subtitle, with a person or entity for the provision of health care services to subscribers shall be responsible for all claims or payments for health care services:

(i) Covered under the subscriber's contract; and

(ii) Rendered by a provider, who is not the person or entity which entered into the administrative service provider contract with the health maintenance organization, pursuant to a referral by a person or entity which entered into the administrative service provider contract with the health maintenance organization.

(2) Responsibility for claims and payments under this subsection is subject to the provisions of **[**§ 15–1005**] §§ 15–113(B), 15–1005, AND 15–1005.1** of the Insurance Article.

Article – Insurance

15–113.

(b) A carrier**:**

(1) may not reimburse a health care practitioner in an amount less than the sum or rate negotiated in the carrier's provider contract with the health care practitioner**; AND**

(2) SHALL COMPLY WITH § 15–1005.1 OF THIS TITLE BEFORE REDUCING A CLAIM SUBMITTED BY A HEALTH CARE PROVIDER TO A LOWER LEVEL OF EVALUATION AND MANAGEMENT SERVICE CODE OR OTHER SERVICE CODE RESULTING IN A LOWER PAYMENT FOR SERVICE.

15–1005.1.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "DOWNCODE" MEANS THE UNILATERAL ALTERATION BY AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION, OR BY ANY ENTITY WORKING ON BEHALF OF AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION, OF THE LEVEL OF EVALUATION AND MANAGEMENT SERVICE CODE OR ANY OTHER SERVICE CODE SUBMITTED BY A HEALTH CARE PROVIDER, RESULTING IN A LOWER PAYMENT.

(3) "HEALTH CARE PROVIDER" MEANS:

(I) AN INDIVIDUAL WHO IS LICENSED UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE SERVICES IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION AND IS A TREATING PROVIDER OF THE MEMBER;

(II) A HOSPITAL, AS DEFINED IN § 19–301 OF THE HEALTH – GENERAL ARTICLE; OR

(III) A FREESTANDING MEDICAL FACILITY, AS DEFINED IN § 19–3A–01 OF THE HEALTH – GENERAL ARTICLE.

(B) IN PAYING A CLAIM FOR REIMBURSEMENT UNDER § 15–1005 OF THIS SUBTITLE, AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION MAY NOT:

(1) USE A PROCESS, SYSTEM, OR TOOL, INCLUDING ARTIFICIAL INTELLIGENCE, ALGORITHMS, SOFTWARE TOOLS, OR MACHINE LEARNING, TO DOWNCODE A CLAIM WITHOUT A REVIEW OF CLINICAL DOCUMENTATION AS REQUIRED UNDER THIS SECTION;

(2) DOWNCODE A CLAIM BASED SOLELY ON THE REPORTED DIAGNOSIS CODE;

(3) FOR A CLAIM INVOLVING EMERGENCY SERVICES, AS DEFINED IN § 15–1A–14 OF THIS TITLE, DOWNCODE THE CLAIM BASED ON THE FINAL DIAGNOSIS RATHER THAN THE SYMPTOMS PRESENTED, AS DOCUMENTED BY A HEALTH CARE PROVIDER AND MEASURED AGAINST THE STANDARD OF A PRUDENT LAYPERSON; OR

(4) USE DOWNCODING PRACTICES THAT TARGET HEALTH CARE PROVIDERS WHO ROUTINELY TREAT PATIENTS WITH COMPLEX OR CHRONIC CONDITIONS THAT MAY HAVE A GREATER INCIDENCE OF HIGHER EVALUATION AND MANAGEMENT AND OTHER SERVICE CODES.

(C) (1) WITHIN 30 DAYS AFTER RECEIVING A CLAIM FOR REIMBURSEMENT, IF AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION INTENDS ON DOWNCODING THE CLAIM, THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION SHALL PROVIDE NOTICE TO THE HEALTH CARE PROVIDER OF THE INTENT TO DOWNCODE THE CLAIM.

(2) THE NOTICE PROVIDED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL INCLUDE:

(I) THE SPECIFIC REASON FOR DOWNCODING THE CLAIM, INCLUDING REFERENCE TO CLINICAL CRITERIA AND ESTABLISHED FEDERAL OR STATE CODING GUIDELINES USED TO JUSTIFY THE DOWNCODING;

(II) THE ORIGINAL CODES SUBMITTED BY THE HEALTH CARE PROVIDER AND THE REVISED SERVICE CODES SELECTED BY THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION AND CORRESPONDING REIMBURSEMENT AMOUNTS; AND

(III) A STATEMENT INFORMING THE HEALTH CARE PROVIDER OF THE OPPORTUNITY TO RESPOND AND PROVIDE ADDITIONAL DOCUMENTATION:

1. AS NECESSARY TO SUPPORT THE CLAIM; AND

2. WITHIN 90 DAYS AFTER THE DATE THE HEALTH CARE PROVIDER RECEIVED THE NOTICE.

(3) AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION MAY REQUEST ADDITIONAL INFORMATION FROM A HEALTH CARE PROVIDER FOR A CLAIM BEING CONSIDERED FOR DOWNCODING IF THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION:

(I) CONFIRMS THAT REQUESTED INFORMATION WAS NOT PREVIOUSLY SUBMITTED WITH THE CLAIM FOR REIMBURSEMENT BEFORE REQUESTING ADDITIONAL INFORMATION FROM THE HEALTH CARE PROVIDER; AND

(II) COMPLIES WITH § 15–1005(C)(2)(II) OF THIS SUBTITLE AND REGULATIONS ADOPTED UNDER § 15–1003(D)(1)(II) OF THIS SUBTITLE.

(D) A FINAL DETERMINATION OF WHETHER TO DOWNCODE A CLAIM SHALL BE MADE BY A PHYSICIAN WHO IS:

(1) BOARD CERTIFIED OR ELIGIBLE TO BE BOARD CERTIFIED IN THE SAME SPECIALTY AS THE SERVICE OR TREATMENT UNDER REVIEW; AND

(2) KNOWLEDGEABLE ABOUT THE HEALTH CARE SERVICE OR TREATMENT UNDER REVIEW THROUGH ACTUAL CLINICAL EXPERIENCE.

(E) IF AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION MAKES A FINAL DECISION TO DOWNCODE A CLAIM, THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION SHALL PROVIDE A FINAL NOTICE TO THE HEALTH CARE PROVIDER THAT OUTLINES THE RIGHT TO APPEAL THE FINAL DECISION IN ACCORDANCE WITH SUBSECTION (F) OF THIS SECTION.

(F) A FINAL DECISION TO DOWNCODE A CLAIM THAT LEADS TO THE NONPAYMENT OF A CLAIM OR PORTION OF A CLAIM UNDER § 15–1005 OF THIS SUBTITLE CONSTITUTES A COVERAGE DECISION FOR PURPOSES OF AN APPEAL UNDER SUBTITLE 10D OF THIS TITLE.

(G) IN ADDITION TO PENALTIES IMPOSED UNDER § 15–1005 OF THIS SUBTITLE, AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION THAT VIOLATES THIS SECTION IS SUBJECT TO A FINE NOT EXCEEDING $10,000 FOR EACH VIOLATION.

15–10A–06.

(a) (1) On a quarterly basis, each carrier shall submit to the Commissioner, on the form the Commissioner requires, a report that describes the following information aggregated by zip code as required by the Commissioner:

(i) the number of members entitled to health care benefits under a policy, plan, or certificate issued or delivered in the State by the carrier;

(ii) **1.** the number of clean claims for reimbursement processed by the carrier;

2. THE NUMBER OF NOTICES SENT TO HEALTH CARE PROVIDERS INDICATING AN INTENT TO DOWNCODE A CLAIM UNDER § 15–1005.1 OF THIS TITLE; AND

3. THE NUMBER OF CLAIMS THAT WERE DOWNCODED BY THE CARRIER;

(iii) the activities of the carrier under this subtitle, including:

1. the outcome of each grievance filed with the carrier;

2. the number and outcomes of cases that were considered emergency cases under § 15–10A–02(b)(2)(i) of this subtitle;

3. the time within which the carrier made a grievance decision on each emergency case;

4. the time within which the carrier made a grievance decision on all other cases that were not considered emergency cases;

5. the number of grievances filed with the carrier that resulted from an adverse decision involving length of stay for inpatient hospitalization as related to the medical procedure involved;

6. the number of adverse decisions issued by the carrier under § 15–10A–02(f) of this subtitle, whether the adverse decision involved a prior authorization or step therapy protocol, the type of service at issue in the adverse decisions, and whether an artificial intelligence, algorithm, or other software tool was used in making the adverse decision;

7. the number of adverse decisions overturned after a reconsideration request under § 15–10B–06 of this title; and

8. the number of requests made and granted under § 15–831(c)(1) and (2) of this title; and

(iv) the number and outcome of all other cases that are not subject to activities of the carrier under this subtitle that resulted from an adverse decision involving the length of stay for inpatient hospitalization as related to the medical procedure involved.

15–10D–02.

(d) **(1)** A member, a member's representative, or a health care provider filing a complaint on behalf of a member may file a complaint with the Commissioner without first filing an appeal with a carrier **[**only**]** if the coverage decision involves an urgent medical condition, as defined by regulation adopted by the Commissioner, for which care has not been rendered.

(2) A HEALTH CARE PROVIDER MAY FILE A COMPLAINT WITH THE COMMISSIONER WITHOUT FIRST FILING AN APPEAL WITH A CARRIER IF THE COVERAGE DECISION IS THE RESULT OF A FINAL DETERMINATION TO DOWNCODE A CLAIM UNDER § 15–1005.1.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2026.