Department of Legislative Services

Maryland General Assembly
2026 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 797 (Senator Lam)
Finance

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

This bill prohibits insurers, nonprofit health service plans, and health maintenance organizations (collectively carriers) and Medicaid managed care organizations (MCOs) from downcoding a claim for reimbursement under specified circumstances. The bill establishes procedures that carriers and MCOs must follow to "downcode" a claim. A carrier or MCO must comply with these provisions 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. A final decision to downcode a claim that leads to nonpayment of a claim/portion of a claim constitutes a coverage decision subject to appeal. A health care provider may file a complaint with the Insurance Commissioner without first filing an appeal with a carrier if the coverage decision is the result of a final determination to downcode a claim. A carrier must include specified information about downcoding in its quarterly appeals and grievances report. In addition to existing penalties regarding payment of clean claims, a carrier that violates the bill is subject to a fine of up to $10,000 per violation.

Fiscal Summary

State Effect: Any additional workload on the Maryland Insurance Administration can be handled with existing resources. Medicaid expenditures likely increase by an indeterminate amount beginning in FY 2027 for administrative costs (50% general funds, 50% federal funds) and for additional service reimbursement (60% federal funds, 40% general funds), as discussed below. No anticipated impact on the State Employee and Retiree Health and Welfare Benefits Program. Penalty revenues are not expected to have a meaningful impact on State revenues.

Local Effect: None.

Small Business Effect: Potential meaningful.

Analysis

Bill Summary: "Downcode" means the unilateral alteration by a carrier (or any entity working on behalf of a carrier) 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.

Prohibitions

In paying a claim for reimbursement, a carrier may not:

- 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 specified;
- downcode a claim based solely on the reported diagnosis code;
- for a claim involving emergency services, 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
- 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.

Requirements for Downcoding a Claim

Within 30 days after receiving a claim for reimbursement, if a carrier intends on downcoding the claim, the carrier must provide notice to the health care provider of the intent to do so. The notice must include (1) the specific reason for downcoding the claim, including reference to clinical criteria and established federal or State coding guidelines used to justify the downcoding; (2) the original codes submitted by the health care provider and the revised service codes selected by the carrier and corresponding reimbursement amounts; and (3) a statement informing the health care provider of the opportunity to respond and provide additional documentation within 90 days after receipt of the notice as necessary to support the claim.

A carrier may request additional information from a health care provider for a claim being considered for downcoding if the carrier confirms that requested information was not previously submitted and complies with specified clean claims notification requirements.

Final Determination to Downcode a Claim

A final determination to downcode a claim must be made by a physician who is board certified or eligible to be board certified in the same specialty as the service or treatment under review and knowledgeable about the health care service or treatment under review through actual clinical experience.

If a carrier makes a final decision to downcode a claim, the carrier must provide a final notice to the health care provider that outlines the right to appeal the final decision.

Information for Inclusion in Quarterly Appeals and Grievances Reports

A carrier must include in its quarterly appeals and grievances reports filed with the Commissioner the number of notices sent to health care providers indicating an intent to downcode a claim and the number of claims that were downcoded by the carrier.

Current Law: A carrier 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.

Within 30 days of receipt of a claim for reimbursement, a carrier must mail or transmit payment for the claim or send a notice of receipt with the status of the claim. The notice must state that (1) the carrier refuses to reimburse all or part of the claim and the reason for refusal; (2) the legitimacy of the claim or the appropriate amount of reimbursement is in dispute (and the additional information necessary to determine if all or part of the claim will be reimbursed); or (3) the claim is not clean and the specific information necessary to be considered clean. If a carrier wholly or partially denies a claim for reimbursement, the carrier must permit a provider a minimum of 90 working days after the date of denial to appeal the denial.

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. If a carrier requests specific additional information, the carrier must pay the claim within 30 days after receiving receipt of the requested information.

On a quarterly basis, each carrier must submit a report to the Commissioner that describes specified activities about appeals and grievances, including the number of clean claims for reimbursement processed by the carrier. The Commissioner must compile an annual summary report based on the information provided by carriers (and information provided by the Secretary of Health regarding health maintenance organizations) and provide copies of the summary report to the Governor and the General Assembly.

State Fiscal Effect: The Maryland Department of Health advises that the bill is anticipated to result in increased administrative costs and payment amounts as MCOs adhere to these proposed downcoding standards. However, the impact of these changes is indeterminate and depends on the current rate of inappropriately downcoded claims by MCOs. Thus, Medicaid expenditures likely increase by an indeterminate amount beginning in fiscal 2027 for additional administrative costs (50% general funds, 50% federal funds) and for additional reimbursement of claims (60% federal funds, 40% general funds).

Small Business Effect: Small business health care providers may benefit by receiving some payment of improperly coded claims, but only after the process outlined in the bill is followed. A provider may file a complaint with the Insurance Commissioner without first filing an appeal with a carrier if the coverage decision is the result of a final determination to downcode a claim.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced within the last three years.

Designated Cross File: HB 1153 (Delegate Guzzone, *et al.*) - Health.

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

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