TESTIMONY IN SUPPORT OF SB 797

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

TO: Chair of the Senate Finance Committee and Members of the Committee

FROM: Amy Thomas; Limelight Business Partners Inc President/CEO

DATE: March 1, 2026

POSITION: SUPPORT

Chair and Members of the Committee,

Thank you for the opportunity to speak in support of Senate Bill 797. My name is Amy Thomas. I have worked in healthcare for over 10 years and own two healthcare companies: one focused on practice analysis and consulting, and the other providing medical billing services. My work centers on revenue cycle management and insurance reimbursement for physician practices across Maryland.

I am here to share real-world data from a local Maryland rheumatology practice experiencing systematic downcoding by commercial insurers.

This three-provider specialty practice submits approximately 80 evaluation and management claims per week. After Aetna expanded its Claim and Code Review Program in March 2025, approximately 70% of its E/M claims were reduced to a lower level of service. The average reduction was about $20 per claim and significantly more when high-complexity visits were reduced. That equates to over $50-60K in lost revenue annually.

Autoimmune diseases affect an estimated 7–10% of Americans, and prevalence is increasing. Rheumatologists are in critically short supply and patients wait months for appointments. As of August 25, 2025, Johns Hopkins Medicine became out of network for United Healthcare members following unsuccessful contract negotiations, effectively eliminating one of Maryland's largest rheumatology providers from that network. As a result, many of those patients are now calling private rheumatology practices seeking new care in an already constrained specialty. When a major academic center is excluded, access tightens even further. These rheumatologic visits legitimately meet higher-level evaluation and management standards because they involve high-risk biologic therapy, ongoing lab surveillance, coordination of complex care, and extensive prior authorization requirements.

To recover payment from a downcoded encounter, staff must manually review remittances, retrieve medical records, and submit individual appeals, consuming approximately 9 hours per week. Without an experienced revenue cycle team closely monitoring payments and adjudications, these reductions can easily go unnoticed, particularly when billing is outsourced, leading to lost, unrecovered revenue.

Physicians and advanced practice providers are audited extensively and required to defend every coding decision with detailed documentation and risk recoupment, civil penalties, fraud allegations, or removal from a payer's network if documentation does not support the claim. Yet insurers can use algorithms and downcode those same services without prior clinical review or transparency. Practices face audits and penalties whereas insurers can apply automated reductions without the same level of scrutiny.

That imbalance is exactly what SB 797 addresses. It restores balance. It requires transparency, same-specialty clinical review, formal appeal time, and it prevents non-transparent mass downcoding.

This bill protects access to medically necessary care across all practice types and safeguards the specialty practices that treat the most complex and vulnerable patients.

For these reasons, I respectfully request a FAVORABLE report on SB 797.