MARTIN O'MALLEY
Governor

ANTHONY G. BROWN
Lt. Governor

RALPH S. TYLER
Commissioner

BETH SAMMIS
Deputy Commissioner

MARYLAND
INSURANCE
ADMINISTRATION

525 St. Paul Place, Baltimore, Maryland 21202-2272
1-800-492-6116 TTY: 1-800-735-2258
www.mdinsurance.state.md.us

BULLETIN 08-30

Date: October 28, 2008

To: Insurers, Nonprofit Health Service Plans, Health Maintenance Organizations, Dental Plan Organizations, and Managed Care Organizations

Re: Retroactive Denial of Claims

****

The circumstances when a carrier may retroactively deny reimbursement to a health care provider are enumerated in §15-1008 of the Insurance Article. The Maryland Insurance Administration has received questions regarding when an insurer, nonprofit health service plan, health maintenance organization, dental plan organization, or any other person that provides health benefit plans subject to regulation by the State, including a managed care organization, ("carrier") may retroactively deny reimbursement to a health care provider under a health benefit plan. The questions and the corresponding answers are provided below.

1. If a carrier performs an audit, or otherwise discovers an improperly paid health care service, can the carrier retroactively deny reimbursement paid to a health care provider?

Generally, a carrier may only retroactively deny reimbursement paid to a health care provider during the six-month period after the date that the carrier paid the health care provider. However, § 15-1008 of the Insurance Article allows a carrier a longer period of time to retroactively deny reimbursement to a health care provider under *certain* circumstances. A carrier may retroactively deny reimbursement of a health care service to a health care provider as a result of an audit as long as the retroactive denial complies with §15-1008 of the Insurance Article.

Section 15-1008 does not limit the period of time to retroactively deny reimbursement to a health care provider if:

- Information submitted to the carrier was fraudulent
- Information submitted to the carrier was improperly coded (See Question 2)
- Payment was made for a duplicate claim

- In the case of a claim submitted to a managed care organization, the claim was for services during a time period the Maryland Medical Assistance Program had permanently retracted capitation payment for the recipient

A carrier may not retroactively deny reimbursement of a health care provider as a result of an extrapolation audit. In addition, a carrier may not enter into a contract with any health care provider that provides different time frames or instances where a carrier may retroactively deny reimbursement. If a carrier is denying benefits due to coordination of benefits, the carrier may retroactively deny reimbursement to a health care provider for 18 months after the date the carrier paid the provider. (See Questions 3 and 4)

Finally, a carrier may make an adjustment to reimbursement as part of an annual contracted reconciliation of a risk sharing arrangement under an administrative service provider contract (See Question 5)

2. For purposes of retroactively denying reimbursement paid to a health care provider, what does "improper coding" mean?

Under § 15-1008 of the Insurance Article, a claim may be considered improperly coded if:

- The provider used a code that did not conform to the coding guidelines used by the carrier applicable on the date the service was rendered; or
- The provider used a code that did not conform to the contractual obligations of the health care provider applicable on the date the service was rendered.

"Coding guidelines" is a defined termed and 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." The term "code" is defined in subparagraph (a)(3). The distribution of coding guidelines is governed by § 15-113 of the Insurance Article. The health care provider must have been given a written copy of the coding guidelines at the time of contract execution *and* receive written or electronic notice of any applicable changes to the coding guidelines at least 30 days prior to the applicable change.

3. When can a carrier retroactively deny payment because of coordination of benefits?

A carrier 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.

In addition, if the carrier retroactively denies reimbursement for services subject to coordination of benefits, the carrier is required to give the provider a written statement that provides the name and address of the entity *acknowledging* responsibility for payment of the denied claim.

4. In order to retroactively deny payment because of coordination of benefits, is it sufficient that the carrier provides the name and contact information of the entity that is or may be responsible for the health care service?

No. Section 15-1008(c)(2)(ii) requires a carrier, that wants to utilize retroactive reimbursement when coordinating benefits, to provide the health care provider the name and contact information of the entity that has acknowledged responsibility for the health care service. A carrier violates this section when a carrier has not obtained an acknowledgment of responsibility from the responsible entity.

5. Can a health maintenance organization make an adjustment to reimbursement as part of an annual contracted reconciliation process?

Yes; however, an adjustment to reimbursement may only be made as part of an annual contracted reconciliation of a risk sharing arrangement as part of an administrative service provider contract where a health maintenance organization's administrative service provider contract complies with the filing requirements of § 19-713.2 of the Health-General Article.

6. If a carrier retroactively denies reimbursement to a health care provider, is the carrier required to provide the notices required under Title 15, Subtitles 10A and 10D of the Insurance Article?

Yes. A carrier must provide the notices required under Title 15, Subtitle 10A of the Insurance Article if the carrier retroactively denies reimbursement to a health care provider as a result of an adverse decision. Additionally, a carrier must provide the notices required under Title 15, Subtitle 10D of the Insurance Article if the retroactive denial of reimbursement results in noncoverage of a health care service, including nonpayment of all or any part of the claim, as a result of a coverage decision.

Questions about this bulletin may be directed to the Life/Health Section at 410-468-2170.

Beth Sammis
Deputy Commissioner
Maryland Insurance Administration