Maryland
INSURANCE ADMINISTRATION

An Overview of Maryland Clean Claims Regulations

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Agenda

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- Overview of regulations
- Review of statutory authority or requirements for regulations
- Review of regulations for review
- Questions for consideration
- Questions or comments from stakeholders

Current Regulations

Clean Claims regulations in COMAR 31.10.11 were adopted in 1993 and were last amended in 2017.

The regulations include:

- The designation of specific standard forms as uniform claims forms;
- Essential data elements for a claim to be considered clean;
- Attachments that may be required for a claim to be considered clean;
- Additional information that may be requested to process a claim;
- When a claim is deemed received;
- Disclosure requirements; and
- Data reporting requirements.

Statutory Basis for Regulations

Section 15-1003 of the Insurance Article states:

(c) The Commissioner shall adopt by regulation a uniform claims form for reimbursement of health care practitioners' services.

(d) (1) The Commissioner shall adopt by regulation:

(i) a definition of a clean claim, including:

1. the essential data elements that must be completed on the uniform claims form; and

2. uniform standards for attachments to the uniform claims form;

(ii) permissible categories of disputed claims for which additional information may be requested under §§ 15-1004(c) and 15-1005(c) of this subtitle; and

(iii) standards for determining when a claim is considered received for reimbursement.

Statutory Basis for Regulations

Section 15-1004 of the Insurance Article states:

(a) For services rendered by a person entitled to reimbursement under § 15–701(a) of this title or by a hospital, as defined in § 19–301 of the Health – General Article, an insurer, nonprofit health service plan, or health maintenance organization:

(1) shall accept the uniform claims form and any attachments approved or adopted by the Commissioner under § 15–1003 of this subtitle:

(i) as a properly filed claim with all necessary documentation; and

(ii) as the sole instrument for reimbursement; and

(2) may not impose as a condition of reimbursement a requirement to:

(i) modify the uniform claims form or its content; or

(ii) submit additional claims forms.

Statutory Basis for Regulations

Section 15-1004 of the Insurance Article further states:

(d) (1) Insurers, nonprofit health service plans, and health maintenance organizations shall provide and update, as appropriate, all contracting providers and any other provider on request, with a manual or other document that sets forth the claims filing procedures, including:

(i) the address where the claims should be sent for processing;

(ii) the telephone number at which providers' questions and concerns regarding claims may be addressed;

(iii) the name, address, and telephone number of any entity to which the insurer, nonprofit health service plan, or health maintenance organization has delegated the claims payment function, if applicable; and

(iv) the address and telephone number of any separate claims processing center for specific types of applicable services.

Clean Claims and Prompt Payment

Section 15-1005 states, regarding the carrier's obligations upon receipt of a claim:

(c) Except as provided in § 15–1315 of this title and subsection (i) of this section, within 30 days after receipt of a claim for reimbursement from a person entitled to reimbursement …, an insurer, nonprofit health service plan, or health maintenance organization shall:

(1) mail or otherwise transmit payment for the claim in accordance with this section; or

(2) send a notice of receipt and status of the claim that states:

(i) that the insurer, nonprofit health service plan, or health maintenance organization refuses to reimburse all or part of the claim and the reason for the refusal;

(ii) that, in accordance with § 15–1003(d)(1)(ii) of this subtitle, the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or

(iii) that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.

Sections of Regulations for Review

COMAR 31.10.11.10A lists the documents that a third party payor may require a provider to submit with a claim in order for the claim to be considered clean. Examples:

- EOB from a primary payor if the claim is submitted to a secondary payor;
- Operative notes, if the claim includes specific modifiers; or
- Information related to an audit that demonstrated a pattern of improper coding.

COMAR 31.10.11.10B requires a third party payor to list the attachments it may require, and the circumstances in which the attachments may be required in its manual or other documents that set forth its claim filing procedures.

Sections of Regulations for Review

COMAR 31.10.11.11A lists the permissible categories of disputed claims for which a third party payor may request additional information pursuant to § 15-1005. Examples:

- A reasonable belief of incorrect billing;
- A reasonable belief that a claim for emergency services may not meet the standards for an emergency service; or
- A reasonable belief of improper coding.

COMAR 31.10.11.11D specifies impermissible categories of disputed claims for requesting additional documentation, including for preauthorized services when there is no basis to deny the service under § 15-1009 of the Insurance Article.

Sections of Regulations for Review

COMAR 31.10.11.13A refers to the disclosure requirements in § 15-1004, which were included in slide 6.

COMAR 31.10.11.13B states:

B. If a third-party payor uses auto codes to determine whether health care services provided in a hospital emergency facility are "emergency services" as defined in Health-General Article, §19-701(e), Annotated Code of Maryland, the third-party payor shall provide to all contracting health care practitioners or hospitals rendering emergency services, or to all health care practitioners or hospitals rendering emergency services that request them:

(1) Auto codes used by the third-party payor to determine emergency services; and

(2) Updated auto codes for emergency services at least 30 days before an update of the auto codes will be used, stating the date on which the updated auto codes for emergency services will be used.

Sections of Regulations for Review

COMAR 31.10.11.14A lays out requirements for the semi-annual clean claims data report:

(2) Each claims data filing required pursuant to this regulation shall include, at a minimum, data documenting:

(a) The number of claims received;

(b) The number of claims received that were clean claims pursuant to Regulations .08, .09, and .10 of this chapter;

(c) Claims for which additional information was requested by the third-party payor, or the entity to which the third-party payor has delegated claims processing, pursuant to Regulation .11 of this chapter; and

(d) As to all claims received, compliance or noncompliance with the requirements of Insurance Article, §15-1005, Annotated Code of Maryland, including timeliness of processing claims and paying interest.

Questions for Consideration

- Which provisions of regulations are outdated, and how should they be updated?
- Does the list for attachments to be considered a clean claim require updating?
- Does the list of permissible categories of disputed claims for which additional information may be requested require updating?
- Should the MIA resume issuing a Clean Claims Data Report with de-identified and aggregated data?

Next Steps

1. The MIA will put out draft revisions to the regulations. (Summer)
2. There will be a public comment period during which the MIA will hold a listening session where interested parties can bring forward thoughts and suggestions. (late Summer 2026)
3. The MIA will publish final regulations. (Fall 2026)

Public Comment Period

- Stakeholders will have two weeks after each public meeting to submit comments. Comments for this public meeting are due by **COB Wednesday, July 15th.**
- Please submit comments in **the form of a formal letter - not an email** to Matthew Weiss at matthew.weiss1@maryland.gov
- The MIA will publish comments for public viewing on our website.

Contact Information

Maryland Insurance Administration

800-492-6116 (toll-free)

410-468-2000 (local)

800-735-2258 (TTY)

insurance.maryland.gov

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