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BULLETIN NO. 25-4

DATE: **January 27, 2025**

TO: **All Health Insurers, Nonprofit Health Service Plans, and Health Maintenance Organizations (HMOs)**

RE: **Coding and Coverage of Preventive Services without Cost Sharing**

The Maryland Insurance Administration (Administration) is issuing this bulletin to remind carriers of their obligations to correctly pay claims for preventive care pursuant to Public Health Service (PHS) Act section 2713 and its implementing regulations[1]. On October 21, 2024, the Departments of Labor, Health and Human Services, and the Treasury issued FAQs about Affordable Care Act and Women's Health and Cancer Rights Act Implementation Part 68 (FAQ Part 68). The Administration encourages carriers to review FAQ Part 68. This bulletin will review the portions related to coding and how it interacts with Maryland law.

Maryland laws related to coding guidelines and clean claims

Section 15-113(d)[2] says, in relevant part:

> (1) A carrier shall provide a health care practitioner, a set of health care practitioners, or an eligible provider with a copy of:
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[1] In this Bulletin, "preventive care" and "preventive services" will refer to those services which are required to be covered by non-grandfathered health plans without cost sharing in accordance with federal and state law.
[2] All statutory references are to the Insurance Article, Maryland Annotated Code, unless otherwise noted.

(ii) a description of the coding guidelines used by the carrier that are applicable to the services billed by a health care practitioner in that specialty[.]

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(2) Except as provided in paragraph (4) of this subsection, a carrier shall provide the information required under paragraph (1) of this subsection in the manner indicated in each of the following instances:

(i) in writing before a contract execution;

(ii) in writing or electronically 30 days before a change; and

(iii) in writing or electronically on request of the health care practitioner, set of health care practitioners, or eligible provider.

Section 15-1005 says, in relevant part:

(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 under § 15–701(a) of this title or from a hospital or related institution, as those terms are defined in § 19–301 of the Health – General Article, 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.

Code of Maryland Regulations (COMAR) 31.10.11 states, in relevant part:

.02B(4) (4) "Clean claim" means a claim for reimbursement submitted to a third-party payor by a health care practitioner, pharmacy or pharmacist, hospital, or person entitled to reimbursement, that contains:

(a) In the case of a health care practitioner or person entitled to reimbursement:

(i) The data elements required by Regulation .08 of this chapter, and

(ii) Any attachments requested by the third-party payor pursuant to Regulation .10 of this chapter;

(b) In the case of a hospital or person entitled to reimbursement;

(i) The data elements required by Regulation .09 of this chapter, and

(ii) Any attachments requested by the third-party payor pursuant to Regulation .10 of this chapter[.]

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.07A. A third-party payor shall accept a clean claim which is submitted in compliance with these regulations for the processing of the third-party payor's claims.

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D. A third-party payor shall accept current coding changes by the effective date of the changes set forth by the developers of the codes.

Coding of Preventive Services

FAQ Part 68 discusses how preventive services may be coded, and encourages carriers to educate health care providers on the proper coding to ensure that preventive services are covered without cost-sharing when required by law. The Administration expects that, at a minimum, carriers will describe coding guidelines related to preventive services to health care providers as required by § 15-113(d). The Administration also encourages carriers to take additional steps to educate providers on proper coding of preventive services to ensure that patients are not improperly required to pay cost-sharing. This education should be addressed to not only the primary providers of preventive services, but also to other providers, such as laboratories, anesthesiologists, and pathologists who perform services related to the preventive services.

There are different ways that health care providers may indicate a service is preventive. The American Medical Association publishes and updates Current Procedural Terminology (CPT) codes. Certain CPT codes indicate that a service is preventive when the code is used. A CPT code that is defined as screening mammography should be covered as a preventive service; a CPT code that is defined as diagnostic mammography should be covered as diagnostic. No additional coding is necessary for coverage without cost-sharing if the CPT code definition indicates that the CPT code is inherently preventive.

Modifier 33 may also be used to indicate that a service is an evidence-based service in accordance with the guidelines provided by one of the ACA designated organizations, including an A or B recommendation from the United States Preventive Services Task Force (USPSTF) or recommendations from the Advisory Committee on Immunization Practices or Health Resources and Services Administration that are required to be covered without cost sharing. Modifier 33 may be used when a service may or may not be preventive depending on the circumstances. FAQ Part 68 gives the example of tests to estimate an individual's creatinine levels in order to assess kidney function. These may be given for other medical purposes, but may be used in accordance with the USPSTF's recommendations for PrEP. If used based on the USPSTF's recommendations, then modifier 33 notes that the test is being performed for preventive services, and the claim should be processed without cost sharing.

Finally, a claim may be coded with a diagnosis code that indicates preventive services. The International Classification of Diseases, Tenth Revision (ICD-10) includes codes with the prefix "Z" to indicate that the encounter was for preventive purposes.

Carriers are reminded that a clean claim, coded using standard code sets, must be paid in accordance with § 15-1005. Insurers may not refuse or delay payment of amounts due claimants without just cause[3]; nonprofit health service plans may not, without just cause, require a person making a claim to accept less than the amount due[4]; and HMOs may not fail to fulfill their obligations to provide health care services specified in their contracts with subscribers[5]. Carriers may only request additional information to determine whether a claim is for a preventive service in accordance with COMAR 31.10.11.11.

In order to apply cost-sharing to a claim coded as preventive, the carrier must have individualized information to show that the claim is for services that were not furnished as a recommended preventive service. For example, if the USPSTF gives an age limit for a preventive service, and the patient is outside the covered age range, then the carrier may treat the claim as subject to cost-sharing. If the carrier cannot determine, based on the claim, whether the service was preventive, the carrier can neither deny the claim nor apply cost sharing without obtaining additional information, as permitted by § 15-1005 and COMAR 31.10.11.11. When additional information is received, the claim must be processed within the time frames in § 15-1005. FAQ Part 68 says that the treating provider makes the determination of an individual's risk for purposes of service recommendations that are preventive for high risk individuals.

In addition, a carrier must evaluate a claim based on all information included in the claim. FAQ Part 68 say, "The Departments are aware that some plans and issuers use claims processing systems that determine whether all items and services that are part of the same claim are treated as preventive based on the coding of the first item or service listed on the claim. The use of this type of system may result in the imposition of cost-sharing

[3] § 4-113
[4] § 14-136
[5] § 19-729 of the Health-General Article

requirements with respect to recommended preventive items and services in a manner that is inconsistent with PHS Act section 2713 and its implementing regulations." The Administration considers it a potential violation of §§ 4-113, 15-1005, 15-10D-03, and/or 27-303 to disregard information included in a clean claim in making a determination of claim payment. Carriers should ensure that the claims processing software and systems they use will consider all of the information on a claim, and properly process claims with a modifier 33 or a diagnosis code with a Z prefix. Services and supplies in a claim should be processed without cost sharing if the provider bills with codes from standard code sets that indicate a service is preventive or integral to a preventive service.

The Administration further reminds carriers that a provider's failure to use the correct code for a preventive service may result in imposition of cost-sharing at the initial processing of the claim, but cost-sharing should be promptly reversed upon receipt of an appeal or other documentation that demonstrates the services were in fact preventive. As an example, if the surgeon and facility each submit claims for colonoscopy services as preventive, and the anesthesiologist submits a claim for a diagnostic colonoscopy, then the carrier may impose cost-sharing when it initially processes the anesthesiologist's claim, but must reverse the cost sharing upon receipt of an appeal or inquiry from the member that demonstrates the anesthesiology was provided for a preventive screening colonoscopy. The carrier will have the burden of persuasion that its appeal decision was correct in a complaint before the Commissioner pursuant to § 15-10D-02. Nonprofit health service plans may additionally bear the burden of persuasion to show that they did not violate § 14-136 in failing to reverse cost-sharing promptly.

Questions or comments may be sent to Mary Kwei, Associate Commissioner of Market Regulation and Professional Licensing, Maryland Insurance Administration, 200 Saint Paul Place, Suite 2700, Baltimore, MD 21202, or call 410-468-2113, or email to mary.kwei@maryland.gov

MARIE GRANT
Acting Commissioner

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By: _____
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