



# 130th MAINE LEGISLATURE

## FIRST REGULAR SESSION-2021

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Legislative Document

No. 1317

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S.P. 423

In Senate, March 29, 2021

### **An Act To Regulate Insurance Carrier Concurrent, Prepayment and Postpayment Review**

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Reference to the Committee on Health Coverage, Insurance and Financial Services suggested and ordered printed.

A handwritten signature in black ink, appearing to read 'D M Grant'.

DAREK M. GRANT  
Secretary of the Senate

Presented by Senator BRENNER of Cumberland.  
Cosponsored by Senators: CLAXTON of Androscoggin, KEIM of Oxford, POULIOT of  
Kennebec, SANBORN of Cumberland, Representatives: BROOKS of Lewiston, MEYER of  
Eliot, PERRY of Calais, QUINT of Hodgdon.

1 **Be it enacted by the People of the State of Maine as follows:**

2 **Sec. 1. 24-A MRSA §4303, sub-§24** is enacted to read:

3 **24. Provider audits or reviews.** Any audit or review of the documentation or records  
4 of a provider conducted by a carrier for the purposes of identifying fraud, waste or abuse,  
5 determining whether the documentation is appropriate or adequate to support a claim for  
6 covered health care services or determining whether health care services are or were  
7 medically necessary as a condition of payment must be conducted in accordance with the  
8 following requirements.

9 A. The requirements of this subsection apply whether the audit or review is performed  
10 prior to payment, concurrently with any payment or following any payment made by  
11 the carrier.

12 B. When a carrier subjects a provider to prepayment review, the carrier shall have a  
13 process to allow claims and documentation to be submitted to the carrier electronically  
14 for purposes of proving timely filing and tracking the carrier's compliance with time  
15 limits in other applicable laws.

16 C. Any audit or review must be conducted by a clinical peer licensed in this State to  
17 practice in the same profession as the provider being audited. The clinical peer who  
18 performs the audit or review is the sole contact person for the provider if the provider  
19 has any questions related to an audit or review, denial or nonpayment of a claim. Any  
20 records of an individual enrollee reviewed as part of the audit or review must be  
21 reviewed by the same clinical peer.

22 D. A carrier may not apply additional or different documentation standards beyond the  
23 minimum licensing requirements for the profession of the provider being audited or  
24 reviewed.

25 E. A carrier may not deny payment of a claim for covered health care services by a  
26 provider solely on the basis of a minor documentation error or omission, including, but  
27 not limited to, misspelling, use of an abbreviation or a correctable error. If an error or  
28 omission is the basis of a disputed claim, the carrier shall allow the provider or enrollee  
29 an opportunity to correct the error or omission and then adjudicate the claim.

30 F. Claims subject to a prepayment review must be paid or disputed within 30 days as  
31 required by section 2436 and consistent with retrospective review decisions under  
32 Bureau of Insurance rule Chapter 850, Health Plan Accountability. Any claim that is  
33 not disputed pursuant to section 2436, subsection 2 or paid within 30 days by the carrier  
34 is overdue and subject to interest in accordance with section 2436 and Bureau of  
35 Insurance rule Chapter 850, Health Plan Accountability.

36 G. For purposes of this subsection, claims subjected to prepayment review that are  
37 denied or disputed must be treated as an adverse health care treatment decision and  
38 both provider and enrollee are entitled to the same appeal procedures as a retrospective  
39 review decision under Bureau of Insurance rule Chapter 850, Health Plan  
40 Accountability.

41 H. If a carrier requires additional information as part of an audit or to adjudicate a  
42 claim for covered health care services by a provider, the carrier shall inform the  
43 provider of the precise information needed by the carrier to adjudicate the claim and

1 any general statement such as "attachment is needed" without stating which attachment  
2 is needed or "claim lacks information" without stating which information is required is  
3 not sufficient.

4 I. Any additional information submitted by a provider as required by a carrier is  
5 considered timely filed as of the date the original claim was submitted by the provider.

6 J. If a claim is denied by a carrier, the carrier shall provide accurate information on  
7 how a provider may appeal the claim on behalf of an enrollee, including the address  
8 where a written appeal should be sent. All rights to appeal denied or unpaid claims  
9 afforded to an enrollee under Bureau of Insurance rule Chapter 850, Health Plan  
10 Accountability apply to any appeal made by a provider on an enrollee's behalf,  
11 including the rights provided in section 4312.

12 K. A carrier shall provide an appeal process for any provider placed on prepayment  
13 review and remove the provider from prepayment review if or when the carrier cannot  
14 prove the provider committed fraud, waste or abuse, miscoded services or did not  
15 support the medical necessity of the provider's claims in the provider's documentation  
16 on a routine basis pursuant to an audit or review that meets the requirements of this  
17 subsection.

18 L. When an enrollee designates a provider as the enrollee's authorized representative  
19 in writing for purposes of filing appeals and complaints against a carrier, the  
20 superintendent shall consider any such provider appeals and complaints as if they were  
21 filed by the enrollee without requiring any additional action by the enrollee.

22 M. A carrier may not audit a provider or require that a provider's claims are subject to  
23 prepayment review as retribution for raising contract disputes.

24 For the purposes of this subsection, "prepayment review" means any review or audit  
25 process of a provider's claims by a carrier, or the carrier's agent, for an evaluation of  
26 reimbursement levels, veracity of documentation, accuracy of coding, adjudication for  
27 payment or utilization review of the appropriateness, quality or medical necessity of health  
28 care services prior to making payment to a provider.

29 **Sec. 2. Application.** This Act applies to any claim that has been subjected to  
30 prepayment review as described in the Maine Revised Statutes, Title 24-A, section 4303,  
31 subsection 24 that has not yet been resolved as of the effective date of this Act and to any  
32 claim submitted by a provider subject to audit or review on or after the effective date of  
33 this Act.

## 34 SUMMARY

35 This bill establishes requirements for carriers performing audits or documentation  
36 reviews of claims for payment made by providers for covered health care services. The  
37 requirements apply whether the audit or review is performed prior to payment, concurrently  
38 with any payment or following any payment made by the carrier.