LD 1317
Draft Proposed Amendment
Proposed by Sponsor, Sen. Brenner
For HCIFS Consideration at 4/14 Public Hearing

PROPOSED AMENDMENT to LD 1317,
An Act To Regulate Insurance Carrier Concurrent, Prepayment and Postpayment Review

Note: Change from original bill is in Paragraph D only and shown by strike through and in bold italics

Amend the bill by striking everything after the enacting clause and before the summary and inserting in its place the following:

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

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

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

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

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

D. A carrier may not apply additional or different documentation standards beyond the ~~minimum licensing requirements~~ ***Medicare standards*** for the profession of the provider being audited or reviewed ***or the code billed***. ***If there are no Medicare standards, a carrier may not apply additional or different documentation standards beyond the minimum professional standards required by the licensing board of the provider being audited or reviewed.***

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

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

DRAFT

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

H. If a carrier requires additional information as part of an audit or to adjudicate a claim for covered health care services by a provider, the carrier shall inform the provider of the precise information needed by the carrier to adjudicate the claim and any general statement such as "attachment is needed" without stating which attachment is needed or "claim lacks information" without stating which information is required is not sufficient.

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

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

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

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

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

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

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

SUMMARY

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

DRAFT

made by the carrier. The amendment clarifies that a carrier may not apply additional or different documentation standards beyond Medicare's standards and, if there are no Medicare standards, must apply the minimum professional standards required by the licensing board of the provider being audited or reviewed.

DRAFT