LD 1317
Draft Proposed Amendment to Replace Bill
Proposed by Sponsor, Sen. Brenner
For HCIFS Consideration at May 11 Work Session

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

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 prepayment or postpayment 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. When a carrier subjects a provider or facility to a practice or facility-wide 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.

B. Claims subject to a practice or facility-wide prepayment review must be paid or disputed within 30 days as required by section 2436. Any claim that is not disputed pursuant to section 2436 or paid within 30 days by the carrier is overdue and subject to interest in accordance with section 2436.

C. Any records of an enrollee reviewed as part of a practice or facility-wide prepayment review must be reviewed by the same reviewer to the extent possible. The reviewer who performs the practice or facility-wide prepayment review is the primary contact person for the provider related to an audit, review, denial or nonpayment of a claim. Any practice or facility-wide prepayment review that involves clinical or professional judgement must be conducted by or in consultation with a clinical peer, as defined in section 4301-A, subection 4.

D. A carrier may not apply additional or different documentation standards beyond the standards set by the professional association of the provider being audited or reviewed where those standards are publicly available or made available to the carrier. This does not prohibit carriers from establishing or applying medical policies or clinical guidelines to determine whether a service is a medically necessary covered benefit. This paragraph shall not apply to claims submitted by a hospital or facility.

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 unless the carrier affords the provider or enrollee the opportunity to resubmit the claim to correct the identified error.

F. If a carrier requires additional information as part of prepayment review of a claim for covered health care services by a provider, the carrier shall inform the provider with reasonable specificity of the information needed by the carrier to adjudicate the claim.

G. Additional information required by a carrier is considered timely if submitted within 30 days from the date the provider received notice from the carrier of the errors, omissions or additional information needed.

H. A carrier shall provide information on how a provider may appeal the denial of a claim, including the mailing or electronic address or fax number where an appeal should be sent on its website or in a provider manual.

I. A carrier shall provide an opportunity to appeal the results of an audit leading to the provider being put on a practice or facility-wide prepayment review.

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

For the purposes of this subsection, "practice or facility-wide prepayment review" means a manual review or audit process of all, or substantially all, of a provider's claims by a carrier, or the carrier's agent.

Sec. 2. Application. This Act applies to any claim that has been subjected to practice-wide 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 amendment replaces the bill and 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 made by the carrier.