

MedChi

The Maryland State Medical Society

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TO: The Honorable Dereck E. Davis, Chair
Members, House Economic Matters Committee
The Honorable Cheryl D. Glenn

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise

DATE: February 23, 2016

RE: **OPPOSE** – House Bill 710 – *Workers' Compensation – Medical Benefits – Payment of Medical Services and Treatments*

The Maryland State Medical Society (MedChi), which represents more than 7,600 Maryland physicians and their patients, opposes House Bill 710, which creates an arbitrary standard to allow employers or insurers to unfairly deny payment to health care providers who have provided care to injured workers.

House Bill 710 requires, within 45 days after the date that medical service or treatment is provided to a covered employee, a health care provider to submit to the employer or the employer's insurer a bill for and documentation summarizing the services or treatment provided. An employer or insurer is not required to pay bills submitted after 45 days unless the provider files an application for payment with the Maryland Workers' Compensation Commission (Commission) within three years from the date that service or treatment is provided and the Commission excuses the untimely submission for good cause.

With regard to the requirement to submit "documentation summarizing the services or treatment provided," this requirement simply adds another burden on providers and, more importantly, is unnecessary because the issue of documentation is fully addressed in COMAR 14.09.08. Currently, in order for a provider to obtain reimbursement, a provider must: 1) complete Form CMS-1500 in accordance with the written instructions posted on the Commission's website; and 2) submit to the employer or insurer the complete Form CMS-1500, which shall include: (a) an itemized list of each service; (b) the diagnosis relative to each service; (c) the medical records related to the service being billed; (d) the appropriate CPT/HCPCS code with CPT modifiers, if any, for each service; (e) the date of each service; (f) the specific fee charged for each service; (g) the tax ID number of the provider; (h) the professional license number of the provider; and (i) the National Provider Identifier of the provider.

Likewise, a “45 day standard” is arbitrary and not consistent with other standards. For example, in the commercial market, an insurer, nonprofit health service plan or HMO must allow a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement for the service. The timeframe for claims submission under Medicaid and Medicare is within one year.

Therefore, for the reasons stated above, MedChi strongly urges an unfavorable report.

For more information call:

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