House BILL NO. 406

INTRODUCED BY Cobb

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING THAT PROVIDERS SUBMIT CLEAN CLAIMS FOR REIMBURSEMENT TO MEDICAID WITHIN 90 DAYS OR LOSE REIMBURSEMENT; DEFINING "CLEAN CLAIM"; AND PROVIDING FOR AN EXCEPTION."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Provider billing -- restrictions.** (1) Except as provided in subsection (3), a provider shall submit a clean claim to medicaid within 90 days from the latest of:

(a) the date of the service;

(b) the date for which retroactive eligibility was determined; or

(c) the date on which the disability was determined.

(2) For purposes of this section, "clean claim" means a claim that can be processed without additional information or documentation from or action by the provider of the service.

(3) A provider shall submit a clean claim to medicaid within 90 days of submitting the claim to another third-party insurer.

(4) If a provider fails to submit a clean claim as provided in subsections (1) and (3), medicaid is not responsible for the payment of the claim.

NEW SECTION. **Section 2. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 53, chapter 6, and the provisions of Title 53, chapter 6, apply to [section 1].

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for HB0406, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:
An act requiring that Medicaid providers submit a clean claim for services within 90 days of the date of service in order to receive reimbursement.

ASSUMPTIONS:
1. The Executive Budget present law base serves as the starting point from which to calculate any fiscal impact due to this proposed legislation.
2. The average number of days for receipt of hospital claims is 110; for Medicare crossover claims (those claims where Medicaid pays the cost not reimbursed by Medicare) the average number of days for receipt is 127 days.
3. Claims resolution requests will not be allowed under HB406, since there are no provisions for waiving denial of payment for just cause in late submittal. The Department of Social and Rehabilitation Services (SRS) assumes that there will be an increase in fair hearings requests, which the department must honor, from both providers and recipients in the Medicaid program. Without additional data, the ability to determine the additional workload for fair hearings, a reasonable estimate of the increased cost cannot be made.
4. The Department of Corrections and Human Services (DCHS) anticipates that this legislation would result in a loss of revenue to the department, but is unable to determine the extent of the impact.
5. SRS would probably realize some savings from claims that were not reimbursed due to this legislation, however there is no way to estimate what that amount would be at this time.

Net Impact:
There will be a general fund cost to SRS, but the amount cannot be determined. There will be a DCHS general fund revenue loss, but the amount cannot be determined.

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:
If this legislation impacts the likelihood of providers continuing to participate in the program and for recipients to have access to services, there may be some issue with the federal government regarding the requirement for the program to assure there are no barriers to access for recipients.

TECHNICAL NOTES:
Hospitals and rehabilitation centers often have stays that exceed 90 days. There is no provision in the proposed legislation for this circumstance. This problem could be addressed by amending 1(a) to say the last date of service.

Dave Lewis 2-9-95

DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

JOHN COBB, PRIMARY SPONSOR DATE