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Maryland Managed Care Organization Penalized for Downcoding Physician Claims

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Physician complaints to a state agency about allegedly improper behavior by health maintenance organizations has lead to a significant settlement in a closely watched case in Maryland. Having been followed anxiously by managed care entities and physician groups across the country, the case is likely to generate other cases like it in the months to come.

In late May 1999, the Maryland Insurance Administration ("MIA"), the Maryland agency that regulates health maintenance organizations, found that NYLCare Health Plans of the Mid-Atlantic ("NYLCare"), which is owned by Aetna U.S. Healthcare, improperly downcoded claims (*i.e.*, lowered the level of the procedure reflected on the claim) submitted by physicians. NYLCare was found to have downcoded the claims despite documentation submitted by the physician supporting the higher level of reimbursement. The MIA's findings and penalties stemmed from an investigation into NYLCare's payment practices following a doctor's complaint that forty-five individual claims were not paid in full amount due.

The MIA and NYLCare agreed to settle the matter. The resulting consent order provides that NYLCare will pay an administrative penalty of $100,000, $50,000 of which is suspended provided that NYLCare complies with the consent order within the next twelve months. To suspend the $50,000 NYLCare must:

- cease and desist from improperly downcoding procedures and institute a compliance plan to prevent any further instances of downcoding;
- appoint an individual to oversee compliance with Maryland's insurance laws, reporting to Aetna's chief legal office, regional manager, and vice president for the southeast region. The compliance officer must submit a written report to the Maryland Insurance Commissioner every three months summarizing the officer's activities to increase compliance.

This case is significant for a number of reasons. First, it indicates that a state agency will act on physician's complaints about inappropriate reimbursement by managed care organizations. Second, the case continues the growing trend of cases that treat managed care payment issues as potential fraud and abuse issues.

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