

HOUSE BILL 412

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2000 Regular Session  
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By: **Chairman, Economic Matters Committee (Departmental - Insurance Administration, Maryland)**

Introduced and read first time: February 3, 2000

Assigned to: Economic Matters

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Committee Report: Favorable with amendments

House action: Adopted

Read second time: March 7, 2000

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CHAPTER 123

1 AN ACT concerning

2 **Health Insurance - Private Review Agents**

3 FOR the purpose of altering certain provisions of law relating to administrative and  
4 enforcement oversight of private review agents; requiring certain entities to  
5 conduct utilization review in a certain manner; requiring private review agents  
6 to file a copy of their internal grievance process with the Maryland Insurance  
7 Commissioner; altering the time frame concerning when a representative of a  
8 private review agent must be accessible to patients and health care providers;  
9 requiring private review agents to submit certain information to the Insurance  
10 Commissioner; establishing certain requirements for when a private review  
11 agent must make certain determinations; requiring private review agents to  
12 notify certain health care providers within a certain time frame after a certain  
13 determination has been made; altering certain provisions of law related to  
14 utilization review concerning the types of health care providers that may make  
15 certain determinations; prohibiting certain persons from acting as or using a  
16 private review agent under certain circumstances; requiring certain private  
17 review agents to relinquish the private review agent's certificate of registration  
18 under certain circumstances; altering certain provisions of law relating to  
19 violations of this Act; altering certain provisions of law requiring the  
20 Commissioner to provide a hearing under certain circumstances; altering  
21 certain penalties; establishing certain penalties; altering provisions of law  
22 relating to reporting requirements; defining certain terms; altering certain  
23 terms; making certain stylistic and technical changes; providing for a delayed  
24 effective date; and generally relating to administrative and enforcement  
25 oversight of private review agents.

26 BY repealing and reenacting, with amendments,

1 Article - Insurance  
 2 Section 15-1001, 15-10B-01, 15-10B-03(d), 15-10B-05, and 15-10B-06  
 3 Annotated Code of Maryland  
 4 (1997 Volume and 1999 Supplement)

5 BY repealing and reenacting, without amendments,  
 6 Article - Insurance  
 7 Section 15-10B-02, 15-10B-04, 15-10B-09, and 15-10B-10  
 8 Annotated Code of Maryland  
 9 (1997 Volume and 1999 Supplement)

10 BY repealing  
 11 Article - Insurance  
 12 Section 15-10B-07, 15-10B-08, 15-10B-11, 15-10B-12, 15-10B-13,  
 13 15-10B-14, 15-10B-15, 15-10B-16, 15-10B-17, and 15-10B-18  
 14 Annotated Code of Maryland  
 15 (1997 Volume and 1999 Supplement)

16 BY adding to  
 17 Article - Insurance  
 18 Section 15-10B-07, 15-10B-08, 15-10B-09.1, 15-10B-11, 15-10B-12,  
 19 15-10B-13, 15-10B-14, 15-10B-15, 15-10B-16, 15-10B-17, and  
 20 15-10B-18  
 21 Annotated Code of Maryland  
 22 (1997 Volume and 1999 Supplement)

23 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF  
 24 MARYLAND, That the Laws of Maryland read as follows:

25 **Article - Insurance**

26 15-1001.

27 (a) This section applies to [insurers and nonprofit health service plans]  
 28 ENTITIES that propose to issue or deliver individual, group, or blanket health  
 29 insurance policies or contracts in the State or to administer health benefit programs  
 30 that provide for the coverage of [hospital benefits] HEALTH CARE SERVICES and the  
 31 utilization review of those [benefits] SERVICES, INCLUDING:

32 (1) AN AUTHORIZED INSURER THAT PROVIDES HEALTH INSURANCE IN  
 33 THE STATE;

34 (2) A NONPROFIT HEALTH SERVICE PLAN;

35 (3) A HEALTH MAINTENANCE ORGANIZATION;

36 (4) A DENTAL PLAN ORGANIZATION; OR

1 (5) EXCEPT FOR A MANAGED CARE ORGANIZATION AS DEFINED IN TITLE  
2 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE, ANY OTHER PERSON THAT  
3 PROVIDES HEALTH BENEFIT PLANS SUBJECT TO REGULATION BY THE STATE.

4 (b) (1) [Each] SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, EACH  
5 entity subject to this section shall:

6 [(1)] (I) have a certificate issued under Subtitle 10B of this title; OR

7 [(2)] (II) contract with a private review agent that has a certificate  
8 issued under Subtitle 10B of this title[; or].

9 [(3)] (2) FOR HOSPITAL SERVICES, EACH ENTITY SUBJECT TO THIS  
10 SECTION MAY contract with or delegate utilization review to a hospital utilization  
11 review program approved under § 19-319(d) of the Health - General Article.

12 (c) Notwithstanding any other provision of this article, if the medical  
13 necessity of providing a covered benefit is disputed, an entity subject to this section  
14 that does not meet the requirements of subsection (b) of this section shall pay any  
15 person entitled to reimbursement under the policy[, contract, or certificate] OR  
16 CONTRACT in accordance with the determination of medical necessity by [the  
17 hospital utilization review program approved under § 19-319(d) of the Health -  
18 General Article]:

19 (1) THE TREATING PROVIDER; OR

20 (2) WHEN HOSPITAL SERVICES ARE PROVIDED, THE HOSPITAL  
21 UTILIZATION REVIEW PROGRAM APPROVED UNDER § 19-319(D) OF THE HEALTH -  
22 GENERAL ARTICLE.

23 (D) AN ENTITY SUBJECT TO THIS SECTION MAY NOT:

24 (1) ACT AS A PRIVATE REVIEW AGENT WITHOUT HOLDING A  
25 CERTIFICATE ISSUED UNDER SUBTITLE 10B OF THIS TITLE; OR

26 (2) USE A PRIVATE REVIEW AGENT THAT DOES NOT HOLD A  
27 CERTIFICATE ISSUED UNDER SUBTITLE 10B OF THIS TITLE.

28 (E) AN ENTITY THAT VIOLATES ANY PROVISION OF THIS SECTION IS SUBJECT  
29 TO THE PENALTIES PROVIDED UNDER § 15-10B-12 OF THIS TITLE.

30 15-10B-01.

31 (a) In this subtitle the following words have the meanings indicated.

32 (b) (1) "Adverse decision" means a utilization review determination made by  
33 a private review agent that a proposed or delivered health care service:

34 (i) is or was not medically necessary, appropriate, or efficient; and

35 (ii) may result in noncoverage of the health care service.

1 (2) [There is no adverse decision if the private review agent and the  
2 health care provider on behalf of the patient reach an agreement on the proposed or  
3 delivered health care services.] "ADVERSE DECISION" DOES NOT INCLUDE A  
4 DECISION CONCERNING A SUBSCRIBER'S STATUS AS A MEMBER.

5 (c) "Certificate" means a certificate of registration granted by the  
6 Commissioner to a private review agent.

7 (d) (1) "Employee assistance program" means a health care service plan  
8 that, in accordance with a contract with an employer or labor union:

9 (i) consults with employees or members of an employee's family or  
10 both to:

11 1. identify the employee's or the employee's family member's  
12 mental health, alcohol, or substance abuse problems; and

13 2. refer the employee or the employee's family member to  
14 {health care providers} ~~A PHYSICIAN OR PROVIDER LICENSED OR AUTHORIZED TO~~  
15 ~~PROVIDE HEALTH CARE SERVICES~~ or other community resources for counseling,  
16 therapy, or treatment; and

17 (ii) performs utilization review for the purpose of making claims or  
18 payment decisions on behalf of the employer's or labor union's health insurance or  
19 health benefit plan.

20 (2) "Employee assistance program" does not include a health care service  
21 plan operated by a hospital solely for employees, or members of an employee's family,  
22 of that hospital.

23 (E) (1) "GRIEVANCE" MEANS A PROTEST FILED BY A PATIENT OR A HEALTH  
24 CARE PROVIDER ON BEHALF OF A PATIENT WITH A PRIVATE REVIEW AGENT  
25 THROUGH THE PRIVATE REVIEW AGENT'S INTERNAL GRIEVANCE PROCESS  
26 REGARDING AN ADVERSE DECISION CONCERNING A PATIENT.

27 (2) "GRIEVANCE" DOES NOT INCLUDE A VERBAL REQUEST FOR  
28 RECONSIDERATION OF A UTILIZATION REVIEW DETERMINATION.

29 (F) "GRIEVANCE DECISION" MEANS A FINAL DETERMINATION BY A PRIVATE  
30 REVIEW AGENT THAT ARISES FROM A GRIEVANCE FILED WITH THE PRIVATE REVIEW  
31 AGENT UNDER ITS INTERNAL GRIEVANCE PROCESS REGARDING AN ADVERSE  
32 DECISION CONCERNING A PATIENT.

33 [(e)] (G) "Health care facility" means:

34 (1) a hospital as defined in § 19-301 of the Health - General Article;

35 (2) a related institution as defined in § 19-301 of the Health - General  
36 Article;

1 (3) an ambulatory surgical facility or center which is any entity or part  
 2 thereof that operates primarily for the purpose of providing surgical services to  
 3 patients not requiring hospitalization and seeks reimbursement from third party  
 4 payors as an ambulatory surgical facility or center;

5 (4) a facility that is organized primarily to help in the rehabilitation of  
 6 disabled individuals;

7 (5) a home health agency as defined in § 19-401 of the Health - General  
 8 Article;

9 (6) a hospice as defined in § 19-901 of the Health - General Article;

10 (7) a facility that provides radiological or other diagnostic imagery  
 11 services;

12 (8) a medical laboratory as defined in § 17-201 of the Health - General  
 13 Article; or

14 (9) an alcohol abuse and drug abuse treatment program as defined in §  
 15 8-403 of the Health - General Article.

16 (H) "HEALTH CARE PROVIDER" MEANS:

17 (1) AN INDIVIDUAL WHO:

18 (I) IS LICENSED OR OTHERWISE AUTHORIZED ~~IN THE STATE TO~~  
 19 PROVIDE HEALTH CARE SERVICES IN THE ORDINARY COURSE OF BUSINESS OR  
 20 PRACTICE OF A PROFESSION; AND

21 (II) IS A TREATING PROVIDER OF A ~~MEMBER~~ PATIENT; OR

22 (2) A HOSPITAL, AS DEFINED IN § 19-301 OF THE HEALTH - GENERAL  
 23 ARTICLE.

24 [(f)] (I) "Health care service" means [any] A health or medical CARE  
 25 procedure or service rendered by a health care provider LICENSED OR AUTHORIZED  
 26 TO PROVIDE HEALTH CARE SERVICES that:

27 (1) provides testing, diagnosis, or treatment of a human disease or  
 28 dysfunction; ~~or~~

29 (2) dispenses drugs, medical devices, medical appliances, or medical  
 30 goods for the treatment of a human disease or dysfunction; OR

31 (3) PROVIDES ANY OTHER CARE, SERVICE, OR TREATMENT OF DISEASE  
 32 OR INJURY, THE CORRECTION OF DEFECTS, OR THE MAINTENANCE OF THE  
 33 PHYSICAL AND MENTAL WELL-BEING OF HUMAN BEINGS.

1 (J) "HEALTH CARE SERVICE REVIEWER" MEANS AN INDIVIDUAL WHO IS  
2 LICENSED OR OTHERWISE AUTHORIZED TO PROVIDE HEALTH CARE SERVICES IN  
3 THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION.

4 [(g)] (K) "Private review agent" means:

5 (1) a nonhospital-affiliated person or entity performing utilization  
6 review that is either affiliated with, under contract with, or acting on behalf of:

7 (i) a Maryland business entity; or

8 (ii) a third party that [provides] PAYS FOR, PROVIDES, or  
9 administers [hospital benefits] HEALTH CARE SERVICES to citizens of this State[,  
10 including:

11 1. a health maintenance organization issued a certificate of  
12 authority in accordance with Title 19, Subtitle 7 of the Health - General Article; or

13 2. a health insurer, nonprofit health service plan, health  
14 insurance service organization, or preferred provider organization authorized to offer  
15 health insurance policies or contracts in this State in accordance with this article]; or

16 (2) any person or entity including a hospital-affiliated person  
17 performing utilization review for the purpose of making claims or payment decisions  
18 FOR HEALTH CARE SERVICES on behalf of the employer's or labor union's health  
19 insurance plan under an employee assistance program for employees other than the  
20 employees EMPLOYED BY:

21 (i) [employed by] the hospital; or

22 (ii) [employed by] a business wholly owned by the hospital.

23 [(h)] (L) "Significant beneficial interest" means the ownership of any financial  
24 interest that is greater than the lesser of:

25 (1) 5 percent of the whole; or

26 (2) \$5,000.

27 [(i)] (M) "Utilization review" means a system for reviewing the appropriate  
28 and efficient allocation of health care RESOURCES AND services given or proposed to  
29 be given to a patient or group of patients.

30 [(j)] (N) "Utilization review plan" means a description of the standards  
31 governing utilization review activities performed by a private review agent.

32 15-10B-02.

33 The purpose of this subtitle is to:

34 (1) promote the delivery of quality health care in a cost effective manner;

1 (2) foster greater coordination between payors and providers conducting  
2 utilization review activities;

3 (3) protect patients, business, and providers by ensuring that private  
4 review agents are qualified to perform utilization review activities and to make  
5 informed decisions on the appropriateness of medical care; and

6 (4) ensure that private review agents maintain the confidentiality of  
7 medical records in accordance with applicable State and federal laws.

8 15-10B-03.

9 (d) (1) The Commissioner, after consultation with payors, including the  
10 Health Insurance Association of America, the League of Life and Health Insurers of  
11 Maryland, and the Maryland Association of Health [Maintenance Organizations]  
12 PLANS, and providers of health care, including the [Maryland Hospital Association]  
13 MHA: THE ASSOCIATION OF MARYLAND HOSPITALS AND HEALTH SYSTEMS,  
14 CAREFIRST BLUECROSS BLUESHIELD, the Medical and Chirurgical Faculty of  
15 Maryland, and licensed or certified providers of treatment for a mental illness,  
16 emotional disorder, or a drug abuse or alcohol abuse disorder, shall adopt regulations  
17 to implement the provisions of this subtitle.

18 (2) (i) Subject to the provisions of subparagraph (iii) of this paragraph,  
19 the regulations adopted by the Commissioner shall include a uniform treatment plan  
20 form for utilization review of services for the treatment of a mental illness, emotional  
21 disorder, or a drug abuse or alcohol abuse disorder.

22 (ii) The uniform treatment plan form adopted by the  
23 Commissioner:

24 1. shall adequately protect the confidentiality of the patient;  
25 and

26 2. may only request the patient's membership number, policy  
27 number, or other similar unique patient identifier and first name for patient  
28 identification.

29 (iii) The Commissioner may waive the requirements of regulations  
30 adopted under subparagraph (i) of this paragraph for the use of a uniform treatment  
31 plan form for any entity that would be using the form solely for internal purposes.

32 15-10B-04.

33 (a) An applicant for a certificate shall:

34 (1) submit an application to the Commissioner; and

35 (2) pay to the Commissioner the application fee established by the  
36 Commissioner through regulation.

1 (b) The application shall:

2 (1) be on a form and accompanied by any supporting documentation that  
3 the Commissioner requires; and

4 (2) be signed and verified by the applicant.

5 (c) The ~~application~~ fees required under subsection (a)(2) of this section or §  
6 15-10B-10(b)(2) of this subtitle shall be sufficient to pay for the administrative costs  
7 of the certificate program and any other costs associated with carrying out the  
8 provisions of this subtitle.

9 15-10B-05.

10 (a) In conjunction with the application, the private review agent shall submit  
11 information that the Commissioner requires including:

12 (1) a utilization review plan that includes:

13 (i) the specific criteria and standards to be used in conducting  
14 utilization review of proposed or delivered HEALTH CARE services;

15 (ii) those circumstances, if any, under which utilization review may  
16 be delegated to a hospital utilization review program; and

17 (iii) [the] IF APPLICABLE, ANY provisions by which patients,  
18 physicians, or hospitals may seek reconsideration [or appeal of adverse decisions by  
19 the private review agent];

20 (2) the type and qualifications of the personnel either employed or under  
21 contract to perform the utilization review;

22 (3) A COPY OF THE PRIVATE REVIEW AGENT'S INTERNAL GRIEVANCE  
23 PROCESS IF A CARRIER DELEGATES ITS INTERNAL GRIEVANCE PROCESS TO THE  
24 PRIVATE REVIEW AGENT IN ACCORDANCE WITH § 15-10A-02(L) OF THIS TITLE;

25 [(3)] (4) the procedures and policies to ensure that a representative of  
26 the private review agent is reasonably accessible to patients and HEALTH CARE  
27 providers [5] 7 days a week [during normal business], 24 hours A DAY in this State;

28 [(4)] (5) the policies and procedures to ensure that all applicable State  
29 and federal laws to protect the confidentiality of individual medical records are  
30 followed;

31 [(5)] (6) a copy of the materials designed to inform applicable patients  
32 and providers of the requirements of the utilization review plan;

33 [(6)] (7) a list of the third party payors for which the private review  
34 agent is performing utilization review in this State;

1            [(7)]    (8)    the policies and procedures to ensure that the private review  
2 agent has a formal program for the orientation and training of the personnel either  
3 employed or under contract to perform the utilization review;

4            [(8)]    (9)    a list of the ~~health care providers AS DEFINED IN § 15-10B-07 OF~~  
5 ~~THIS SUBTITLE~~ PERSONS involved in establishing the specific criteria and standards  
6 to be used in conducting utilization review; and

7            [(9)]    (10)   certification by the private review agent that the criteria and  
8 standards to be used in conducting utilization review are:

9                            (i)    objective;

10                           (ii)   clinically valid;

11                           (iii)   compatible with established principles of health care; and

12                           (iv)   flexible enough to allow deviations from norms when justified  
13 on a case by case basis.

14        (b)    (1)    At least ~~{10} 30~~ days before a private review agent requires any  
15 revisions or modifications to [the] EXISTING specific criteria and standards to be  
16 used in conducting utilization review of proposed or delivered services, the private  
17 review agent shall submit those revisions or modifications to the Commissioner.

18            (2)    AT LEAST 10 DAYS BEFORE A PRIVATE REVIEW AGENT REQUIRES  
19 SPECIFIC CRITERIA AND STANDARDS TO BE USED IN CONDUCTING UTILIZATION  
20 REVIEW OF PROPOSED OR DELIVERED SERVICES IN WHICH THERE ARE NO EXISTING  
21 CRITERIA OR STANDARDS, THE PRIVATE REVIEW AGENT SHALL SUBMIT THE  
22 CRITERIA AND STANDARDS TO THE COMMISSIONER.

23        (c)    On the written request of any person or health care facility, the private  
24 review agent shall provide 1 copy of the specific criteria and standards to be used in  
25 conducting utilization review of proposed or delivered services and any subsequent  
26 ~~revisions or modifications~~ REVISIONS, MODIFICATIONS, OR ADDITIONS to the specific  
27 criteria and standards to be used in conducting utilization review of proposed or  
28 delivered services to the person or health care facility making the request.

29        (d)    The private review agent may charge a reasonable fee for a copy of the  
30 specific criteria and standards or any subsequent ~~revisions or modifications~~  
31 REVISIONS, MODIFICATIONS, OR ADDITIONS to the specific criteria to any person or  
32 health care facility requesting a copy under subsection (c) of this section.

33        (e)    [It shall constitute a violation of this subtitle if the Commissioner, in  
34 consultation with an independent review organization, medical expert, the  
35 Department of Health and Mental Hygiene, or other appropriate entity, determines  
36 that the criteria and standards used in conducting utilization review are not:

37                           (1)    objective;

- 1 (2) clinically valid;
- 2 (3) compatible with established principles of health care; or
- 3 (4) flexible enough to allow deviations from norms when justified on a  
4 case by case basis.]

5 A PRIVATE REVIEW AGENT SHALL ADVISE THE COMMISSIONER, IN WRITING, OF  
6 A CHANGE IN:

7 (1) ~~CORPORATE OWNERSHIP, MEDICAL DIRECTOR, OR CHIEF EXECUTIVE~~  
8 ~~OFFICER AT LEAST 60 DAYS BEFORE~~ WITHIN 30 DAYS OF THE DATE OF THE CHANGE;

9 (2) THE NAME, ADDRESS, OR TELEPHONE NUMBER OF THE PRIVATE  
10 REVIEW AGENT WITHIN 30 DAYS OF THE DATE OF THE CHANGE; OR

11 (3) THE PRIVATE REVIEW AGENT'S SCOPE OF RESPONSIBILITY UNDER A  
12 CONTRACT.

13 15-10B-06.

14 [(a) In this section, "utilization review" means a system for reviewing the  
15 appropriate and efficient allocation of health care resources and services given or  
16 proposed to be given to a patient or group of patients by a health care provider,  
17 including a hospital or an intermediate care facility described under § 8-403(e) of the  
18 Health - General Article.

19 (b) In addition to any other requirements under this subtitle, a private review  
20 agent performing utilization review of services related to the treatment of alcoholism,  
21 drug abuse, or mental illness shall meet the requirements of this section.

22 (c) All adverse decisions shall be made by a physician, or a panel of other  
23 appropriate health care providers with at least 1 physician, selected by the private  
24 review agent who is:

25 (1) (i) board certified or eligible in the same specialty as the treatment  
26 under review; or

27 (ii) actively practicing, or has demonstrated expertise, in the  
28 alcohol, drug abuse, or mental health service or treatment under review; and

29 (2) not compensated by the private review agent in a manner that  
30 provides a financial incentive directly or indirectly to deny or reduce coverage.

31 (d) If a course of treatment has been preauthorized or approved for a patient,  
32 a private review agent may not revise or modify the specific criteria or standards used  
33 for the utilization review to make an adverse decision regarding the services delivered  
34 to that patient.

35 (e) (1) In the event a patient or health care provider, including a physician,  
36 intermediate care facility described under § 8-403(e) of the Health - General Article,

1 or hospital seeks reconsideration or appeal of an adverse decision by a private review  
2 agent, the final determination of the appeal of the adverse decision shall be made  
3 based on the professional judgment of a physician, or a panel of other appropriate  
4 health care providers with at least 1 physician, selected by the private review agent  
5 who is:

6 (i) 1. board certified or eligible in the same specialty as the  
7 treatment under review; or

8 2. actively practicing or has demonstrated expertise in the  
9 alcohol, drug abuse, or mental health service or treatment under review; and

10 (ii) not compensated by the private review agent in a manner that  
11 provides a financial incentive directly or indirectly to deny or reduce coverage.

12 (2) In the event a patient or health care provider, including a physician,  
13 intermediate care facility described under § 8-403(e) of the Health - General Article,  
14 or hospital seeks reconsideration or appeal of an adverse decision by a private review  
15 agent, the final determination of the appeal of the adverse decision shall be stated in  
16 writing and shall reference the specific criteria and standards, including interpretive  
17 guidelines, upon which the denial or reduction in coverage is based.

18 (f) A private review agent may not charge a fee to a patient or health care  
19 provider for an appeal of an adverse decision.]

20 (A) (1) A PRIVATE REVIEW AGENT SHALL:

21 (I) MAKE ALL INITIAL DETERMINATIONS ON WHETHER TO  
22 AUTHORIZE OR CERTIFY A NONEMERGENCY COURSE OF TREATMENT FOR A PATIENT  
23 WITHIN 2 WORKING DAYS AFTER RECEIPT OF THE INFORMATION NECESSARY TO  
24 MAKE THE DETERMINATION;

25 (II) MAKE ALL DETERMINATIONS ON WHETHER TO AUTHORIZE OR  
26 CERTIFY AN EXTENDED STAY IN A HEALTH CARE FACILITY OR ADDITIONAL HEALTH  
27 CARE SERVICES WITHIN 1 WORKING DAY AFTER RECEIPT OF THE INFORMATION  
28 NECESSARY TO MAKE THE DETERMINATION; AND

29 (III) PROMPTLY NOTIFY THE HEALTH CARE PROVIDER OF THE  
30 DETERMINATION.

31 (2) IF WITHIN 3 CALENDAR DAYS AFTER RECEIPT OF THE INITIAL  
32 REQUEST FOR HEALTH CARE SERVICES THE PRIVATE REVIEW AGENT DOES NOT  
33 HAVE SUFFICIENT INFORMATION TO MAKE A DETERMINATION, THE PRIVATE  
34 REVIEW AGENT SHALL INFORM THE HEALTH CARE PROVIDER THAT ADDITIONAL  
35 INFORMATION MUST BE PROVIDED.

36 (B) IF AN INITIAL DETERMINATION IS MADE BY A PRIVATE REVIEW AGENT  
37 NOT TO AUTHORIZE OR CERTIFY A HEALTH CARE SERVICE AND THE HEALTH CARE  
38 PROVIDER BELIEVES THE DETERMINATION WARRANTS AN IMMEDIATE  
39 RECONSIDERATION, A PRIVATE REVIEW AGENT ~~SHALL~~ MAY PROVIDE THE HEALTH

1 CARE PROVIDER THE OPPORTUNITY TO SPEAK WITH THE PHYSICIAN THAT  
2 RENDERED THE DETERMINATION, BY TELEPHONE ON AN EXPEDITED BASIS, WITHIN  
3 A PERIOD OF TIME NOT TO EXCEED 24 HOURS OF THE HEALTH CARE PROVIDER  
4 SEEKING THE RECONSIDERATION.

5 (C) FOR EMERGENCY INPATIENT ADMISSIONS, A PRIVATE REVIEW AGENT  
6 MAY NOT RENDER AN ADVERSE DECISION SOLELY BECAUSE THE HOSPITAL DID NOT  
7 NOTIFY THE PRIVATE REVIEW AGENT OF THE EMERGENCY ADMISSION WITHIN 24  
8 HOURS OR OTHER PRESCRIBED PERIOD OF TIME AFTER THAT ADMISSION IF THE  
9 PATIENT'S MEDICAL CONDITION PREVENTED THE HOSPITAL FROM DETERMINING:

10 (1) THE PATIENT'S INSURANCE STATUS; AND

11 (2) IF APPLICABLE, THE PRIVATE REVIEW AGENT'S EMERGENCY  
12 ADMISSION NOTIFICATION REQUIREMENTS.

13 (D) A PRIVATE REVIEW AGENT MAY NOT RENDER AN ADVERSE DECISION AS  
14 TO AN ADMISSION OF A PATIENT DURING THE FIRST 24 HOURS AFTER ADMISSION  
15 WHEN:

16 (1) THE ADMISSION IS BASED ON A DETERMINATION THAT THE PATIENT  
17 IS IN IMMINENT DANGER TO SELF OR OTHERS;

18 (2) THE DETERMINATION HAS BEEN MADE BY THE PATIENT'S  
19 PHYSICIAN OR PSYCHOLOGIST IN CONJUNCTION WITH A MEMBER OF THE MEDICAL  
20 STAFF OF THE FACILITY WHO HAS PRIVILEGES TO MAKE THE ADMISSION; AND

21 (3) THE HOSPITAL IMMEDIATELY NOTIFIES THE PRIVATE REVIEW  
22 AGENT OF:

23 (I) THE ADMISSION OF THE PATIENT; AND

24 (II) THE REASONS FOR THE ADMISSION.

25 [(g)] (E) (1) A private review agent that requires a health care provider to  
26 submit a treatment plan in order for the private review agent to conduct utilization  
27 review of proposed or delivered services for the treatment of a mental illness,  
28 emotional disorder, or a drug abuse or alcohol abuse disorder:

29 (i) shall accept the uniform treatment plan form adopted by the  
30 Commissioner under § 15-10B-03(d) of this subtitle as a properly submitted  
31 treatment plan form; and

32 (ii) may not impose any requirement to:

33 1. modify the uniform treatment plan form or its content; or

34 2. submit additional treatment plan forms.

35 (2) A uniform treatment plan form submitted under the provisions of  
36 this subsection:

1 (i) shall be properly completed by the health care provider; and

2 (ii) may be submitted by electronic transfer.

3 [15-10B-07.

4 (a) Except as specifically provided in § 15-10B-06 of this subtitle:

5 (1) except as provided in paragraph (2) of this subsection, all adverse  
6 decisions shall be made by a physician or a panel of other appropriate health care  
7 providers with at least 1 physician on the panel.

8 (2) when the health care service under review is a dental service, the  
9 adverse decision shall be made by a licensed dentist or a panel of other appropriate  
10 health care providers with at least 1 licensed dentist on the panel.

11 (3) in the event a patient or health care provider, including a physician,  
12 intermediate care facility described in § 8-403(e) of the Health - General Article, or  
13 hospital seeks reconsideration or appeal of an adverse decision by a private review  
14 agent, the final determination of the appeal of the adverse decision shall be made  
15 based on the professional judgment of:

16 (i) a physician or a panel of other appropriate health care  
17 providers with at least 1 physician on the panel who is board certified or eligible in  
18 the same specialty as the treatment under review; or

19 (ii) when the adverse decision involves a dental service, a licensed  
20 dentist, or a panel of appropriate health care providers with at least 1 dentist on the  
21 panel who is a licensed dentist, who shall consult with a dentist who is board certified  
22 or eligible in the same specialty as the service under review.

23 (4) in the event a patient or health care provider, including a physician,  
24 intermediate care facility described in § 8-403(e) of the Health - General Article, or  
25 hospital seeks reconsideration or appeal of an adverse decision by a private review  
26 agent, the final determination of the appeal of the adverse decision shall:

27 (i) be stated in writing and provide an explanation of the reason for  
28 the adverse decision; and

29 (ii) reference the specific criteria and standards, including  
30 interpretive guidelines, upon which the adverse decision is based.

31 (b) A private review agent may not charge a fee to a patient or health care  
32 provider for an appeal of an adverse decision.

33 (c) (1) Except as provided in paragraph (2) of this subsection, if a course of  
34 treatment has been preauthorized or approved for a patient, a private review agent  
35 may not retrospectively render an adverse decision regarding the preauthorized or  
36 approved services delivered to that patient.

1 (2) A private review agent may retrospectively render an adverse  
2 decision regarding preauthorized or approved services delivered to a patient if:

3 (i) the information submitted to the private review agent  
4 regarding the services to be delivered to the patient was fraudulent or intentionally  
5 misrepresentative or critical information requested by the private review agent  
6 regarding services to be delivered to the patient was omitted such that the private  
7 review agent's determination would have been different had it known the critical  
8 information; or

9 (ii) the planned course of treatment for the patient that was  
10 approved by the private review agent was not substantially followed by the provider.]  
11 15-10B-07.

12 (A) (1) EXCEPT AS PROVIDED ~~FOR~~ IN PARAGRAPHS (2) AND (3) OF THIS  
13 SUBSECTION, ALL ADVERSE DECISIONS SHALL BE MADE BY A PHYSICIAN, OR A  
14 PANEL OF OTHER APPROPRIATE HEALTH CARE SERVICE REVIEWERS WITH AT LEAST  
15 ONE PHYSICIAN ON THE PANEL WHO IS BOARD CERTIFIED OR ELIGIBLE IN THE SAME  
16 SPECIALTY AS THE TREATMENT UNDER REVIEW.

17 (2) WHEN THE HEALTH CARE SERVICE UNDER REVIEW IS A MENTAL  
18 HEALTH OR SUBSTANCE ABUSE SERVICE, THE ADVERSE DECISION SHALL BE MADE  
19 BY A PHYSICIAN, OR A PANEL OF OTHER APPROPRIATE HEALTH CARE SERVICE  
20 REVIEWERS WITH AT LEAST ONE PHYSICIAN, SELECTED BY THE PRIVATE REVIEW  
21 AGENT WHO:

22 (I) IS BOARD CERTIFIED OR ELIGIBLE IN THE SAME SPECIALTY AS  
23 THE TREATMENT UNDER REVIEW; OR

24 (II) IS ACTIVELY PRACTICING OR HAS DEMONSTRATED EXPERTISE  
25 IN THE SUBSTANCE ABUSE OR MENTAL HEALTH SERVICE OR TREATMENT UNDER  
26 REVIEW.

27 (3) WHEN THE HEALTH CARE SERVICE UNDER REVIEW IS A DENTAL  
28 SERVICE, THE ADVERSE DECISION SHALL BE MADE BY A LICENSED DENTIST, OR A  
29 PANEL OF OTHER APPROPRIATE HEALTH CARE SERVICE REVIEWERS WITH AT LEAST  
30 ONE LICENSED DENTIST ON THE PANEL.

31 (B) ALL ADVERSE DECISIONS SHALL BE MADE BY A PHYSICIAN OR A PANEL OF  
32 OTHER APPROPRIATE HEALTH CARE SERVICE REVIEWERS WHO ARE NOT  
33 COMPENSATED BY THE PRIVATE REVIEW AGENT IN A MANNER THAT VIOLATES §  
34 19-705.1 OF THE HEALTH - GENERAL ARTICLE OR THAT DETERS THE DELIVERY OF  
35 MEDICALLY APPROPRIATE CARE.

36 (C) EXCEPT AS PROVIDED IN SUBSECTION (D) OF THIS SECTION, IF A COURSE  
37 OF TREATMENT HAS BEEN PREAUTHORIZED OR APPROVED FOR A PATIENT, A  
38 PRIVATE REVIEW AGENT MAY NOT RETROSPECTIVELY RENDER AN ADVERSE  
39 DECISION REGARDING THE PREAUTHORIZED OR APPROVED SERVICES DELIVERED  
40 TO THAT PATIENT.

1 (D) A PRIVATE REVIEW AGENT MAY RETROSPECTIVELY RENDER AN ADVERSE  
2 DECISION REGARDING PREAUTHORIZED OR APPROVED SERVICES DELIVERED TO A  
3 PATIENT IF:

4 (1) THE INFORMATION SUBMITTED TO THE PRIVATE REVIEW AGENT  
5 REGARDING THE SERVICES TO BE DELIVERED TO THE PATIENT WAS FRAUDULENT  
6 OR INTENTIONALLY MISREPRESENTATIVE;

7 (2) CRITICAL INFORMATION REQUESTED BY THE PRIVATE REVIEW  
8 AGENT REGARDING SERVICES TO BE DELIVERED TO THE PATIENT WAS OMITTED  
9 SUCH THAT THE PRIVATE REVIEW AGENT'S DETERMINATION WOULD HAVE BEEN  
10 DIFFERENT HAD THE AGENT KNOWN THE CRITICAL INFORMATION; OR

11 (3) THE PLANNED COURSE OF TREATMENT FOR THE PATIENT THAT WAS  
12 APPROVED BY THE PRIVATE REVIEW AGENT WAS NOT SUBSTANTIALLY FOLLOWED  
13 BY THE PROVIDER.

14 (E) IF A COURSE OF TREATMENT HAS BEEN PREAUTHORIZED OR APPROVED  
15 FOR A PATIENT, A PRIVATE REVIEW AGENT MAY NOT REVISE OR MODIFY THE  
16 SPECIFIC CRITERIA OR STANDARDS USED FOR THE UTILIZATION REVIEW TO MAKE  
17 AN ADVERSE DECISION REGARDING THE SERVICES DELIVERED TO THAT PATIENT.

18 [15-10B-08.

19 (a) Except as provided in subsection (b) of this section, a private review agent  
20 shall:

21 (1) make all initial determinations on whether to authorize or certify a  
22 nonemergency course of treatment for a patient within 2 working days of receipt of  
23 the information necessary to make the determination; and

24 (2) promptly notify the attending health care provider and patient of the  
25 determination.

26 (b) A private review agent shall:

27 (1) make all determinations on whether to authorize or certify an  
28 extended stay in a health care facility or additional health care services within 1  
29 working day of receipt of the information necessary to make the determination; and

30 (2) promptly notify the attending health care provider of the  
31 determination.

32 (c) If an initial determination is made by the private review agent not to  
33 authorize or certify a course of treatment, an extended stay in a health care facility, or  
34 additional health care services and the attending health care provider believes the  
35 determination warrants an immediate reconsideration, the private review agent shall  
36 provide the attending health care provider an opportunity to seek a reconsideration of  
37 that determination by telephone on an expedited basis not to exceed 24 hours of the  
38 health care provider seeking the reconsideration.

1 (d) For emergency inpatient admissions, a private review agent may not  
2 render an adverse decision or deny coverage for medically necessary covered services  
3 solely because the hospital did not notify the private review agent of the emergency  
4 admission within 24 hours or other prescribed period of time after that admission if  
5 the patient's medical condition prevented the hospital from determining:

6 (1) the patient's insurance status; and

7 (2) the private review agent's emergency admission notification  
8 requirements.

9 (e) For an involuntary or voluntary inpatient admission of a patient  
10 determined by the patient's physician or psychologist in conjunction with a member of  
11 the medical staff of the hospital who has privileges to admit patients to be in  
12 imminent danger to self or others, a private review agent may not render an adverse  
13 decision as to the admission of a patient during the first 24 hours the patient is in an  
14 inpatient facility or until the next business day of the private review agent, whichever  
15 is later. The hospital shall immediately notify the private review agent that a patient  
16 has been admitted and shall state the reasons for the admission.]

17 15-10B-08.

18 (A) IF A CARRIER DELEGATES ITS INTERNAL GRIEVANCE PROCESS TO A  
19 PRIVATE REVIEW AGENT, THE PRIVATE REVIEW AGENT SHALL ESTABLISH AN  
20 INTERNAL GRIEVANCE PROCESS FOR ITS PATIENTS AND HEALTH CARE PROVIDERS  
21 ACTING ON BEHALF OF A PATIENT.

22 (B) A PRIVATE REVIEW AGENT'S INTERNAL GRIEVANCE PROCESS SHALL  
23 MEET THE SAME REQUIREMENTS ESTABLISHED UNDER §§ 15-10A-02 THROUGH  
24 15-10A-05 OF THIS TITLE.

25 (C) ~~AN INTERNAL GRIEVANCE PROCESS ESTABLISHED BY A PRIVATE REVIEW~~  
26 ~~AGENT UNDER THIS SECTION MAY NOT CHARGE A FEE TO A PATIENT OR HEALTH~~  
27 ~~CARE PROVIDER FOR FILING A GRIEVANCE.~~

28 15-10B-09.

29 (a) In this section, "attending provider" means an obstetrician, pediatrician, or  
30 other physician or certified nurse midwife or pediatric nurse practitioner attending  
31 the mother or newborn child.

32 (b) Except as provided in subsections (c) and (d) of this section, the criteria  
33 and standards used by a private review agent or health maintenance organization in  
34 performing utilization review of hospital services related to maternity and newborn  
35 care, including length of stay, shall be in accordance with the medical criteria outlined  
36 in the most current version of the "Guidelines for Perinatal Care" prepared by the  
37 American Academy of Pediatrics and the American College of Obstetricians and  
38 Gynecologists.

1 (c) Subject to the provisions of subsection (d) of this section, a private review  
2 agent or health maintenance organization performing utilization review of hospital  
3 services related to maternity and newborn care shall authorize a minimum coverage  
4 of:

5 (1) 48 hours of inpatient hospitalization care following an uncomplicated  
6 vaginal delivery; and

7 (2) 96 hours of inpatient hospitalization care following an uncomplicated  
8 cesarean section.

9 (d) (1) The private review agent or health maintenance organization may  
10 authorize a shorter length of stay than that provided in subsection (c) of this section  
11 if the mother, in consultation with her attending provider, decides that less time is  
12 needed for recovery.

13 (2) For a mother and newborn child who have a hospital stay shorter in  
14 length than that provided under subsection (c) of this section, the private review  
15 agent or health maintenance organization performing utilization review shall  
16 authorize:

17 (i) one home visit scheduled to occur within 24 hours after hospital  
18 discharge; and

19 (ii) an additional home visit as may be prescribed by the attending  
20 provider.

21 (3) For a mother and newborn child who remain in the hospital for at  
22 least the period of time provided under subsection (c) of this section, the private  
23 review agent or health maintenance organization performing utilization review shall  
24 authorize a home visit as may be prescribed by the attending provider.

25 (4) A home visit under paragraph (2) or (3) of this subsection shall:

26 (i) be provided in accordance with generally accepted standards of  
27 nursing practice for home care of a mother and newborn child;

28 (ii) be provided by a registered nurse with at least 1 year of  
29 experience in maternal and child health nursing or in community health nursing with  
30 an emphasis on maternal and child health; and

31 (iii) include any services required by the attending provider.

32 (e) (1) The private review agent or health maintenance organization may  
33 not require additional documentation from, require additional utilization review of, or  
34 otherwise provide financial disincentives for an attending provider who orders care  
35 for which coverage is required to be provided under this section, § 19-703 of the  
36 Health - General Article, or § 15-811 of this article.

1 (2) The private review agent, hospital, or health maintenance  
2 organization may not deny, limit, or otherwise impair the participation of an  
3 attending provider under a contract or any privilege granted an attending provider  
4 who advocates more than 48 hours of inpatient hospital care following a complicated  
5 vaginal delivery or more than 96 hours of inpatient hospital care following a  
6 complicated cesarean section.

7 15-10B-09.1.

8 A GRIEVANCE DECISION SHALL BE MADE BASED ON THE PROFESSIONAL  
9 JUDGMENT OF:

10 (1) A PHYSICIAN, OR A PANEL OF OTHER APPROPRIATE HEALTH CARE  
11 SERVICE REVIEWERS WITH AT LEAST ONE PHYSICIAN ON THE PANEL WHO IS BOARD  
12 CERTIFIED OR ELIGIBLE IN THE SAME SPECIALTY AS THE TREATMENT UNDER  
13 REVIEW;

14 (2) WHEN THE ~~ADVERSE~~ GRIEVANCE DECISION INVOLVES A DENTAL  
15 SERVICE, A LICENSED DENTIST, OR A PANEL OF APPROPRIATE HEALTH CARE  
16 SERVICE REVIEWERS WITH AT LEAST ONE DENTIST ON THE PANEL WHO IS A  
17 LICENSED DENTIST WHO SHALL CONSULT WITH A DENTIST WHO IS BOARD  
18 CERTIFIED OR ELIGIBLE IN THE SAME SPECIALTY AS THE SERVICE UNDER REVIEW;  
19 OR

20 (3) WHEN THE ~~ADVERSE~~ GRIEVANCE DECISION INVOLVES A MENTAL  
21 HEALTH OR SUBSTANCE ABUSE SERVICE, A LICENSED PHYSICIAN, OR A PANEL OF  
22 OTHER APPROPRIATE HEALTH CARE SERVICE REVIEWERS WITH AT LEAST ONE  
23 PHYSICIAN, SELECTED BY THE PRIVATE REVIEW AGENT WHO:

24 (I) IS BOARD CERTIFIED OR ELIGIBLE IN THE SAME SPECIALTY AS  
25 THE TREATMENT UNDER REVIEW; OR

26 (II) IS ACTIVELY PRACTICING OR HAS DEMONSTRATED EXPERTISE  
27 IN THE ALCOHOL, DRUG ABUSE, OR MENTAL HEALTH SERVICE OR TREATMENT  
28 UNDER REVIEW.

29 15-10B-10.

30 (a) A certificate expires on the second anniversary of its effective date unless  
31 the certificate is renewed for a 2-year term as provided in this section.

32 (b) Before the certificate expires, a certificate may be renewed for an  
33 additional 2-year term if the applicant:

34 (1) otherwise is entitled to the certificate;

35 (2) pays to the Commissioner the renewal fee set by the Commissioner  
36 through regulation; and

37 (3) submits to the Commissioner:

1 (i) a renewal application on the form that the Commissioner  
2 requires; and

3 (ii) satisfactory evidence of compliance with any requirement under  
4 this subtitle for certificate renewal.

5 (c) If the requirements of this section are met, the Commissioner shall renew  
6 a certificate.

7 [15-10B-11.

8 (a) (1) The Commissioner shall deny a certificate to any applicant if, upon  
9 review of the application, the Commissioner finds that the applicant proposing to  
10 conduct utilization review does not:

11 (i) have available the services of sufficient numbers of registered  
12 nurses, medical records technicians or similarly qualified persons supported and  
13 supervised by appropriate physicians to carry out its utilization review activities; and

14 (ii) meet any applicable regulations the Commissioner adopts  
15 under this subtitle relating to the qualifications of private review agents or the  
16 performance of utilization review.

17 (2) The Commissioner shall deny a certificate to any applicant that does  
18 not provide assurances satisfactory to the Commissioner that:

19 (i) the procedures and policies of the private review agent will  
20 protect the confidentiality of medical records in accordance with applicable State and  
21 federal laws; and

22 (ii) the private review agent will be accessible to patients and  
23 providers 5 working days a week during normal business hours in this State.

24 (b) The Commissioner may revoke a certificate if the holder does not comply  
25 with performance assurances under this section, violates any provision of this  
26 subtitle, or violates any regulation adopted under any provision of this subtitle.

27 (c) (1) Before denying or revoking a certificate under this section, the  
28 Commissioner shall provide the applicant or certificate holder with reasonable time  
29 to supply additional information demonstrating compliance with the requirements of  
30 this subtitle and the opportunity to request a hearing.

31 (2) If an applicant or certificate holder requests a hearing, the  
32 Commissioner shall send a hearing notice by certified mail, return receipt requested,  
33 at least 30 days before the hearing.

34 (3) The Commissioner shall hold the hearing in accordance with Title 10,  
35 Subtitle 2 of the State Government Article.]

1 15-10B-11.

2 A PRIVATE REVIEW AGENT MAY NOT:

3 (1) VIOLATE ANY PROVISION OF THIS SUBTITLE OR ANY RULE OR  
4 REGULATION ADOPTED UNDER THIS SUBTITLE;

5 (2) FAIL TO MEET THE REQUIREMENTS FOR CERTIFICATION UNDER  
6 THIS SUBTITLE;

7 (3) OBTAIN OR ATTEMPT TO OBTAIN CERTIFICATION BASED ON  
8 INACCURATE INFORMATION;

9 (4) FRAUDULENTLY OR DECEPTIVELY OBTAIN OR USE A CERTIFICATE;

10 (5) FAIL TO MAKE AVAILABLE THE SERVICES OF SUFFICIENT NUMBERS  
11 OF REGISTERED NURSES, MEDICAL RECORDS TECHNICIANS, OR SIMILARLY  
12 QUALIFIED PERSONS SUPPORTED AND SUPERVISED BY APPROPRIATE PHYSICIANS  
13 TO CARRY OUT ITS UTILIZATION REVIEW ACTIVITIES;

14 (6) FAIL TO MEET ANY APPLICABLE REGULATIONS THE COMMISSIONER  
15 ADOPTS UNDER THIS SUBTITLE RELATING TO THE QUALIFICATIONS OF PRIVATE  
16 REVIEW AGENTS OR THE PERFORMANCE OF UTILIZATION REVIEW;

17 (7) FAIL TO PROTECT THE CONFIDENTIALITY OF MEDICAL RECORDS IN  
18 ACCORDANCE WITH APPLICABLE STATE AND FEDERAL LAWS; ~~OR~~

19 (8) USE CRITERIA AND STANDARDS TO CONDUCT UTILIZATION REVIEW  
20 UNLESS THE CRITERIA AND STANDARDS USED BY THE PRIVATE REVIEW AGENT ARE:

21 (I) OBJECTIVE;

22 (II) CLINICALLY VALID;

23 (III) COMPATIBLE WITH ESTABLISHED PRINCIPLES OF HEALTH  
24 CARE; OR

25 (IV) FLEXIBLE ENOUGH TO ALLOW DEVIATIONS FROM NORMS  
26 WHEN JUSTIFIED ON A CASE-BY-CASE BASIS; OR

27 (9) ACT AS A PRIVATE REVIEW AGENT WITHOUT HOLDING A  
28 CERTIFICATE ISSUED UNDER THIS SUBTITLE.

29 [15-10B-12.

30 The Commissioner may waive the requirements of this subtitle for a private  
31 review agent that operates solely under contract with the federal government for  
32 utilization review of patients eligible for hospital services under Title XVIII of the  
33 Social Security Act.]

1 15-10B-12.

2 (A) (1) A PERSON WHO VIOLATES ANY PROVISION OF § 15-10B-11 OF THIS  
3 SUBTITLE IS GUILTY OF A MISDEMEANOR AND ON CONVICTION IS SUBJECT TO A  
4 PENALTY NOT EXCEEDING \$1,000.

5 (2) EACH DAY A VIOLATION IS CONTINUED AFTER THE FIRST  
6 CONVICTION IS A SEPARATE OFFENSE.

7 (B) IN ADDITION TO THE PROVISIONS OF SUBSECTION (A) OF THIS SECTION, IF  
8 ANY PERSON VIOLATES ANY PROVISION OF § 15-10B-11 OF THIS SUBTITLE, THE  
9 COMMISSIONER MAY:

10 (1) DENY, SUSPEND, OR REVOKE THE CERTIFICATE TO DO BUSINESS AS  
11 A PRIVATE REVIEW AGENT;

12 (2) ISSUE AN ORDER TO CEASE AND DESIST FROM ACTING AS A PRIVATE  
13 REVIEW AGENT WITHOUT HOLDING A CERTIFICATE ISSUED UNDER THIS SUBTITLE;

14 ~~(2)~~ (3) REQUIRE A PRIVATE REVIEW AGENT TO MAKE RESTITUTION TO  
15 A PATIENT WHO HAS SUFFERED ACTUAL ECONOMIC DAMAGE BECAUSE OF THE  
16 VIOLATION; AND

17 ~~(3)~~ (4) IMPOSE AN ADMINISTRATIVE PENALTY OF UP TO \$5,000 FOR  
18 EACH VIOLATION OF ANY PROVISION OF THIS SUBTITLE.

19 [15-10B-13.

20 The Commissioner shall periodically provide a list of private review agents  
21 issued certificates and the renewal date for those certificates to any person on  
22 request.]

23 15-10B-13.

24 ANY PERSON AGGRIEVED BY AN ORDER OF THE COMMISSIONER UNDER THIS  
25 SUBTITLE HAS THE RIGHT TO A HEARING AND THE RIGHT TO APPEAL FROM THE  
26 ACTION OF THE COMMISSIONER IN ACCORDANCE WITH §§ 2-210 THROUGH 2-215 OF  
27 THIS ARTICLE.

28 [15-10B-14.

29 The Commissioner may establish reporting requirements to:

30 (1) evaluate the effectiveness of private review agents; and

31 (2) determine if the utilization review programs are in compliance with  
32 the provisions of this section and applicable regulations.]

1 15-10B-14.

2 THE COMMISSIONER MAY WAIVE THE REQUIREMENTS OF THIS SUBTITLE FOR A  
3 PRIVATE REVIEW AGENT THAT OPERATES SOLELY UNDER CONTRACT WITH THE  
4 FEDERAL GOVERNMENT FOR UTILIZATION REVIEW OF PATIENTS ELIGIBLE FOR  
5 HOSPITAL SERVICES UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT.

6 [15-10B-15.

7 A private review agent may not disclose or publish individual medical records or  
8 any other confidential medical information obtained in the performance of utilization  
9 review activities.]

10 15-10B-15.

11 THE COMMISSIONER SHALL PERIODICALLY PROVIDE A LIST OF PRIVATE  
12 REVIEW AGENTS ISSUED CERTIFICATES AND THE RENEWAL DATE FOR THOSE  
13 CERTIFICATES TO ANY PERSON ON REQUEST.

14 [15-10B-16.

15 (a) (1) Except as provided in paragraph (2) of this subsection, this section  
16 does not apply to:

17 (i) a private review agent referring an individual to a health care  
18 provider or facility that participates in a health maintenance organization;

19 (ii) a preferred provider organization network of participating  
20 health care providers or facilities to which the individual would otherwise be referred  
21 as part of the individual's membership or insurance contract; or

22 (iii) an employee assistance program referring an individual to a  
23 network of participating health care providers or facilities in accordance with a  
24 contract with the individual's employer or labor union to provide comprehensive  
25 mental health and substance abuse services.

26 (2) A private review agent or any other individual who is either affiliated  
27 with, under contract with, or acting on behalf of a private review agent may not  
28 approve or fail to approve a course of treatment based on whether the treatment is  
29 delivered by a provider who is a participating or nonparticipating provider in the  
30 preferred provider organization or employee assistance program network.

31 (b) A private review agent or any individual who is either affiliated with,  
32 under contract with, or acting on behalf of a private review agent may not:

33 (1) refer a patient who has undergone utilization review by the private  
34 review agent to:

35 (i) a health care facility in which the private review agent owns a  
36 significant beneficial interest; or

- 1 (ii) the private review agent's own health care practice;
- 2 (2) pay or agree to pay any sum to, or accept or agree to accept any sum  
3 from, any person for bringing or referring a patient to the private review agent; or
- 4 (3) provide for different insurance coverage or benefits based on  
5 receiving the service from a health care facility or health care provider in which the  
6 private review agent owns a significant beneficial interest.

7 (c) A private review agent or any individual who is either affiliated with,  
8 under contract with, or acting on behalf of a private review agent may refer a patient  
9 who has undergone utilization review by the private review agent to another health  
10 care provider regulated under the Health Occupations Article if:

11 (1) (i) the patient or provider requests the private review agent to  
12 provide the patient with the name of a health care provider appropriate to meet the  
13 health care needs of the patient; or

14 (ii) the patient has no attending physician; and

15 (2) the private review agent provides the patient with the names of at  
16 least 2 health care providers appropriate to meet the health care needs of the  
17 patient.]

18 15-10B-16.

19 THE COMMISSIONER MAY ESTABLISH REPORTING REQUIREMENTS TO:

20 (1) EVALUATE THE EFFECTIVENESS OF PRIVATE REVIEW AGENTS; AND

21 (2) DETERMINE IF THE UTILIZATION REVIEW PROGRAMS ARE IN  
22 COMPLIANCE WITH THE PROVISIONS OF THIS SECTION AND APPLICABLE  
23 REGULATIONS.

24 [15-10B-17.

25 (a) A person who violates any provision of this subtitle or any regulation  
26 adopted under this subtitle is guilty of a misdemeanor and on conviction is subject to  
27 a penalty not exceeding \$1,000. Each day a violation is continued after the first  
28 conviction is a separate offense.

29 (b) (1) In addition to the provisions of subsection (a) of this section, the  
30 Commissioner may impose an administrative penalty of up to \$5,000 for a violation of  
31 any provision of this subtitle.

32 (2) The Commissioner shall adopt regulations to provide standards for  
33 the imposition of an administrative penalty under paragraph (1) of this subsection.]

1 15-10B-17.

2 (A) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, THIS  
3 SECTION DOES NOT APPLY TO:

4 (I) A PRIVATE REVIEW AGENT REFERRING AN INDIVIDUAL TO A  
5 HEALTH CARE PROVIDER OR FACILITY THAT PARTICIPATES IN A HEALTH  
6 MAINTENANCE ORGANIZATION;

7 (II) A PREFERRED PROVIDER ORGANIZATION NETWORK OF  
8 PARTICIPATING HEALTH CARE PROVIDERS OR FACILITIES TO WHICH THE  
9 INDIVIDUAL WOULD OTHERWISE BE REFERRED AS PART OF THE INDIVIDUAL'S  
10 MEMBERSHIP OR INSURANCE CONTRACT; OR

11 (III) AN EMPLOYEE ASSISTANCE PROGRAM REFERRING AN  
12 INDIVIDUAL TO A NETWORK OF PARTICIPATING HEALTH CARE PROVIDERS OR  
13 FACILITIES IN ACCORDANCE WITH A CONTRACT WITH THE INDIVIDUAL'S EMPLOYER  
14 OR LABOR UNION TO PROVIDE COMPREHENSIVE MENTAL HEALTH AND SUBSTANCE  
15 ABUSE SERVICES.

16 (2) A PRIVATE REVIEW AGENT OR ANY OTHER INDIVIDUAL WHO IS  
17 EITHER AFFILIATED WITH, UNDER CONTRACT WITH, OR ACTING ON BEHALF OF A  
18 PRIVATE REVIEW AGENT MAY NOT APPROVE OR FAIL TO APPROVE A COURSE OF  
19 TREATMENT BASED ON WHETHER THE TREATMENT IS DELIVERED BY A PROVIDER  
20 WHO IS A PARTICIPATING OR NONPARTICIPATING PROVIDER IN THE PREFERRED  
21 PROVIDER ORGANIZATION OR EMPLOYEE ASSISTANCE PROGRAM NETWORK.

22 (B) A PRIVATE REVIEW AGENT OR ANY INDIVIDUAL WHO IS EITHER  
23 AFFILIATED WITH, UNDER CONTRACT WITH, OR ACTING ON BEHALF OF A PRIVATE  
24 REVIEW AGENT MAY NOT:

25 (1) REFER A PATIENT WHO HAS UNDERGONE UTILIZATION REVIEW BY  
26 THE PRIVATE REVIEW AGENT TO:

27 (I) A HEALTH CARE FACILITY IN WHICH THE PRIVATE REVIEW  
28 AGENT OWNS A SIGNIFICANT BENEFICIAL INTEREST; OR

29 (II) THE PRIVATE REVIEW AGENT'S OWN HEALTH CARE PRACTICE;

30 (2) PAY OR AGREE TO PAY ANY SUM TO, OR ACCEPT OR AGREE TO  
31 ACCEPT ANY SUM FROM, ANY PERSON FOR BRINGING OR REFERRING A PATIENT TO  
32 THE PRIVATE REVIEW AGENT; OR

33 (3) PROVIDE FOR DIFFERENT INSURANCE COVERAGE OR BENEFITS  
34 BASED ON RECEIVING THE SERVICE FROM A HEALTH CARE FACILITY OR HEALTH  
35 CARE PROVIDER IN WHICH THE PRIVATE REVIEW AGENT OWNS A SIGNIFICANT  
36 BENEFICIAL INTEREST.

37 (C) A PRIVATE REVIEW AGENT OR ANY INDIVIDUAL WHO IS EITHER  
38 AFFILIATED WITH, UNDER CONTRACT WITH, OR ACTING ON BEHALF OF A PRIVATE

1 REVIEW AGENT MAY REFER A PATIENT WHO HAS UNDERGONE UTILIZATION REVIEW  
2 BY THE PRIVATE REVIEW AGENT TO ANOTHER HEALTH CARE PROVIDER REGULATED  
3 UNDER THE HEALTH OCCUPATIONS ARTICLE IF:

4           (1)     (I)     THE PATIENT OR PROVIDER REQUESTS THE PRIVATE REVIEW  
5 AGENT TO PROVIDE THE PATIENT WITH THE NAME OF A HEALTH CARE PROVIDER  
6 APPROPRIATE TO MEET THE HEALTH CARE NEEDS OF THE PATIENT; OR

7                   (II)    THE PATIENT HAS NO ATTENDING PHYSICIAN; AND

8           (2)     THE PRIVATE REVIEW AGENT PROVIDES THE PATIENT WITH THE  
9 NAMES OF AT LEAST TWO HEALTH CARE PROVIDERS APPROPRIATE TO MEET THE  
10 HEALTH CARE NEEDS OF THE PATIENT.

11 [15-10B-18.

12     (a)     Any person aggrieved by a final decision of the Commissioner in a  
13 contested case under this subtitle may take a direct judicial appeal.

14     (b)     The appeal shall be made as provided for the judicial review of final  
15 decisions under Title 10, Subtitle 2 of the State Government Article.]

16 15-10B-18.

17     (A)     A PRIVATE REVIEW AGENT SHALL ADVISE THE COMMISSIONER, IN  
18 WRITING, OF ITS INTENTION TO WITHDRAW ITS CERTIFICATE WITHIN 60 DAYS OF  
19 INTENTION TO CEASE OPERATIONS AS A PRIVATE REVIEW AGENT.

20     (B)     A PRIVATE REVIEW AGENT SHALL SUBMIT ITS CERTIFICATE TO THE  
21 ADMINISTRATION WITHIN 30 DAYS AFTER THE DATE THAT THE PRIVATE REVIEW  
22 AGENT CEASED OPERATIONS.

23     SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect  
24 January 1, 2001.