
By: **Senator Bromwell**

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Assigned to: Rules

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Committee Report: Favorable with amendments

Senate action: Adopted

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CHAPTER 173

1 AN ACT concerning

2 **Health Insurance - Appeals and Grievances Procedures - Modifications**

3 FOR the purpose of establishing, for a retrospective denial, a certain minimum time
4 period for a member or a health care provider on behalf of a member to file a
5 grievance related to a carrier's adverse decision; extending the time period for a
6 member or a health care provider on behalf of a member to file a complaint with
7 the Insurance Commissioner for review of a carrier's grievance decision; altering
8 certain notice requirements; requiring carriers to report certain information to
9 the Insurance Commissioner on a quarterly basis; providing for the application
10 of certain portions of this Act; and generally relating to modifications of the
11 procedures for appeals and grievances of adverse decisions and grievance
12 decisions related to health insurance claims.

13 BY repealing and reenacting, with amendments,
14 Article - Insurance
15 Section 15-10A-02(b), (f), and (i), 15-10A-03(a), and 15-10A-06(a)
16 Annotated Code of Maryland
17 (1997 Volume and 2000 Supplement)

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

1 **Article - Insurance**

2 15-10A-02.

3 (b) (1) An internal grievance process shall meet the same requirements
4 established under Subtitle 10B of this title.5 (2) In addition to the requirements of Subtitle 10B of this title, an
6 internal grievance process established by a carrier under this section shall:7 (i) include an expedited procedure for use in an emergency case for
8 purposes of rendering a grievance decision within 24 hours of the date a grievance is
9 filed with the carrier;10 (ii) provide that a carrier render a final decision in writing on a
11 grievance within 30 working days after the date on which the grievance is filed
12 unless:13 1. the grievance involves an emergency case under item (i) of
14 this paragraph;15 2. the member or a health care provider filing a grievance on
16 behalf of a member agrees in writing to an extension for a period of no longer than 30
17 working days; or18 3. the grievance involves a retrospective denial under item
19 (iv) of this paragraph;20 (iii) allow a grievance to be filed on behalf of a member by a health
21 care provider; [and]22 (iv) provide that a carrier render a final decision in writing on a
23 grievance within 45 working days after the date on which the grievance is filed when
24 the grievance involves a retrospective denial; AND25 (V) FOR A RETROSPECTIVE DENIAL, ALLOW A MEMBER OR A
26 HEALTH CARE PROVIDER ON BEHALF OF A MEMBER TO FILE A GRIEVANCE FOR AT
27 LEAST 180 DAYS AFTER THE MEMBER RECEIVES AN ADVERSE DECISION.28 (3) For purposes of using the expedited procedure for an emergency case
29 that a carrier is required to include under paragraph (2)(i) of this subsection, the
30 Commissioner shall define by regulation the standards required for a grievance to be
31 considered an emergency case.32 (f) For nonemergency cases, when a carrier renders an adverse decision, the
33 carrier shall:34 (1) document the adverse decision in writing after the carrier has
35 provided oral communication of the decision to the member or the health care
36 provider acting on behalf of the member; and

1 (2) send, within 5 working days after the adverse decision has been
2 made, a written notice to the member and a health care provider acting on behalf of
3 the member that:

4 (i) states in detail in clear, understandable language the specific
5 factual bases for the carrier's decision;

6 (ii) references the specific criteria and standards, including
7 interpretive guidelines, on which the decision was based, and may not solely use
8 generalized terms such as "experimental procedure not covered", "cosmetic procedure
9 not covered", "service included under another procedure", or "not medically
10 necessary";

11 (iii) states the name, business address, and business telephone
12 number of:

13 1. the medical director or associate medical director, as
14 appropriate, who made the decision if the carrier is a health maintenance
15 organization; or

16 2. the designated employee or representative of the carrier
17 who has responsibility for the carrier's internal grievance process if the carrier is not
18 a health maintenance organization;

19 (iv) gives written details of the carrier's internal grievance process
20 and procedures under this subtitle; and

21 (v) includes the following information:

22 1. that the member or a health care provider on behalf of the
23 member has a right to file a complaint with the Commissioner within 30 WORKING
24 days after receipt of a carrier's grievance decision;

25 2. that a complaint may be filed without first filing a
26 grievance if the member or a health care provider filing a grievance on behalf of the
27 member can demonstrate a compelling reason to do so as determined by the
28 Commissioner;

29 3. the Commissioner's address, telephone number, and
30 facsimile number;

31 4. a statement that the Health Advocacy Unit is available to
32 assist the member in both mediating and filing a grievance under the carrier's
33 internal grievance process; and

34 5. the address, telephone number, facsimile number, and
35 email address of the Health Advocacy Unit.

36 (i) (1) For nonemergency cases, when a carrier renders a grievance decision,
37 the carrier shall:

1 (i) document the grievance decision in writing after the carrier has
2 provided oral communication of the decision to the member or the health care
3 provider acting on behalf of the member; and

4 (ii) send, within 5 working days after the grievance decision has
5 been made, a written notice to the member and a health care provider acting on
6 behalf of the member that:

7 1. states in detail in clear, understandable language the
8 specific factual bases for the carrier's decision;

9 2. references the specific criteria and standards, including
10 interpretive guidelines, on which the grievance decision was based;

11 3. states the name, business address, and business telephone
12 number of:

13 A. the medical director or associate medical director, as
14 appropriate, who made the grievance decision if the carrier is a health maintenance
15 organization; or

16 B. the designated employee or representative of the carrier
17 who has responsibility for the carrier's internal grievance process if the carrier is not
18 a health maintenance organization; and

19 4. includes the following information:

20 A. that the member has a right to file a complaint with the
21 Commissioner within 30 WORKING days after receipt of a carrier's grievance decision;
22 and

23 B. the Commissioner's address, telephone number, and
24 facsimile number.

25 (2) A carrier may not use solely in a notice sent under paragraph (1) of
26 this subsection generalized terms such as "experimental procedure not covered",
27 "cosmetic procedure not covered", "service included under another procedure", or "not
28 medically necessary" to satisfy the requirements of this subsection.

29 15-10A-03.

30 (a) (1) Within 30 WORKING days after the date of receipt of a grievance
31 decision, a member or a health care provider, who filed the grievance on behalf of the
32 member under § 15-10A-02(b)(2)(iii) of this subtitle, may file a complaint with the
33 Commissioner for review of the grievance decision.

34 (2) Whenever the Commissioner receives a complaint under this
35 subsection, the Commissioner shall notify the carrier that is the subject of the
36 complaint within 5 working days after the date the complaint is filed with the
37 Commissioner.

1 (3) Except for an emergency case under subsection (b)(1)(ii) of this
 2 section, the carrier that is the subject of a complaint filed under paragraph (1) of this
 3 subsection shall provide to the Commissioner any information requested by the
 4 Commissioner no later than 7 working days from the date the carrier receives the
 5 request for information.

6 SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland
 7 read as follows:

8 **Article - Insurance**

9 15-10A-06.

10 (a) On a quarterly basis, each carrier shall submit to the Commissioner, on the
 11 form the Commissioner requires, a report that describes:

12 (1) the activities of the carrier under this subtitle, including:

13 (i) the outcome of each grievance filed with the carrier;

14 (ii) the number and outcomes of cases that were considered
 15 emergency cases under § 15-10A-02(b)(2)(i) of this subtitle;

16 (iii) the time within which the carrier made a grievance decision on
 17 each emergency case;

18 (iv) the time within which the carrier made a grievance decision on
 19 all other cases that were not considered emergency cases; [and]

20 (v) the number of grievances filed with the carrier that resulted
 21 from an adverse decision involving length of stay for inpatient hospitalization as
 22 related to the medical procedure involved; and

23 (VI) THE NUMBER OF ADVERSE DECISIONS ISSUED BY THE CARRIER
 24 UNDER § 15-10A-02(F) OF THIS SUBTITLE AND THE TYPE OF SERVICE AT ISSUE IN THE
 25 ADVERSE DECISIONS; AND

26 (2) the number and outcome of all other cases that are not subject to
 27 activities of the carrier under this subtitle that resulted from an adverse decision
 28 involving the length of stay for inpatient hospitalization as related to the medical
 29 procedure involved.

30 ~~SECTION 2. 3.~~ AND BE IT FURTHER ENACTED, That Section 1 of this Act
 31 applies to all adverse decisions and grievance decisions made on or after October 1,
 32 2001.

33 SECTION 4. AND BE IT FURTHER ENACTED, That Section 2 of this Act
 34 applies to adverse decisions made on or after January 1, 2002.

1 SECTION ~~3~~.5. AND BE IT FURTHER ENACTED, That this Act shall take
2 effect October 1, 2001.