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§19–319.

(a) To qualify for a license, an applicant and the hospital or related institution to be operated shall meet the requirements of this section.

(b) An applicant who is an individual, and any individual who is applying on behalf of a corporation, association, or government agency shall be:

- (1) At least 18 years old; and
- (2) Of reputable and responsible character.

(c) (1) The applicant shall have a certificate of need, as required under Subtitle 1 of this title, for the hospital, residential treatment center, or related institution to be operated.

(2) The hospital, residential treatment center, or related institution to be operated shall meet the requirements that the Secretary adopts under this subtitle and Subtitle 12 of this title.

(d) (1) As a condition of licensure, each hospital shall establish a utilization review program for all patients admitted to the hospital. The utilization review program:

(i) May be conducted by an independent, nonhospital-affiliated review agent;

(ii) Shall be performed by registered nurses, medical records technicians, or similar qualified personnel supported and supervised by physicians as may be required;

(iii) Shall be certified by the Secretary if the program meets the minimum standards established under paragraph (4) of this subsection; and

(iv) Shall be recertified by the Secretary if the hospital makes any changes to the program after the initial certification.

(2) Any change made to a certified utilization review program shall be reported to the Secretary by the hospital within 30 days of the date the change was made.

(3) If a hospital fails to provide the utilization review program required under this subsection, the Secretary may impose the following penalties:

- (i) Delicensure of hospital; or

(ii) \$500 per day for each day the violation continues.

(4) The Secretary shall, by regulation and in consultation with health care providers and payors, establish minimum standards for a utilization review program, directed at appropriateness and quality of inpatient care, as enumerated in the following items:

- (i) Preadmission review of elective admissions;
- (ii) Postadmission review of emergency admissions;
- (iii) Concurrent or retrospective review of all admissions as appropriate;
- (iv) Preauthorization of certain selected procedures if proposed to be performed on an inpatient basis;
- (v) Continued stay review based on recognized objective criteria;
- (vi) Discharge planning review; and
- (vii) Readmission review.

(5) A patient may not be charged for any days disallowed as a result of retrospective review under paragraph (4) of this subsection unless the patient refuses to leave the hospital when it is medically appropriate to do so and the disallowed days occur:

- (i) After the hospital has notified the patient in writing of the potential disallowance; or
- (ii) As a direct result of the noncompliance by the patient to treatment or hospital regulations.

(6) A hospital shall be exempt from requiring a utilization review program for a patient if:

- (i) 1. The patient is insured by a third-party payor; and
2. The third-party payor has a utilization review program for its subscribers or beneficiaries which meets the minimum standards as adopted in paragraph (4) of this subsection; or
- (ii) The patient is a subscriber or member of a health maintenance organization as defined in § 19-701 of this title.

(7) Where federal regulations or guidelines for a federally mandated utilization review program for federally insured patients differ from standards established under paragraph (4) of this subsection, the Secretary may waive a specific

standard if the program achieves the same objectives as the standards established by the Secretary.

(8) The Secretary may establish record keeping and reporting requirements:

(i) To evaluate the effectiveness of hospitals' utilization review programs; and

(ii) To determine if the utilization review programs are in compliance with the provisions of this section and regulations adopted by the Secretary to administer this section.

(e) (1) (i) In this subsection the following words have the meanings indicated.

(ii) 1. "Telemedicine" means the use of interactive audio, video, or other telecommunications or electronic technology by a physician in the practice of medicine outside the physical presence of the patient.

2. "Telemedicine" does not include:

A. An audio-only telephone conversation between a physician and a patient;

B. An electronic mail message between a physician and a patient; or

C. A facsimile transmission between a physician and a patient.

(iii) "Uniform standard credentialing form" means:

1. The form designated by the Secretary through regulation for credentialing physicians who seek to be employed by or have staff privileges at a hospital; or

2. The uniform credentialing form that the Insurance Commissioner designates under § 15-112.1 of the Insurance Article.

(2) As a condition of licensure, each hospital shall:

(i) Establish a credentialing process for the physicians who are employed by or who have staff privileges at the hospital; and

(ii) Use the uniform standard credentialing form as the initial application of a physician seeking to be credentialed.

(3) Use of the uniform standard credentialing form does not preclude a hospital from requiring supplemental or additional information as part of the hospital's

credentialing process.

(4) The Secretary shall, by regulation and in consultation with hospitals, physicians, interested community and advocacy groups, and representatives of the Maryland Defense Bar and Plaintiffs' Bar, establish minimum standards for a credentialing process which shall include:

(i) A formal written appointment process documenting the physician's education, clinical expertise, licensure history, insurance history, medical history, claims history, and professional experience.

(ii) A requirement that an initial appointment to staff not be complete until the physician has successfully completed a probationary period.

(iii) A formal, written reappointment process to be conducted at least every 2 years. The reappointment process shall document the physician's pattern of performance by analyzing:

1. Claims filed against the physician;
2. Data dealing with utilization, quality, and risk;
3. Clinical skills;
4. Adherence to hospital bylaws, policies, and procedures;
5. Compliance with continuing education requirements;
6. Mental and physical status; and
7. The results of the practitioner performance evaluation process under subsection (i) of this section.

(5) If requested by the Department, a hospital shall provide documentation that, prior to employing or granting privileges to a physician, the hospital has complied with the requirements of this subsection and that, prior to renewing employment or privileges, the hospital has complied with the requirements of this subsection.

(6) Notwithstanding any other provision of this subsection, in its credentialing and privileging process for a physician who provides medical services to patients at the hospital only through telemedicine from a distant-site hospital or distant-site telemedicine entity, a hospital may rely on the credentialing and privileging decisions made for the physician by the distant-site hospital or distant-site telemedicine entity, as authorized under 42 C.F.R. Part 482, if:

(i) The physician who provides medical services through telemedicine holds a license to practice medicine in the State issued under Title

14 of the Health Occupations Article; and

(ii) The credentialing and privileging decisions with respect to the physician who provides medical services through telemedicine are:

1. Approved by the medical staff of the hospital; and
2. Recommended by the medical staff of the hospital to the hospital's governing body.

(7) If a hospital fails to establish or maintain a credentialing process required under this subsection, the Secretary may impose the following penalties:

- (i) Delicensure of the hospital; or
- (ii) \$500 per day for each day the violation continues.

(f) As a condition of licensure, each accredited and nonaccredited hospital shall develop a protocol for the procurement of organs and tissues.

(g) (1) As a condition of licensure, each hospital shall establish a risk management program.

(2) The Secretary shall, by regulation and in consultation with hospitals, physicians, interested community and advocacy groups, and representatives of the Maryland Defense Bar and Plaintiffs' Bar establish minimum standards for a risk management program which shall include:

- (i) A board policy statement indicating commitment to the risk management program;
- (ii) A requirement that one person be assigned the responsibility for coordinating the program;
- (iii) An internal staff committee structure to conduct ongoing review and evaluation of risk management activities;
- (iv) A formal written program for addressing patient complaints;
- (v) A documented facility-wide risk reporting system;
- (vi) Ongoing risk management education programs for all staff; and
- (vii) Documentation that the risk management and quality assurance programs share relevant information.

(3) If a hospital fails to establish or maintain a risk management program required under this subsection, the Secretary may impose the following penalties:

- (i) Delicensure of the hospital; or
- (ii) \$500 per day for each day the violation continues.

(h) (1) As a condition of licensure, each hospital and related institution shall:

(i) Adopt, implement, and enforce a policy that requires, except in an emergency life-threatening situation where it is not feasible or practicable, all employees and medical staff involved in patient care services to comply with the Centers for Disease Control and Prevention guidelines on universal precautions; and

(ii) Display the notice developed under § 1-207 of the Health Occupations Article at the entrance to the hospital or related institution.

(2) If a hospital or related institution fails to comply with the requirements of this subsection, the Secretary may impose a fine of up to \$500 per day per violation for each day a violation continues.

(i) (1) As a condition of licensure, each hospital shall establish a practitioner performance evaluation process that objectively evaluates the performance of each member of the medical staff at the hospital.

(2) The practitioner performance evaluation process shall include a review of care provided to patients at the hospital by the members of the medical staff.

(3) The review of care shall:

(i) Be undertaken for cases chosen at random and for cases with unexpected adverse outcomes;

(ii) Be based on objective review standards;

(iii) Include a review of the appropriateness of the plan of care for the patient, particularly any medical procedures performed on the patient, in relation to the patient's condition; and

(iv) Be conducted by members of the medical staff or, at the discretion of the hospital, external reviewers, who:

1. Are of the same specialty as the member of the medical staff under review;

2. Have been trained to perform practitioner performance evaluation; and

3. Are not otherwise associated with the case under review.

(4) A hospital shall take into account the results of the practitioner performance evaluation process for a member of the medical staff in the reappointment

process established under subsection (e) of this section.

(5) If a hospital fails to comply with the requirements of this subsection, the Secretary may impose a fine of up to \$500 per day per violation for each day a violation continues.

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