

Article - Insurance

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§15–10A–01.

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

(b) (1) “Adverse decision” means:

(i) a utilization review determination by a private review agent, a carrier, or a health care provider acting on behalf of a carrier that:

1. a proposed or delivered health care service covered under the member’s contract is or was not medically necessary, appropriate, or efficient; and

2. may result in noncoverage of the health care service; or

(ii) a denial by a carrier of a request by a member for an alternative standard or a waiver of a standard to satisfy the requirements of a wellness program under § 15–509 of this title.

(2) “Adverse decision” does not include a decision concerning a subscriber’s status as a member.

(c) “Carrier” means a person that offers a health benefit plan and is:

(1) an authorized insurer that provides health insurance in the State;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization; or

(5) except for a managed care organization as defined in Title 15, Subtitle 1 of the Health - General Article, any other person that provides health benefit plans subject to regulation by the State.

(d) “Complaint” means a protest filed with the Commissioner involving an adverse decision or grievance decision concerning the member.

(e) “Designee of the Commissioner” means any person to whom the Commissioner has delegated the authority to review and decide complaints filed under this subtitle, including an administrative law judge to whom the authority to conduct a hearing has been delegated for recommended or final decision.

(f) “Grievance” means a protest filed by a member, a member’s representative, or a health care provider on behalf of a member with a carrier through the carrier’s

internal grievance process regarding an adverse decision concerning the member.

(g) “Grievance decision” means a final determination by a carrier that arises from a grievance filed with the carrier under its internal grievance process regarding an adverse decision concerning a member.

(h) “Health Advocacy Unit” means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General established under Title 13, Subtitle 4A of the Commercial Law Article.

(i) “Health benefit plan” has the meaning stated in § 2-112.2(a) of this article.

(j) “Health care provider” means:

(1) an individual who is licensed under the Health Occupations Article to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the member; or

(2) a hospital, as defined in § 19-301 of the Health - General Article.

(k) “Health care service” means a health or medical care procedure or service rendered by a health care provider that:

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

(2) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

(l) (1) “Member” means a person entitled to health care benefits under a policy, plan, or certificate issued or delivered in the State by a carrier.

(2) “Member” includes:

(i) a subscriber; and

(ii) unless preempted by federal law, a Medicare recipient.

(3) “Member” does not include a Medicaid recipient.

(m) “Member’s representative” means an individual who has been authorized by the member to file a grievance or a complaint on the member’s behalf.

(n) “Private review agent” has the meaning stated in § 15–10B–01 of this title.

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