

Article - Insurance

[Previous][Next]

§15–138.

(a) (1) In this section the following words have the meanings indicated.

(2) “Ambulance” means any conveyance designed and constructed or modified and equipped to be used, maintained, or operated to transport individuals who are sick, injured, wounded, or otherwise incapacitated.

(3) “Ambulance service provider” means a provider of ambulance services that:

(i) is owned, operated, or under the jurisdiction of a political subdivision of the State or a volunteer fire company or volunteer rescue squad; or

(ii) has contracted to provide ambulance services for a political subdivision of the State.

(4) “Assignment of benefits” means the transfer by an insured, a subscriber, or an enrollee of health care coverage reimbursement benefits or other rights under a health insurance policy or contract.

(5) “Carrier” means:

(i) an insurer that provides benefits on an expense–incurred basis;

(ii) a nonprofit health service plan; or

(iii) a health maintenance organization.

(6) “Nonpreferred provider” has the meaning stated in § 14–201 of this article.

(7) “Preferred provider” has the meaning stated in § 14–201 of this article.

(8) “Preferred provider insurance policy” has the meaning stated in § 14–201 of this article.

(b) This section applies to individual or group policies or contracts issued or delivered in the State by a carrier.

(c) (1) Except for a health maintenance organization, a carrier shall reimburse directly an ambulance service provider that obtains an assignment of benefits from an insured, a subscriber, or an enrollee for covered services provided to the insured, subscriber, enrollee, or any other individual covered by a policy or contract issued by the carrier.

(2) A health maintenance organization shall reimburse an ambulance service provider directly for covered services provided to a subscriber, enrollee, or any other individual covered by a policy or contract issued by the health maintenance organization.

(d) (1) This subsection applies to an ambulance service provider that receives direct reimbursement under subsection (c) of this section.

(2) Except as provided in paragraph (4) of this subsection, an insured, a subscriber, or an enrollee may not be liable to an ambulance service provider for covered services.

(3) An ambulance service provider or a representative of the ambulance service provider may not:

(i) collect or attempt to collect from an insured, a subscriber, or an enrollee of a carrier any money owed to the ambulance service provider by the carrier for covered services rendered to the insured, subscriber, or enrollee by the ambulance service provider; or

(ii) maintain any action against an insured, a subscriber, or an enrollee of a carrier to collect or attempt to collect any money owed to the ambulance service provider by the carrier for covered services rendered to the insured, subscriber, or enrollee by the ambulance service provider.

(4) An ambulance service provider or a representative of the ambulance service provider may collect or attempt to collect from an insured, a subscriber, or an enrollee of a carrier:

(i) any copayment, deductible, or coinsurance amount owed by the insured, subscriber, or enrollee for covered services rendered to the insured, subscriber, or enrollee by the ambulance service provider;

(ii) if Medicare is the primary insurer and the carrier is the secondary insurer, any amount up to the Medicare–approved or limiting amount, as specified under the federal Social Security Act, that is not owed to the ambulance service provider by Medicare or the carrier after coordination of benefits has been completed, for Medicare covered services rendered to the insured, subscriber, or enrollee by the ambulance service provider; and

(iii) any payment or charge for services that are not covered services.

(e) (1) Notwithstanding § 19–710.1 of the Health – General Article, a health maintenance organization’s allowed amount for a covered health care service provided by an ambulance service provider that is not under written contract with the health maintenance organization may not be less than the allowed amount paid to an ambulance service provider that is under written contract with the health maintenance organization for the same covered service in the same geographic region,

as defined by the Centers for Medicare and Medicaid Services.

(2) An insurer's or nonprofit health service plan's allowed amount for a health care service covered under a preferred provider insurance policy and provided by an ambulance service provider that is a nonpreferred provider may not be less than the allowed amount paid to an ambulance service provider who is a preferred provider for the same health care service in the same geographic region, as defined by the Centers for Medicare and Medicaid Services.

(f) The Commissioner may adopt regulations to implement this section.

[Previous][Next]