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§15–10B–06.

(a) (1) A private review agent shall:

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

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

(iii) promptly notify the health care provider of the determination.

(2) If within 3 calendar days after receipt of the initial request for health care services the private review agent does not have sufficient information to make a determination, the private review agent shall inform the health care provider that additional information must be provided.

(3) If a private review agent requires prior authorization for an emergency inpatient admission, or an admission for residential crisis services as defined in § 15-840 of this title, for the treatment of a mental, emotional, or substance abuse disorder, the private review agent shall:

(i) make all determinations on whether to authorize or certify an inpatient admission, or an admission for residential crisis services as defined in § 15-840 of this title, within 2 hours after receipt of the information necessary to make the determination; and

(ii) promptly notify the health care provider of the determination.

(b) If an initial determination is made by a private review agent not to authorize or certify a health care service and the health care provider believes the determination warrants an immediate reconsideration, a private review agent may provide the health care provider the opportunity to speak with the physician that rendered the determination, by telephone on an expedited basis, within a period of time not to exceed 24 hours of the health care provider seeking the reconsideration.

(c) For emergency inpatient admissions, a private review agent may not render an adverse decision solely because the hospital did not notify the private review agent of the emergency admission within 24 hours or other prescribed period of time after that admission if the patient's medical condition prevented the hospital from determining:

(1) the patient's insurance status; and

(2) if applicable, the private review agent's emergency admission notification requirements.

(d) (1) Subject to paragraph (2) of this subsection, a private review agent may not render an adverse decision as to an admission of a patient during the first 24 hours after admission when:

(i) the admission is based on a determination that the patient is in imminent danger to self or others;

(ii) the determination has been made by the patient's physician or psychologist in conjunction with a member of the medical staff of the facility who has privileges to make the admission; and

(iii) the hospital immediately notifies the private review agent of:

1. the admission of the patient; and

2. the reasons for the admission.

(2) A private review agent may not render an adverse decision as to an admission of a patient to a hospital for up to 72 hours, as determined to be medically necessary by the patient's treating physician, when:

(i) the admission is an involuntary admission under §§ 10-615 and 10-617(a) of the Health - General Article; and

(ii) the hospital immediately notifies the private review agent of:

1. the admission of the patient; and

2. the reasons for the admission.

(e) (1) A private review agent that requires a health care provider to submit a treatment plan in order for the private review agent to conduct utilization review of proposed or delivered services for the treatment of a mental illness, emotional disorder, or a substance abuse disorder:

(i) shall accept:

1. the uniform treatment plan form adopted by the Commissioner under § 15-10B-03(d) of this subtitle as a properly submitted treatment plan form; or

2. if a service was provided in another state, a treatment plan form mandated by the state in which the service was provided; and

(ii) may not impose any requirement to:

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

2. submit additional treatment plan forms.

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

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

(ii) may be submitted by electronic transfer.

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