HOUSE BILL 86

Unofficial Copy 1996 Regular Session

(PRE-FILED)

J3 6lr0281

By: Delegate Bonsack
Requested: August 30, 1995
Introduced and read first time: January 10, 1996
Assigned to: Environmental Matters

A BILL ENTITLED

AN ACT concerning

Utilization Review - Health Benefits and Hospitals - Prohibition

FOR the purpose of repealing certain provisions of law regarding utilization review and private review agents; prohibiting the review of the allocation of certain health care resources for certain purposes; prohibiting hospitals from conducting certain utilization review programs; providing for certain exceptions; and generally relating to a prohibition against utilization review.

BY repealing
Article 48A - Insurance Code
Section 354CC, 354HH, 470V, 470Y, 477DD, and 477-II
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

BY repealing and reenacting, with amendments,
Article 48A - Insurance Code
Section 490-O(d)(1)
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

BY adding to
Article 48A - Insurance Code
Section 490FF
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 4-305(b)(5)
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

BY repealing and reenacting, without amendments,

Article - Health - General
Section 19-3B-01(a)
Annotated Code of Maryland
(1990 Replacement Volume and 1995 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-213(4), 19-308(b)(2), 19-3B-01(c)(2) and (d)(2), 19-706(k), and 19-710(k)
Annotated Code of Maryland
(1990 Replacement Volume and 1995 Supplement)

BY repealing
Article - Health - General
Section 19-319(d); 19-1301 through 19-1313 and the subtitle "Subtitle 13. Private Review Agents"
Annotated Code of Maryland
(1990 Replacement Volume and 1995 Supplement)

BY renumbering
Article - Health - General
Section 19-319(e), (f), (g), and (h), respectively
to be Section 19-319(d), (e), (f), and (g), respectively
Annotated Code of Maryland
(1990 Replacement Volume and 1995 Supplement)

BY adding to
Article - Health - General
Section 19-319.3
Annotated Code of Maryland
(1990 Replacement Volume and 1995 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That Section(s) 354CC, 354HH, 470V, 470Y, 477DD, and 477-II of Article 48A - Insurance Code of the Annotated Code of Maryland be repealed.

SECTION 2. AND BE IT FURTHER ENACTED, That Section(s) 19-319(d); and 19-1301 through 19-1313 and the subtitle "Subtitle 13. Private Review Agents" of Article - Health - General of the Annotated Code of Maryland be repealed.

SECTION 3. AND BE IT FURTHER ENACTED, That Section(s) 19-319(e), (f), (g), and (h), respectively, of Article - Health - General of the Annotated Code of Maryland be renumbered to be Section(s) 19-319(d), (e), (f), and (g), respectively.

SECTION 4. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article 48A - Insurance Code

490-O.

(d) (1) A limited benefits policy:

(i) Shall contain an exclusion for services that are not medically necessary or are not covered preventive health services; and

(ii) Subject to the approval of the Commissioner, may include other managed care provisions to control costs, including:

1. [Utilization review by the insurer or nonprofit health service plan;

2.] Second surgical opinions;

[3.] 2. A procedure for preauthorization of a medicalservice the costs of which are anticipated to exceed a minimum threshold amount; and

[4.] 3. A panel of preferred providers to provide services at specified levels of reimbursement.

490FF.

EXCEPT AS REQUIRED UNDER FEDERAL LAW, FOR THE PURPOSE OF MAKING CLAIMS OR PAYMENT DECISIONS, A PERSON MAY NOT REVIEW OR OTHERWISE PARTICIPATE IN A SYSTEM THAT REVIEWS THE APPROPRIATE AND EFFICIENT ALLOCATION OF HOSPITAL OR OTHER HEALTH CARE RESOURCES OR SERVICES THAT ARE GIVEN OR PROPOSED TO BE GIVEN TO A PATIENT.

Article - Health - General

4-305.

(b) A health care provider may disclose a medical record without the authorization of a person in interest:

(5) If a claim has been or may be filed by, or with the authorization of a patient or recipient on behalf of the patient or recipient, for coveredinsureds, covered beneficiaries, or enrolled recipients only, to third party payors and their agents, [if the payors or agents have met the applicable provisions of Title 19, Subtitle 13 of the Health - General Article,] including nonprofit health service plans, health maintenance organizations, fiscal intermediaries and carriers, the Department of Health and Mental Hygiene and its agents, the United States Department of Health and Human Services and its agents, or any other person obligated by contract or law to pay forthe health care rendered for the sole purposes of:

(i) Submitting a bill to the third party payor;

(ii) Reasonable prospective, concurrent, or retrospective [utilization review or] predetermination of benefit coverage;

(iii) Review, audit, and investigation of a specific claimfor payment of benefits; or

(iv) Coordinating benefit payments in accordance with the provisions of Article 48A of the Code under more than 1 sickness and accident, dental, or hospital and medical insurance policy;

19-213.

The Commission shall require each facility to give the Commission information that:

(4) Includes physician information sufficient to identify practice patterns of individual physicians across all facilities. The names of individual physicians are confidential and are not discoverable or admissible in evidence in a civil or criminal proceeding, and may only be disclosed to the following:

(i) [The utilization review committee of a Maryland hospital;

(ii)] The Medical and Chirurgical Faculty of the State of Maryland; or

[(iii)] (II) The State Board of Physician Quality Assurance.

19-308.

(b) (2) An accredited hospital shall be subject to inspections underthis subtitle by the Department for:

(i) A complaint investigation in accordance with § 19-309 of this part;

(ii) Reviewing compliance with licensure requirements for risk management[,utilization review,] and physician credentialing under § 19-319 of this subtitle; or

(iii) Reviewing compliance with a written progress report or other documentation of corrective action in response to a focused survey submitted by the hospital to the Joint Commission on Accreditation of Health Care Organizations in response to a Type I finding that the hospital is only in partial compliance with the patient care standards established by the Joint Commission on Accreditation of Health Care Organizations.

19-319.3.

EXCEPT AS REQUIRED UNDER FEDERAL LAW, A HOSPITAL MAY NOT CONDUCT UTILIZATION REVIEW OR ANY OTHER PROGRAM OR SYSTEM THAT EVALUATES THE APPROPRIATENESS AND QUALITY OF INPATIENT CARE BY CONDUCTING:

(1) PREADMISSION REVIEW OF ELECTIVE ADMISSIONS;

(2) POSTADMISSION REVIEW OF EMERGENCY ADMISSIONS;

(3) CONCURRENT OR RETROSPECTIVE REVIEW OF ALL ADMISSIONS AS APPROPRIATE;

(4) PREAUTHORIZATION OF CERTAIN SELECTED PROCEDURES IF PROPOSED TO BE PERFORMED ON AN INPATIENT BASIS;

(5) CONTINUED STAY REVIEW BASED ON RECOGNIZED OBJECTIVE CRITERIA;

(6) DISCHARGE PLANNING REVIEW; OR

(7) READMISSION REVIEW.

19-3B-01.

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

(c) (2) "An ambulatory surgical facility" does not include:

(i) The office of one or more health care practitioners seeking only professional reimbursement for the provisions of medical services, unless:

1. The office operates under contract or other agreement with a payor as an ambulatory surgical facility regardless of whether it is paid a technical or facility fee; or

2. The office is designated to receive ambulatory surgical referrals in accordance with [utilization review or other] policies adopted by a payor;

(ii) Any facility or service owned or operated by a hospital and regulated under Subtitle 2 of this title;

(iii) The office of a health care practitioner with not more than one operating room if:

1. The office does not receive a technical or facility fee; and

2. The operating room is used exclusively by the health care practitioner for patients of the health care practitioner;

(iv) The office of a group of health care practitioners with not more than one operating room if:

1. The office does not receive a technical or facility fee; and

2. The operating room is used exclusively by members of the group practice for patients of the group practice; or

(v) An office owned or operated by one or more dentists licensed under the Health Occupations Article.

(d) (2) "Freestanding endoscopy facility" does not include:

(i) The office of one or more health care practitioners unless:

1. The office operates under a contract or other agreement with a payor as a freestanding endoscopy facility regardless of whether it is paid a technical or facility fee; or

2. The office is designated to receive endoscopic referrals in accordance with [utilization review or other] policies adopted by a payor; or

(ii) Any facility or service operated by a hospital and regulated under Subtitle 2 of this title.

19-706.

(k) THE PROVISIONS OF ARTICLE 48A, § 490FF OF THE CODE SHALL APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

(L) (1) A health maintenance organization shall:

(i) Classify an obstetrician/gynecologist as a primary care physician; or

(ii) Permit a woman to receive an annual visit to an in-network obstetrician/gynecologist for routine gynecological care without requiring the woman to first visit a primary care provider.

(2) If a health maintenance organization classifies an obstetrician/gynecologist as a primary care physician as provided underparagraph (1) of this subsection, and a woman does not choose an obstetrician/gynecologist as her primary care provider, the health maintenance organization shall permit the woman to receive an annual visit to an in-network obstetrician/gynecologist for routine gynecological care without requiring the woman to first visit her primary care provider, whether or not the primary care provider is qualified to and regularly provides routine gynecological care.

19-710.

(k) [(1)] With the approval of the Department, the health maintenance organization shall provide continuous internal peer review for monitoring and evaluating patient records for:

[(i)] (1) Quality of care; and

[(ii)] (2) Overuse and underuse of provider care[; and

(2) The health maintenance organization shall meet the requirements of Subtitle 13 of this title and all regulations for the performance of utilization review].

SECTION 5. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 1996.