HOUSE BILL 3

Unofficial Copy 1998 Regular Session
C3 8lr0093

(PRE-FILED)

By: **Delegates Donoghue, Taylor, Busch, Guns, Dewberry, Hurson, Rawlings, Curran, Vallario, Hixson, Harrison, Menes, Kopp, Arnick, Owings, W. Baker, Barve, Benson, Bozman, E. Burns, Cadden, Clagett, Conroy, Conway, C. Davis, Dembrow, Doory, Dypski, Finifter, Franchot, Frank, Frush, Fulton, Genn, Goldwater, Hammen, Hecht, Heller, Howard, Jones, Krysiak, Linton, Love, Malone, Mandel, Marriott, McIntosh, Minnick, V. Mitchell, Morhaim, Nathan-Pulliam, Patterson, Perry, Petzold, Pitkin, Preis, Rosenberg, Rudolph, Shriver, Slade, Turner, Weir, Wood, and Workman**

Requested: November 14, 1997
Introduced and read first time: January 14, 1998
Assigned to: Economic Matters and Environmental Matters

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance - Complaint Process for Adverse Decisions and**
3 **Grievances**

4 FOR the purpose of requiring a carrier to establish a certain internal grievance
5 process for its members; requiring a carrier to file a copy of its internal
6 grievance process with the Maryland Insurance Commissioner and the Health
7 Education and Advocacy Unit in the Division of Consumer Protection of the
8 Office of the Attorney General; requiring a carrier to provide certain information
9 about the internal grievance process to a member under certain circumstances;
10 requiring a carrier to send a member or certain other individuals written notice
11 of an adverse decision or grievance decision under certain circumstances;
12 specifying the contents of the notice; requiring that certain information related
13 to the internal grievance process be included in a policy, certificate, enrollment
14 materials, or other evidence of coverage a carrier provides to a member;
15 specifying that a carrier has the burden of persuasion that its grievance decision
16 or adverse decision is correct during a certain review by the Commissioner;
17 authorizing the Commissioner to seek and receive certain advice from an
18 independent review organization under certain circumstances; requiring the
19 Commissioner to make a final decision on all complaints filed that are within
20 the Commissioner's jurisdiction; authorizing the Commissioner to issue certain
21 orders under certain circumstances; requiring the Commissioner to adopt
22 regulations; requiring certain persons to prepare and publish certain annual
23 reports; providing that the failure of an insurer or nonprofit health service plan
24 to satisfy the provisions of this Act is an unfair claim settlement practice;
25 transferring the administrative and enforcement responsibility for private
26 review agents to the Insurance Commissioner; requiring certain individuals to

1 obtain a certification from the Commissioner in order to perform their
2 responsibilities as a medical director for certain persons; requiring the
3 Commissioner to adopt certain regulations related to the certification of medical
4 directors; requiring the Health Education and Advocacy Unit and the
5 Commissioner to enter into a certain Memorandum of Understanding by a
6 certain date; requiring the Health Education and Advocacy Unit to make certain
7 recommendations to certain committees of the General Assembly by a certain
8 date; providing for the delayed effective date of certain provisions of this Act;
9 providing for the termination of certain provisions of this Act; altering certain
10 definitions; defining certain terms; and generally relating to a carrier's internal
11 grievance process for members.

12 BY transferring
13 Article - Health - General
14 Section 19-1301 through 19-1305, 19-1305.1, 19-1305.2, 19-1305.3,
15 19-1305.4, 19-1306 through 19-1311, 19-1311.1, 19-1312, and 19-1313
16 and the subtitle "Subtitle 13. Private Review Agents", respectively
17 Annotated Code of Maryland
18 (1996 Replacement Volume and 1997 Supplement)
19 to be
20 Article - Insurance
21 Section 15-10B-01 through 15-10B-18 and the subtitle "Subtitle 10B. Private
22 Review Agents", respectively
23 Annotated Code of Maryland
24 (1997 Volume)

25 BY adding to
26 Article - Commercial Law
27 Section 13-4A-04
28 Annotated Code of Maryland
29 (1990 Replacement Volume and 1997 Supplement)

30 BY adding to
31 Article - Health - General
32 Section 19-706(y)
33 Annotated Code of Maryland
34 (1996 Replacement Volume and 1997 Supplement)

35 BY repealing and reenacting, with amendments,
36 Article - Health - General
37 Section 19-729
38 Annotated Code of Maryland
39 (1996 Replacement Volume and 1997 Supplement)

40 BY repealing and reenacting, with amendments,

1 Article - Insurance
2 Section 15-1001 and 27-304
3 Annotated Code of Maryland
4 (1997 Volume)

5 BY adding to
6 Article - Insurance
7 Section 15-10A-01 through 15-10A-09, inclusive, to be under the new subtitle
8 "Subtitle 10A. Complaint Process for Adverse Decisions or Grievances";
9 and 15-10C-01 through 15-10C-03, inclusive, to be under the new
10 subtitle "Subtitle 10C. Medical Directors"
11 Annotated Code of Maryland
12 (1997 Volume)

13 BY repealing and reenacting, with amendments,
14 Article - Insurance
15 Section 15-10B-01, 15-10B-03, 15-10B-04, 15-10B-05(a) and (b),
16 15-10B-06(a), (e), and (g), 15-10B-07(a), 15-10B-09(e)(1), 15-10B-10,
17 15-10B-11, 15-10B-12, 15-10B-13, 15-10B-14, 15-10B-17(b), and
18 15-10B-18(a)
19 Annotated Code of Maryland
20 (1997 Volume)
21 (As enacted by Section 1 of this Act)

22 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF
23 MARYLAND, That Section(s) 19-1301 through 19-1305, 19-1305.1, 19-1305.2,
24 19-1305.3, 19-1305.4, 19-1306 through 19-1311, 19-1311.1, 19-1312, and 19-1313
25 and the subtitle "Subtitle 13. Private Review Agents", respectively, of Article - Health
26 - General of the Annotated Code of Maryland be transferred to be Section(s)
27 15-10B-01 through 15-10B-18 and the subtitle "Subtitle 10B. Private Review
28 Agents", respectively, of Article - Insurance of the Annotated Code of Maryland.

29 SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland
30 read as follows:

31 **Article - Commercial Law**

32 13-4A-04.

33 THE UNIT SHALL PREPARE EACH ANNUAL AND QUARTERLY REPORT REQUIRED
34 UNDER TITLE 15, SUBTITLE 10A OF THE INSURANCE ARTICLE.

1 **Article - Health - General**

2 19-706.

3 (Y) THE PROVISIONS OF TITLE 15, SUBTITLES 10A AND 10C OF THE INSURANCE
4 ARTICLE SHALL APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

5 19-729.

6 (a) A health maintenance organization may not:

7 (1) Violate any provision of this subtitle or any rule or regulation
8 adopted under it;

9 (2) Fail to fulfill its obligations to provide the health care services
10 specified in its contracts with subscribers;

11 (3) Make any false statement with respect to any report or statement
12 required by this subtitle or by the Commissioner under this subtitle;

13 (4) Advertise, merchandise, or attempt to merchandise its services in a
14 way that misrepresents its services or capacity for service;

15 (5) Engage in a deceptive, misleading, unfair, or unauthorized practice
16 as to advertising or merchandising;

17 (6) Prevent or attempt to prevent the Commissioner or the Department
18 from performing any duty imposed by this subtitle;

19 (7) Fraudulently obtain or fraudulently attempt to obtain any benefit
20 under this subtitle;

21 (8) Fail to fulfill the basic requirements to operate as a health
22 maintenance organization as provided in § 19-710 of this subtitle;

23 (9) Violate any applicable provision of Title 15, Subtitle 12 of the
24 Insurance Article; [or]

25 (10) Fail to provide services to a member in a timely manner as provided
26 in § 19-705.1(b)(1) of this subtitle; OR

27 (11) FAIL TO COMPLY WITH THE PROVISIONS OF TITLE 15, SUBTITLE 10A
28 OF THE INSURANCE ARTICLE.

29 (b) If any health maintenance organization violates this section, the
30 Commissioner may pursue any one or more of the courses of action described in §
31 19-730 of this subtitle.

1 **Article - Insurance**

2 15-1001.

3 (a) This section applies to insurers and nonprofit health service plans that
4 propose to issue or deliver individual, group, or blanket health insurance policies or
5 contracts in the State or to administer health benefit programs that provide for the
6 coverage of hospital benefits and the utilization review of those benefits.

7 (b) Each entity subject to this section shall:

8 (1) have a certificate issued under [Title 19, Subtitle 13 of the Health -
9 General Article] SUBTITLE 10B OF THIS TITLE;

10 (2) contract with a private review agent that has a certificate issued
11 under [Title 19, Subtitle 13 of the Health - General Article] SUBTITLE 10B OF THIS
12 TITLE; or

13 (3) contract with or delegate utilization review to a hospital utilization
14 review program approved under § 19-319(d) of the Health - General Article.

15 (c) Notwithstanding any other provision of this article, if the medical
16 necessity of providing a covered benefit is disputed, an entity subject to this section
17 that does not meet the requirements of subsection (b) of this section shall pay any
18 person entitled to reimbursement under the policy, contract, or certificate in
19 accordance with the determination of medical necessity by the hospital utilization
20 review program approved under § 19-319(d) of the Health - General Article.

21 SUBTITLE 10A. COMPLAINT PROCESS FOR ADVERSE DECISIONS OR GRIEVANCES.

22 15-10A-01.

23 (A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS
24 INDICATED.

25 (B) "ADVERSE DECISION" MEANS A DETERMINATION BY A PRIVATE REVIEW
26 AGENT, A CARRIER, OR A HEALTH CARE PROVIDER ACTING ON BEHALF OF A CARRIER
27 THAT A PROPOSED OR DELIVERED HEALTH CARE SERVICE:

28 (1) IS OR WAS NOT MEDICALLY NECESSARY; AND

29 (2) MAY RESULT IN NONCOVERAGE OF THE HEALTH CARE SERVICE.

30 (C) "CARRIER" MEANS:

31 (1) AN INSURER;

32 (2) A NONPROFIT HEALTH SERVICE PLAN;

33 (3) A HEALTH MAINTENANCE ORGANIZATION;

1 (4) A DENTAL PLAN ORGANIZATION; OR

2 (5) ANY OTHER PERSON THAT PROVIDES HEALTH BENEFIT PLANS
3 SUBJECT TO REGULATION BY THE STATE.

4 (D) "COMPLAINT" MEANS A PROTEST FILED WITH THE COMMISSIONER
5 INVOLVING AN ADVERSE DECISION OR GRIEVANCE DECISION CONCERNING THE
6 MEMBER.

7 (E) "GRIEVANCE DECISION" MEANS A FINAL DETERMINATION BY A CARRIER
8 THAT ARISES FROM A GRIEVANCE FILED WITH THE CARRIER UNDER ITS INTERNAL
9 GRIEVANCE PROCESS REGARDING AN ADVERSE DECISION CONCERNING A MEMBER.

10 (F) "HEALTH ADVOCACY UNIT" MEANS THE HEALTH EDUCATION AND
11 ADVOCACY UNIT IN THE DIVISION OF CONSUMER PROTECTION OF THE OFFICE OF
12 THE ATTORNEY GENERAL ESTABLISHED UNDER TITLE 13, SUBTITLE 4A OF THE
13 COMMERCIAL LAW ARTICLE.

14 (G) "HEALTH CARE PROVIDER" MEANS AN INDIVIDUAL WHO IS LICENSED
15 UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE SERVICES
16 IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION.

17 (H) "HEALTH CARE SERVICE" MEANS A HEALTH OR MEDICAL CARE
18 PROCEDURE OR SERVICE RENDERED BY A HEALTH CARE PROVIDER THAT:

19 (1) PROVIDES TESTING, DIAGNOSIS, OR TREATMENT OF A HUMAN
20 DISEASE OR DYSFUNCTION; OR

21 (2) DISPENSES DRUGS, MEDICAL DEVICES, MEDICAL APPLIANCES, OR
22 MEDICAL GOODS FOR THE TREATMENT OF A HUMAN DISEASE OR DYSFUNCTION.

23 (I) (1) "MEMBER" MEANS A PERSON ENTITLED TO HEALTH CARE BENEFITS
24 UNDER A POLICY, PLAN, OR CERTIFICATE ISSUED OR DELIVERED IN THE STATE BY A
25 CARRIER.

26 (2) "MEMBER" INCLUDES A SUBSCRIBER.

27 (J) "PRIVATE REVIEW AGENT" HAS THE MEANING STATED IN § 15-10B-01 OF
28 THIS TITLE.

29 15-10A-02.

30 (A) EACH CARRIER SHALL ESTABLISH AN INTERNAL GRIEVANCE PROCESS
31 FOR ITS MEMBERS.

32 (B) (1) AN INTERNAL GRIEVANCE PROCESS SHALL MEET THE SAME
33 REQUIREMENTS ESTABLISHED UNDER SUBTITLE 10B OF THIS TITLE.

34 (2) IN ADDITION TO THE REQUIREMENTS OF SUBTITLE 10B OF THIS
35 TITLE, AN INTERNAL GRIEVANCE PROCESS ESTABLISHED BY A CARRIER UNDER THIS
36 SECTION SHALL:

1 (I) INCLUDE AN EXPEDITED PROCEDURE FOR USE IN AN
2 EMERGENCY CASE FOR PURPOSES OF RENDERING A GRIEVANCE DECISION WITHIN
3 24 HOURS OF THE DATE A GRIEVANCE IS FILED WITH THE CARRIER;

4 (II) PROVIDE THAT A CARRIER RENDER A FINAL DECISION ON A
5 GRIEVANCE WITHIN 30 WORKING DAYS AFTER THE DATE ON WHICH THE GRIEVANCE
6 IS FILED UNLESS:

7 1. THE GRIEVANCE INVOLVES AN EMERGENCY CASE UNDER
8 ITEM (I) OF THIS PARAGRAPH; OR

9 2. THE MEMBER OR A HEALTH CARE PROVIDER FILING A
10 GRIEVANCE ON BEHALF OF A MEMBER AGREES IN WRITING TO AN EXTENSION FOR A
11 PERIOD OF NO LONGER THAN 30 WORKING DAYS; AND

12 (III) ALLOW A GRIEVANCE TO BE FILED ON BEHALF OF A MEMBER
13 BY A HEALTH CARE PROVIDER.

14 (C) EXCEPT AS PROVIDED IN SUBSECTION (D) OF THIS SECTION, THE
15 CARRIER'S INTERNAL GRIEVANCE PROCESS SHALL BE EXHAUSTED PRIOR TO FILING
16 A COMPLAINT WITH THE COMMISSIONER UNDER THIS SUBTITLE.

17 (D) (1) A MEMBER OR A HEALTH CARE PROVIDER FILING A COMPLAINT ON
18 BEHALF OF A MEMBER MAY FILE A COMPLAINT WITH THE COMMISSIONER WITHOUT
19 FIRST FILING A GRIEVANCE WITH A CARRIER AND RECEIVING A FINAL DECISION ON
20 THE GRIEVANCE IF THE MEMBER OR THE HEALTH CARE PROVIDER PROVIDES
21 SUFFICIENT INFORMATION AND SUPPORTING DOCUMENTATION IN THE COMPLAINT
22 THAT DEMONSTRATES A COMPELLING REASON TO DO SO.

23 (2) SUBJECT TO SUBSECTIONS (B)(2)(II) AND (H) OF THIS SECTION, A
24 MEMBER OR A HEALTH CARE PROVIDER MAY FILE A COMPLAINT WITH THE
25 COMMISSIONER IF THE MEMBER OR THE HEALTH CARE PROVIDER DOES NOT
26 RECEIVE A GRIEVANCE DECISION FROM THE CARRIER ON OR AFTER THE 30TH
27 WORKING DAY ON WHICH THE GRIEVANCE IS FILED.

28 (E) EACH CARRIER SHALL:

29 (1) FILE WITH THE COMMISSIONER AND SUBMIT TO THE HEALTH
30 ADVOCACY UNIT A COPY OF ITS INTERNAL GRIEVANCE PROCESS; AND

31 (2) UPDATE THE INITIAL FILING ANNUALLY TO REFLECT ANY CHANGES
32 MADE.

33 (F) EXCEPT FOR AN EMERGENCY CASE UNDER SUBSECTION (B)(2)(I) OF THIS
34 SECTION, AT THE TIME A MEMBER FIRST CONTACTS A CARRIER ABOUT AN ADVERSE
35 DECISION, THE CARRIER SHALL SEND IN WRITING TO THE MEMBER WITHIN 1
36 WORKING DAY AFTER THE INITIAL CONTACT:

37 (1) THE DETAILS OF ITS INTERNAL GRIEVANCE PROCESS AND
38 PROCEDURES UNDER THE PROVISIONS OF THIS SUBTITLE;

1 (2) INFORMATION STATING THAT:

2 (I) THE HEALTH ADVOCACY UNIT:

3 1. IS AVAILABLE TO ASSIST THE MEMBER WITH FILING A
4 GRIEVANCE UNDER THE CARRIER'S INTERNAL GRIEVANCE PROCESS; BUT

5 2. IS NOT AVAILABLE TO REPRESENT OR ACCOMPANY THE
6 MEMBER DURING THE PROCEEDINGS OF THE INTERNAL GRIEVANCE PROCESS;

7 (II) THE HEALTH ADVOCACY UNIT CAN ASSIST THE MEMBER IN
8 MEDIATING A RESOLUTION OF THE ADVERSE DECISION WITH THE CARRIER, BUT
9 THAT ANY TIME DURING THE MEDIATION, THE MEMBER OR A HEALTH CARE
10 PROVIDER ON BEHALF OF THE MEMBER MAY FILE A GRIEVANCE; AND

11 (III) THE MEMBER OR A HEALTH CARE PROVIDER ON BEHALF OF
12 THE MEMBER MAY FILE A COMPLAINT WITH THE COMMISSIONER WITHOUT FIRST
13 FILING A GRIEVANCE IF SUFFICIENT INFORMATION AND SUPPORTING
14 DOCUMENTATION IS FILED WITH THE COMPLAINT THAT DEMONSTRATES A
15 COMPELLING REASON TO DO SO;

16 (3) THE ADDRESS, TELEPHONE NUMBER, FACSIMILE NUMBER, AND
17 E-MAIL ADDRESS OF THE HEALTH ADVOCACY UNIT;

18 (4) THE ADDRESS, TELEPHONE NUMBER, AND FACSIMILE NUMBER OF
19 THE COMMISSIONER; AND

20 (5) INFORMATION ON WHERE THE INFORMATION REQUIRED BY THIS
21 SUBSECTION CAN BE FOUND IN THE MEMBER'S POLICY, PLAN, CERTIFICATE,
22 ENROLLMENT MATERIALS, OR OTHER EVIDENCE OF COVERAGE.

23 (G) IF WITHIN 5 WORKING DAYS AFTER A MEMBER OR A HEALTH CARE
24 PROVIDER, WHO HAS FILED A GRIEVANCE ON BEHALF OF A MEMBER, FILES A
25 GRIEVANCE WITH THE CARRIER, AND IF THE CARRIER DOES NOT HAVE SUFFICIENT
26 INFORMATION TO COMPLETE ITS INTERNAL GRIEVANCE PROCESS, THE CARRIER
27 SHALL:

28 (1) NOTIFY THE MEMBER OR HEALTH CARE PROVIDER THAT IT CANNOT
29 PROCEED WITH REVIEWING THE GRIEVANCE UNLESS ADDITIONAL INFORMATION IS
30 PROVIDED; AND

31 (2) ASSIST THE MEMBER OR HEALTH CARE PROVIDER IN GATHERING
32 THE NECESSARY INFORMATION WITHOUT FURTHER DELAY.

33 (H) A CARRIER MAY EXTEND THE 30-DAY PERIOD REQUIRED FOR MAKING A
34 FINAL GRIEVANCE DECISION UNDER SUBSECTION (B)(2)(II) OF THIS SECTION WITH
35 THE WRITTEN CONSENT OF THE MEMBER OR THE HEALTH CARE PROVIDER WHO
36 FILED THE GRIEVANCE ON BEHALF OF THE MEMBER.

1 (I) (1) FOR NONEMERGENCY CASES, EACH CARRIER'S INTERNAL
2 GRIEVANCE PROCESS ESTABLISHED UNDER SUBSECTION (A) OF THIS SECTION
3 SHALL INCLUDE A PROVISION THAT REQUIRES THE CARRIER TO:

4 (I) DOCUMENT IN WRITING ANY ADVERSE DECISION OR
5 GRIEVANCE DECISION MADE BY THE CARRIER AFTER THE CARRIER HAS PROVIDED
6 ORAL COMMUNICATION OF THE DECISION TO THE MEMBER OR THE HEALTH CARE
7 PROVIDER WHO FILED THE GRIEVANCE ON BEHALF OF THE MEMBER; AND

8 (II) WITHIN 2 WORKING DAYS AFTER THE DECISION HAS BEEN
9 MADE, SEND NOTICE OF THE ADVERSE DECISION OR GRIEVANCE DECISION TO:

10 1. THE MEMBER; AND

11 2. IF THE GRIEVANCE WAS FILED ON BEHALF OF THE
12 MEMBER UNDER SUBSECTION (B)(2)(III) OF THIS SECTION, THE HEALTH CARE
13 PROVIDER.

14 (2) NOTICE OF THE ADVERSE DECISION OR GRIEVANCE DECISION
15 REQUIRED TO BE SENT UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL:

16 (I) STATE IN DETAIL IN CLEAR, UNDERSTANDABLE LANGUAGE
17 THE SPECIFIC FACTUAL BASES FOR THE CARRIER'S DECISION;

18 (II) REFERENCE THE SPECIFIC CRITERIA AND STANDARDS,
19 INCLUDING INTERPRETIVE GUIDELINES, ON WHICH THE ADVERSE DECISION OR
20 GRIEVANCE DECISION WAS BASED; AND

21 (III) INCLUDE THE FOLLOWING INFORMATION:

22 1. THAT THE MEMBER HAS A RIGHT TO FILE A COMPLAINT
23 WITH THE COMMISSIONER WITHIN 30 DAYS AFTER RECEIPT OF A CARRIER'S
24 GRIEVANCE DECISION;

25 2. THAT A COMPLAINT MAY BE FILED WITHOUT FIRST
26 FILING A GRIEVANCE IF THE MEMBER OR A HEALTH CARE PROVIDER FILING A
27 GRIEVANCE ON BEHALF OF THE MEMBER CAN DEMONSTRATE A COMPELLING
28 REASON TO DO SO; AND

29 3. THE COMMISSIONER'S ADDRESS, TELEPHONE NUMBER,
30 AND FACSIMILE NUMBER.

31 (J) (1) FOR AN EMERGENCY CASE UNDER SUBSECTION (B)(2)(I) OF THIS
32 SECTION, WITHIN 1 WORKING DAY AFTER A DECISION HAS BEEN ORALLY
33 COMMUNICATED TO THE MEMBER OR HEALTH CARE PROVIDER, THE CARRIER SHALL
34 SEND NOTICE IN WRITING OF ANY ADVERSE DECISION OR GRIEVANCE DECISION TO:

35 (I) THE MEMBER; AND

1 (II) IF THE GRIEVANCE WAS FILED ON BEHALF OF THE MEMBER
2 UNDER SUBSECTION (B)(2)(III) OF THIS SECTION, THE HEALTH CARE PROVIDER.

3 (2) THE NOTICE SHALL INCLUDE THE INFORMATION REQUIRED UNDER
4 SUBSECTION (I)(2) OF THIS SECTION.

5 (K) EACH CARRIER SHALL INCLUDE THE INFORMATION REQUIRED BY
6 SUBSECTIONS (F) AND (I)(2)(III) OF THIS SECTION IN THE POLICY, PLAN, CERTIFICATE,
7 ENROLLMENT MATERIALS, OR OTHER EVIDENCE OF COVERAGE THAT THE CARRIER
8 PROVIDES TO A MEMBER AT THE TIME OF THE MEMBER'S INITIAL COVERAGE OR
9 RENEWAL OF COVERAGE.

10 15-10A-03.

11 (A) WITHIN 30 DAYS AFTER THE DATE OF RECEIPT OF A GRIEVANCE
12 DECISION, A MEMBER OR A HEALTH CARE PROVIDER, WHO FILED THE GRIEVANCE
13 ON BEHALF OF THE MEMBER UNDER § 15-10A-02(B)(2)(III) OF THIS SUBTITLE, MAY
14 FILE A COMPLAINT WITH THE COMMISSIONER FOR REVIEW OF THE GRIEVANCE
15 DECISION.

16 (B) IN DEVELOPING PROCEDURES TO BE USED IN REVIEWING AND DECIDING
17 COMPLAINTS, THE COMMISSIONER SHALL:

18 (1) ALLOW A HEALTH CARE PROVIDER TO FILE A COMPLAINT ON
19 BEHALF OF A MEMBER; AND

20 (2) ESTABLISH AN EXPEDITED PROCEDURE FOR USE IN AN EMERGENCY
21 CASE FOR THE PURPOSE OF MAKING A FINAL DECISION ON A COMPLAINT WITHIN 24
22 HOURS AFTER THE COMPLAINT IS FILED WITH THE COMMISSIONER.

23 (C) EXCEPT FOR AN EMERGENCY CASE UNDER SUBSECTION (B)(2) OF THIS
24 SECTION, THE COMMISSIONER SHALL MAKE A FINAL DECISION ON A COMPLAINT
25 WITHIN 30 WORKING DAYS AFTER THE COMPLAINT IS FILED.

26 (D) IN CASES CONSIDERED APPROPRIATE BY THE COMMISSIONER, THE
27 COMMISSIONER MAY SEEK ADVICE FROM AN INDEPENDENT REVIEW
28 ORGANIZATION, AS PROVIDED IN § 15-10A-05 OF THIS SUBTITLE, FOR COMPLAINTS
29 FILED WITH THE COMMISSIONER UNDER THIS SUBTITLE THAT INVOLVE A QUESTION
30 OF WHETHER A HEALTH CARE SERVICE PROVIDED OR TO BE PROVIDED TO A
31 MEMBER IS MEDICALLY NECESSARY.

32 (E) (1) DURING THE REVIEW OF A COMPLAINT BY THE COMMISSIONER OR A
33 DESIGNEE OF THE COMMISSIONER, A CARRIER SHALL HAVE THE BURDEN OF
34 PERSUASION THAT ITS ADVERSE DECISION OR GRIEVANCE DECISION, AS
35 APPLICABLE, IS CORRECT.

36 (2) AS PART OF THE REVIEW OF A COMPLAINT, THE COMMISSIONER OR
37 A DESIGNEE OF THE COMMISSIONER MAY CONSIDER ALL OF THE FACTS OF THE
38 CASE AND ANY OTHER EVIDENCE THAT THE COMMISSIONER OR DESIGNEE OF THE
39 COMMISSIONER CONSIDERS APPROPRIATE.

1 (3) AS REQUIRED UNDER § 15-10A-02(I) OF THIS SUBTITLE, THE
2 CARRIER'S ADVERSE DECISION OR GRIEVANCE DECISION SHALL STATE IN DETAIL IN
3 CLEAR, UNDERSTANDABLE LANGUAGE THE FACTUAL BASES FOR THE DECISION AND
4 REFERENCE THE SPECIFIC CRITERIA AND STANDARDS, INCLUDING INTERPRETIVE
5 GUIDELINES ON WHICH THE DECISION WAS BASED.

6 (4) (I) EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS
7 PARAGRAPH, IN RESPONDING TO A COMPLAINT, A CARRIER MAY NOT RELY ON ANY
8 BASIS NOT STATED IN ITS ADVERSE DECISION OR GRIEVANCE DECISION.

9 (II) WHEN THE COMMISSIONER HAS OBTAINED ADVICE FROM AN
10 INDEPENDENT REVIEW ORGANIZATION AS PROVIDED IN SUBSECTION (D) OF THIS
11 SECTION, A CARRIER MAY INCLUDE IN ITS WRITTEN RESPONSE TO A COMPLAINT
12 OTHER BASES NOT STATED IN ITS ADVERSE DECISION OR GRIEVANCE DECISION
13 WITH REFERENCE TO SPECIFIC CRITERIA AND STANDARDS, INCLUDING
14 INTERPRETATIVE GUIDELINES, THAT RELATE TO THE ADVICE GIVEN TO THE
15 COMMISSIONER BY THE INDEPENDENT REVIEW ORGANIZATION.

16 (F) THE COMMISSIONER MAY REQUEST THE MEMBER THAT FILED THE
17 COMPLAINT OR A LEGALLY AUTHORIZED DESIGNEE OF THE MEMBER TO SIGN A
18 CONSENT FORM AUTHORIZING THE RELEASE OF THE MEMBER'S MEDICAL RECORDS
19 TO THE COMMISSIONER OR THE COMMISSIONER'S DESIGNEE THAT ARE NEEDED IN
20 ORDER FOR THE COMMISSIONER TO MAKE A FINAL DECISION ON THE COMPLAINT.

21 15-10A-04.

22 (A) THE COMMISSIONER SHALL:

23 (1) MAKE AND ISSUE IN WRITING A FINAL DECISION ON ALL
24 COMPLAINTS FILED WITH THE COMMISSIONER UNDER THIS SUBTITLE THAT ARE
25 WITHIN THE COMMISSIONER'S JURISDICTION; AND

26 (2) PROVIDE NOTICE IN WRITING TO ALL PARTIES TO A COMPLAINT OF
27 THE OPPORTUNITY AND TIME PERIOD FOR REQUESTING A HEARING TO BE HELD IN
28 ACCORDANCE WITH TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE TO
29 CONTEST A FINAL DECISION OF THE COMMISSIONER MADE AND ISSUED UNDER THIS
30 SUBTITLE.

31 (B) (1) FOR EMERGENCY CASES, THE COMMISSIONER SHALL SEND
32 WRITTEN NOTIFICATION OF THE COMMISSIONER'S FINAL DECISION WITHIN 1
33 WORKING DAY AFTER THE COMMISSIONER OR THE COMMISSIONER'S DESIGNEE HAS
34 INFORMED THE MEMBER OR A HEALTH CARE PROVIDER WHO FILED THE COMPLAINT
35 ON BEHALF OF THE MEMBER OF THE FINAL DECISION THROUGH AN ORAL
36 COMMUNICATION.

37 (2) THE COMMISSIONER SHALL INCLUDE IN THE NOTICE THE
38 INFORMATION REQUIRED UNDER SUBSECTION (A)(2) OF THIS SECTION.

39 (C) IF THE COMMISSIONER DETERMINES THAT A GRIEVANCE DECISION OR
40 ADVERSE DECISION MADE BY A CARRIER IS IMPROPER, THE COMMISSIONER MAY

1 ORDER THE CARRIER TO PAY OR PROVIDE REIMBURSEMENT FOR THE HEALTH CARE
2 SERVICE TO THE MEMBER OR OTHER PERSON DESIGNATED BY THE MEMBER.

3 (D) THE COMMISSIONER MAY REFER COMPLAINTS NOT WITHIN THE
4 COMMISSIONER'S JURISDICTION TO THE HEALTH ADVOCACY UNIT OR ANY OTHER
5 APPROPRIATE FEDERAL OR STATE GOVERNMENT AGENCY OR UNIT FOR DISPOSITION
6 OR RESOLUTION.

7 15-10A-05.

8 (A) FOR COMPLAINTS FILED WITH THE COMMISSIONER UNDER THIS
9 SUBTITLE THAT INVOLVE A QUESTION OF WHETHER THE HEALTH CARE SERVICE
10 PROVIDED OR TO BE PROVIDED TO A MEMBER IS MEDICALLY NECESSARY, THE
11 COMMISSIONER MAY SELECT AND ACCEPT AND BASE THE FINAL DECISION ON A
12 COMPLAINT ON THE PROFESSIONAL JUDGMENT OF AN INDEPENDENT REVIEW
13 ORGANIZATION.

14 (B) TO ENSURE ACCESS TO ADVICE WHEN NEEDED, THE COMMISSIONER, IN
15 CONSULTATION WITH THE SECRETARY OF HEALTH AND MENTAL HYGIENE AND
16 CARRIERS, SHALL COMPILE A LIST OF INDEPENDENT REVIEW ORGANIZATIONS.

17 (C) (1) THE CARRIER THAT IS THE SUBJECT OF THE COMPLAINT SHALL BE
18 RESPONSIBLE FOR PAYING THE REASONABLE EXPENSES OF THE INDEPENDENT
19 REVIEW ORGANIZATION SELECTED BY THE COMMISSIONER IN ACCORDANCE WITH
20 SUBSECTION (A) OF THIS SECTION.

21 (2) THE COMMISSIONER SHALL:

22 (I) REQUEST AND RECEIVE FROM THE INDEPENDENT REVIEW
23 ORGANIZATION A DETAILED ACCOUNT OF THE EXPENSES INCURRED BY THE
24 INDEPENDENT REVIEW ORGANIZATION; AND

25 (II) PRESENT THE DETAILED ACCOUNT OF EXPENSES TO THE
26 CARRIER FOR PAYMENT.

27 (3) THE CARRIER THAT IS THE SUBJECT OF A COMPLAINT MAY NOT PAY
28 ANY PERSON ASSOCIATED WITH OR PART OF AN INDEPENDENT REVIEW
29 ORGANIZATION THAT IS USED BY THE COMMISSIONER IN MAKING A FINAL DECISION
30 ON THE COMPLAINT IN ACCORDANCE WITH SUBSECTION (A) OF THIS SECTION MAY
31 NOT ACCEPT ANY COMPENSATION FOR RENDERING A PROFESSIONAL JUDGMENT TO
32 THE COMMISSIONER IN ADDITION TO THE EXPENSES PAID UNDER PARAGRAPH (1) OF
33 THIS SUBSECTION.

34 (D) ANY INDIVIDUAL WHO IS AFFILIATED WITH OR WHO IS PART OF AN
35 INDEPENDENT REVIEW ORGANIZATION THAT GIVES ADVICE TO THE COMMISSIONER
36 UNDER THIS SECTION MAY NOT HAVE A DIRECT FINANCIAL OR PERSONAL INTEREST
37 IN OR CONNECTION WITH THE CASE FROM WHICH THE COMPLAINT ARISES.

1 15-10A-06.

2 (A) ON A QUARTERLY BASIS, EACH CARRIER SHALL SUBMIT TO THE
3 COMMISSIONER, ON THE FORM THE COMMISSIONER REQUIRES, A REPORT THAT
4 DESCRIBES:

5 (1) THE ACTIVITIES OF THE CARRIER UNDER THIS SUBTITLE,
6 INCLUDING:

7 (I) THE OUTCOME OF EACH GRIEVANCE FILED WITH THE
8 CARRIER;

9 (II) THE NUMBER AND OUTCOMES OF CASES THAT WERE
10 CONSIDERED EMERGENCY CASES UNDER § 15-10A-02(B)(2)(I) OF THIS SUBTITLE;

11 (III) THE TIME WITHIN WHICH THE CARRIER MADE A GRIEVANCE
12 DECISION ON EACH EMERGENCY CASE;

13 (IV) THE TIME WITHIN WHICH THE CARRIER MADE A GRIEVANCE
14 DECISION ON ALL OTHER CASES THAT WERE NOT CONSIDERED EMERGENCY CASES;
15 AND

16 (V) THE NUMBER OF GRIEVANCES FILED WITH THE CARRIER THAT
17 RESULTED FROM AN ADVERSE DECISION INVOLVING LENGTH OF STAY FOR
18 INPATIENT HOSPITALIZATION AS RELATED TO THE MEDICAL PROCEDURE
19 INVOLVED; AND

20 (2) THE NUMBER AND OUTCOME OF ALL OTHER CASES THAT ARE NOT
21 SUBJECT TO ACTIVITIES OF THE CARRIER UNDER THIS SUBTITLE THAT RESULTED
22 FROM AN ADVERSE DECISION INVOLVING THE LENGTH OF STAY FOR INPATIENT
23 HOSPITALIZATION AS RELATED TO THE MEDICAL PROCEDURE INVOLVED.

24 (B) THE COMMISSIONER SHALL:

25 (1) COMPILE AN ANNUAL SUMMARY REPORT BASED ON THE
26 INFORMATION PROVIDED UNDER SUBSECTION (A) OF THIS SECTION; AND

27 (2) PROVIDE COPIES OF THE SUMMARY REPORT TO THE LEGISLATIVE
28 POLICY COMMITTEE, THE SENATE FINANCE COMMITTEE, THE HOUSE ECONOMIC
29 MATTERS COMMITTEE, AND THE HOUSE ENVIRONMENTAL MATTERS COMMITTEE.

30 15-10A-07.

31 ON A QUARTERLY BASIS, THE HEALTH ADVOCACY UNIT SHALL SUBMIT A
32 REPORT TO THE COMMISSIONER THAT:

33 (1) DESCRIBES ACTIVITIES IT PERFORMED ON BEHALF OF MEMBERS
34 THAT HAVE PARTICIPATED IN AN INTERNAL GRIEVANCE PROCESS OF A CARRIER
35 ESTABLISHED UNDER THIS SUBTITLE;

1 (2) DESCRIBES ITS EFFORTS TO MEDIATE CASES THAT INVOLVE AN
2 ADVERSE DECISION;

3 (3) NAMES EACH CARRIER INVOLVED IN THE CASES DESCRIBED IN THE
4 REPORT;

5 (4) STATES THE NUMBER AND OUTCOME OF EACH GRIEVANCE
6 CONSIDERED AN EMERGENCY CASE UNDER § 15-10A-02(B)(2)(I) OF THIS SUBTITLE
7 DESCRIBED IN THE REPORT, INCLUDING THE TIME WITHIN WHICH THE CARRIER
8 MADE A GRIEVANCE DECISION ON EACH EMERGENCY CASE; AND

9 (5) STATES THE NUMBER AND OUTCOME OF EACH CASE DESCRIBED IN
10 THE REPORT THAT WAS NOT CONSIDERED AN EMERGENCY CASE, INCLUDING THE
11 TIME WITHIN WHICH THE CARRIER MADE A GRIEVANCE DECISION ON THE CASE.

12 15-10A-08.

13 (A) ON OR BEFORE NOVEMBER 1, 1999, AND EACH NOVEMBER 1 THEREAFTER,
14 THE HEALTH ADVOCACY UNIT SHALL PUBLISH AN ANNUAL SUMMARY REPORT AND
15 PROVIDE COPIES OF THE REPORT TO THE LEGISLATIVE POLICY COMMITTEE, THE
16 SENATE FINANCE COMMITTEE, THE HOUSE ECONOMIC MATTERS COMMITTEE, AND
17 THE HOUSE ENVIRONMENTAL MATTERS COMMITTEE.

18 (B) (1) THE ANNUAL SUMMARY REPORT REQUIRED UNDER SUBSECTION (A)
19 OF THIS SECTION SHALL BE ON THE GRIEVANCES AND COMPLAINTS FILED WITH OR
20 REFERRED TO A CARRIER, THE COMMISSIONER, THE HEALTH ADVOCACY UNIT, OR
21 ANY OTHER FEDERAL OR STATE GOVERNMENT AGENCY OR UNIT UNDER THIS
22 SUBTITLE DURING THE PREVIOUS FISCAL YEAR.

23 (2) IN CONSULTATION WITH THE COMMISSIONER AND ANY AFFECTED
24 STATE GOVERNMENT AGENCY OR UNIT, THE HEALTH ADVOCACY UNIT SHALL:

25 (I) EVALUATE THE EFFECTIVENESS OF THE INTERNAL
26 GRIEVANCE PROCESS AND COMPLAINT PROCESS AVAILABLE TO MEMBERS; AND

27 (II) INCLUDE IN THE ANNUAL SUMMARY REPORT THE RESULTS OF
28 THE EVALUATION AND ANY PROPOSED CHANGES THAT IT CONSIDERS NECESSARY.

29 15-10A-09.

30 THE COMMISSIONER SHALL ADOPT REGULATIONS TO CARRY OUT THIS
31 SUBTITLE.

32 Subtitle 10B. Private Review Agents.

33 15-10B-01.

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

1 (b) (1) "Adverse decision" means a utilization review determination made by
2 a private review agent that a proposed or delivered health care service:

3 (i) Is or was not MEDICALLY necessary[, appropriate, or efficient];
4 and

5 (ii) May result in noncoverage of the health care service.

6 (2) There is no adverse decision if the private review agent and the
7 health care provider on behalf of the patient reach an agreement on the proposed or
8 delivered health care services.

9 (C) "CERTIFICATE" MEANS A CERTIFICATE OF REGISTRATION GRANTED BY
10 THE COMMISSIONER TO A PRIVATE REVIEW AGENT.

11 [(c)] (D) (1) "Employee assistance program" means a health care service
12 plan that, in accordance with a contract with an employer or labor union:

13 (i) Consults with employees or members of an employee's family or
14 both to:

15 1. Identify the employee's or the employee's family member's
16 mental health, alcohol, or substance abuse problems; and

17 2. Refer the employee or the employee's family member to
18 health care providers or other community resources for counseling, therapy, or
19 treatment; and

20 (ii) Performs utilization review for the purpose of making claims or
21 payment decisions on behalf of the employer's or labor union's health insurance or
22 health benefit plan.

23 (2) "Employee assistance program" does not include a health care service
24 plan operated by a hospital solely for employees, or members of an employee's family,
25 of that hospital.

26 [(d)] (E) "Health care facility" means:

27 (1) A hospital as defined in § 19-301 of [this title] THE HEALTH -
28 GENERAL ARTICLE;

29 (2) A related institution as defined in § 19-301 of [this title] THE
30 HEALTH - GENERAL ARTICLE;

31 (3) An ambulatory surgical facility or center which is any entity or part
32 thereof that operates primarily for the purpose of providing surgical services to
33 patients not requiring hospitalization and seeks reimbursement from third party
34 payors as an ambulatory surgical facility or center;

35 (4) A facility that is organized primarily to help in the rehabilitation of
36 disabled individuals;

1 (5) A home health agency as defined in § 19-401 of [this title] THE
2 HEALTH - GENERAL ARTICLE;

3 (6) A hospice as defined in § 19-901 of [this title] THE HEALTH -
4 GENERAL ARTICLE;

5 (7) A facility that provides radiological or other diagnostic imagery
6 services;

7 (8) A medical laboratory as defined in § 17-201 of [this article] THE
8 HEALTH - GENERAL ARTICLE; or

9 (9) An alcohol abuse and drug abuse treatment program as defined in §
10 8-403 of [this article] THE HEALTH - GENERAL ARTICLE.

11 (F) "HEALTH CARE SERVICE" MEANS ANY HEALTH OR MEDICAL PROCEDURE
12 OR SERVICE RENDERED BY A HEALTH CARE PROVIDER THAT:

13 (1) PROVIDES TESTING, DIAGNOSIS, OR TREATMENT OF A HUMAN
14 DISEASE OR DYSFUNCTION; OR

15 (2) DISPENSES DRUGS, MEDICAL DEVICES, MEDICAL APPLIANCES, OR
16 MEDICAL GOODS FOR THE TREATMENT OF A HUMAN DISEASE OR DYSFUNCTION.

17 [(e) "Utilization review" means a system for reviewing the appropriate and
18 efficient allocation of hospital resources and services given or proposed to be given to
19 a patient or group of patients.]

20 [(f)] (G) "Private review agent" means:

21 (1) A nonhospital-affiliated person or entity performing utilization
22 review that is either affiliated with, under contract with, or acting on behalf of:

23 (i) A Maryland business entity; or

24 (ii) A third party that provides or administers hospital benefits to
25 citizens of this State, including:

26 1. A health maintenance organization issued a certificate of
27 authority in accordance with TITLE 19, Subtitle 7 of [this title] THE HEALTH -
28 GENERAL ARTICLE; or

29 2. A health insurer, nonprofit health service plan, health
30 insurance service organization, or preferred provider organization authorized to offer
31 health insurance policies or contracts in this State in accordance with the Insurance
32 Article; or

33 (2) Any person or entity including a hospital-affiliated person
34 performing utilization review for the purpose of making claims or payment decisions
35 on behalf of the employer's or labor union's health insurance plan under an employee
36 assistance program for employees other than the employees:

1 (i) Employed by the hospital; or

2 (ii) Employed by a business wholly owned by the hospital.

3 [(g)] (H) "Significant beneficial interest" means the ownership of any financial
4 interest that is greater than the lesser of:

5 (1) 5 percent of the whole; or

6 (2) $5,000.

7 (I) "UTILIZATION REVIEW" MEANS A SYSTEM FOR REVIEWING THE
8 APPROPRIATE AND EFFICIENT ALLOCATION OF HEALTH CARE SERVICES GIVEN OR
9 PROPOSED TO BE GIVEN TO A PATIENT OR GROUP OF PATIENTS.

10 [(h)] (J) "Utilization review plan" means a description of the standards
11 governing utilization review activities performed by a private review agent.

12 [(i) "Secretary" means the Secretary of Health and Mental Hygiene.

13 (j) "Commissioner" means the Insurance Commissioner.

14 (k) "Certificate" means a certificate of registration granted by the Secretary to
15 a private review agent.]

16 15-10B-03.

17 (a) A private review agent may not conduct utilization review in this State
18 unless the [Secretary] COMMISSIONER has granted the private review agent a
19 certificate.

20 (b) The [Secretary] COMMISSIONER shall issue a certificate to an applicant
21 that has met all the requirements of this subtitle and all applicable regulations of the
22 [Secretary] COMMISSIONER.

23 [(c) The Secretary may delegate the authority to issue a certificate to the
24 Commissioner for any health insurer or nonprofit health service plan regulated under
25 the Insurance Article or health maintenance organization issued a certificate of
26 authority in accordance with Subtitle 7 of this title that meets the requirements of
27 this subtitle and all applicable regulations of the Secretary.]

28 [(d)] (C) A certificate issued under this subtitle is not transferable.

29 [(e)] (D) (1) The [Secretary] COMMISSIONER, after consultation with [the
30 Commissioner,] payors, including the Health Insurance Association of America and
31 the Maryland Association of Health Maintenance Organizations, and providers of
32 health care, including the Maryland Hospital Association, the Medical and
33 Chirurgical Faculty of Maryland, and licensed or certified providers of treatment for
34 a mental illness, emotional disorder, or a drug abuse or alcohol abuse disorder, shall
35 adopt regulations to implement the provisions of this subtitle.

1 (2) (i) Subject to the provisions of subparagraph (iii) of this paragraph,
2 the regulations adopted by the [Secretary] COMMISSIONER shall include a uniform
3 treatment plan form for utilization review of services for the treatment of a mental
4 illness, emotional disorder, or a drug abuse or alcohol abuse disorder.

5 (ii) The uniform treatment plan form adopted by the [Secretary]
6 COMMISSIONER:

7 1. Shall adequately protect the confidentiality of the patient;
8 and

9 2. May only request the patient's membership number, policy
10 number, or other similar unique patient identifier and first name for patient
11 identification.

12 (iii) The [Secretary] COMMISSIONER may waive the requirements
13 of regulations adopted under subparagraph (i) of this paragraph for the use of a
14 uniform treatment plan form for any entity that would be using the form solely for
15 internal purposes.

16 15-10B-04.

17 (a) An applicant for a certificate shall:

18 (1) Submit an application to the [Secretary] COMMISSIONER; and

19 (2) Pay to the [Secretary] COMMISSIONER the application fee
20 established by the [Secretary] COMMISSIONER through regulation.

21 (b) The application shall:

22 (1) Be on a form and accompanied by any supporting documentation that
23 the [Secretary] COMMISSIONER requires; and

24 (2) Be signed and verified by the applicant.

25 (c) The application fees required under subsection (a)(2) of this section or [§
26 19-1306(b)(2)] § 15-10B-10(B)(2) of this subtitle shall be sufficient to pay for the
27 administrative costs of the certificate program and any other costs associated with
28 carrying out the provisions of this subtitle.

29 15-10B-05.

30 (a) In conjunction with the application, the private review agent shall submit
31 information that the [Secretary] COMMISSIONER requires including:

32 (1) A utilization review plan that includes:

33 (i) The specific criteria and standards to be used in conducting
34 utilization review of proposed or delivered services;

1 (ii) Those circumstances, if any, under which utilization review may
2 be delegated to a hospital utilization review program; and

3 (iii) The provisions by which patients, physicians, or hospitals may
4 seek reconsideration or appeal of adverse decisions by the private review agent;

5 (2) The type and qualifications of the personnel either employed or
6 under contract to perform the utilization review;

7 (3) The procedures and policies to ensure that a representative of the
8 private review agent is reasonably accessible to patients and providers 5 days a week
9 during normal business hours in this State;

10 (4) The policies and procedures to ensure that all applicable State and
11 federal laws to protect the confidentiality of individual medical records are followed;

12 (5) A copy of the materials designed to inform applicable patients and
13 providers of the requirements of the utilization review plan;

14 (6) A list of the third party payors for which the private review agent is
15 performing utilization review in this State;

16 (7) The policies and procedures to ensure that the private review agent
17 has a formal program for the orientation and training of the personnel either
18 employed or under contract to perform the utilization review;

19 (8) A list of the health care providers involved in establishing the specific
20 criteria and standards to be used in conducting utilization review; and

21 (9) Certification by the private review agent that the criteria and
22 standards to be used in conducting utilization review are:

23 (i) Objective;

24 (ii) Clinically valid;

25 (iii) Compatible with established principles of health care; and

26 (iv) Flexible enough to allow deviations from norms when justified
27 on a case by case basis.

28 (b) At least 10 days before a private review agent requires any revisions or
29 modifications to the specific criteria and standards to be used in conducting
30 utilization review of proposed or delivered services, the private review agent shall
31 submit those revisions or modifications to the [Secretary] COMMISSIONER.

32 15-10B-06.

33 (a) In this section, "utilization review" means a system for reviewing the
34 appropriate and efficient allocation of health care resources and services given or
35 proposed to be given to a patient or group of patients by a health care provider,

1 including a hospital or an intermediate care facility described under § 8-403(e) of
2 [this article] THE HEALTH - GENERAL ARTICLE.

3 (e) (1) In the event a patient or health care provider, including a physician,
4 intermediate care facility described under § 8-403(e) of [this article] THE HEALTH -
5 GENERAL ARTICLE, or hospital seeks reconsideration or appeal of an adverse decision
6 by a private review agent, the final determination of the appeal of the adverse
7 decision shall be made based on the professional judgment of a physician, or a panel
8 of other appropriate health care providers with at least 1 physician, selected by the
9 private review agent who is:

10 (i) 1. Board certified or eligible in the same specialty as the
11 treatment under review; or

12 2. Actively practicing or has demonstrated expertise in the
13 alcohol, drug abuse, or mental health service or treatment under review; and

14 (ii) Not compensated by the private review agent in a manner that
15 provides a financial incentive directly or indirectly to deny or reduce coverage.

16 (2) In the event a patient or health care provider, including a physician,
17 intermediate care facility described under § 8-403(e) of [this article] THE HEALTH -
18 GENERAL ARTICLE, or hospital seeks reconsideration or appeal of an adverse decision
19 by a private review agent, the final determination of the appeal of the adverse
20 decision shall be stated in writing and shall reference the specific criteria and
21 standards, including interpretive guidelines, upon which the denial or reduction in
22 coverage is based.

23 (g) (1) A private review agent that requires a health care provider to submit
24 a treatment plan in order for the private review agent to conduct utilization review of
25 proposed or delivered services for the treatment of a mental illness, emotional
26 disorder, or a drug abuse or alcohol abuse disorder:

27 (i) Shall accept the uniform treatment plan form adopted by the
28 [Secretary under § 19-1303(e)] COMMISSIONER UNDER § 15-10B-03(D) of this
29 subtitle as a properly submitted treatment plan form; and

30 (ii) May not impose any requirement to:

31 1. Modify the uniform treatment plan form or its content; or

32 2. Submit additional treatment plan forms.

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

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

36 (ii) May be submitted by electronic transfer.

1 15-10B-07.

2 (a) Except as specifically provided in [§ 19-1305.1] § 15-10B-06 of this
3 subtitle:

4 (1) All adverse decisions shall be made by a physician or a panel of other
5 appropriate health care providers with at least 1 physician on the panel.

6 (2) In the event a patient or health care provider, including a physician,
7 intermediate care facility described in § 8-403(e) of [this article] THE HEALTH -
8 GENERAL ARTICLE, or hospital seeks reconsideration or appeal of an adverse decision
9 by a private review agent, the final determination of the appeal of the adverse
10 decision shall be made based on the professional judgment of a physician or a panel of
11 other appropriate health care providers with at least 1 physician on the panel.

12 (3) In the event a patient or health care provider, including a physician,
13 intermediate care facility described in § 8-403(e) of [this article] THE HEALTH -
14 GENERAL ARTICLE, or hospital seeks reconsideration or appeal of an adverse decision
15 by a private review agent, the final determination of the appeal of the adverse
16 decision shall:

17 (i) Be stated in writing and provide an explanation of the reason
18 for the adverse decision; and

19 (ii) Reference the specific criteria and standards, including
20 interpretive guidelines, upon which the adverse decision is based.

21 15-10B-09.

22 (e) (1) The private review agent or health maintenance organization may
23 not require additional documentation from, require additional utilization review of, or
24 otherwise provide financial disincentives for an attending provider who orders care
25 for which coverage is required to be provided under this section, § 19-703 of [this
26 article] THE HEALTH - GENERAL ARTICLE, or § 15-811 of [the Insurance Article]
27 THIS ARTICLE.

28 15-10B-10.

29 (a) A certificate expires on the second anniversary of its effective date unless
30 the certificate is renewed for a 2-year term as provided in this section.

31 (b) Before the certificate expires, a certificate may be renewed for an
32 additional 2-year term if the applicant:

33 (1) Otherwise is entitled to the certificate;

34 (2) Pays to the [Secretary] COMMISSIONER the renewal fee set by the
35 [Secretary] COMMISSIONER through regulation; and

36 (3) Submits to the [Secretary] COMMISSIONER:

1 (i) A renewal application on the form that the [Secretary]
2 COMMISSIONER requires; and

3 (ii) Satisfactory evidence of compliance with any requirement
4 under this subtitle for certificate renewal.

5 (c) If the requirements of this section are met, the [Secretary]
6 COMMISSIONER shall renew a certificate.

7 [(d) The Secretary may delegate to the Commissioner the authority to renew a
8 certificate to any health insurer or nonprofit health service plan regulated under the
9 Insurance Article or health maintenance organization issued a certificate of authority
10 in accordance with Subtitle 7 of this title that meets the requirements of this subtitle
11 and all applicable regulations of the Secretary.]

12 15-10B-11.

13 (a) (1) The [Secretary] COMMISSIONER shall deny a certificate to any
14 applicant if, upon review of the application, the [Secretary] COMMISSIONER finds
15 that the applicant proposing to conduct utilization review does not:

16 (i) Have available the services of sufficient numbers of registered
17 nurses, medical records technicians or similarly qualified persons supported and
18 supervised by appropriate physicians to carry out its utilization review activities; and

19 (ii) Meet any applicable regulations the [Secretary]
20 COMMISSIONER adopts under this subtitle relating to the qualifications of private
21 review agents or the performance of utilization review.

22 (2) The [Secretary] COMMISSIONER shall deny a certificate to any
23 applicant that does not provide assurances satisfactory to the [Secretary]
24 COMMISSIONER that:

25 (i) The procedures and policies of the private review agent will
26 protect the confidentiality of medical records in accordance with applicable State and
27 federal laws; and

28 (ii) The private review agent will be accessible to patients and
29 providers 5 working days a week during normal business hours in this State.

30 (b) The [Secretary] COMMISSIONER may revoke a certificate if the holder
31 does not comply with performance assurances under this section, violates any
32 provision of this subtitle, or violates any regulation adopted under any provision of
33 this subtitle.

34 (c) (1) Before denying or revoking a certificate under this section, the
35 [Secretary] COMMISSIONER shall provide the applicant or certificate holder with
36 reasonable time to supply additional information demonstrating compliance with the
37 requirements of this subtitle and the opportunity to request a hearing.

1 (2) If an applicant or certificate holder requests a hearing, the
2 [Secretary] COMMISSIONER shall send a hearing notice by certified mail, return
3 receipt requested, at least 30 days before the hearing.

4 (3) The [Secretary] COMMISSIONER shall hold the hearing in
5 accordance with Title 10, Subtitle 2 of the State Government Article.

6 15-10B-12.

7 The [Secretary] COMMISSIONER may waive the requirements of this subtitle
8 for a private review agent that operates solely under contract with the federal
9 government for utilization review of patients eligible for hospital services under Title
10 XVIII of the Social Security Act.

11 15-10B-13.

12 The [Secretary] COMMISSIONER shall periodically provide a list of private
13 review agents issued certificates and the renewal date for those certificates to:

14 (1) The Maryland Chamber of Commerce;

15 (2) The Medical and Chirurgical Faculty of Maryland;

16 (3) The Maryland Hospital Association;

17 (4) All hospital utilization review programs; and

18 (5) Any other business or labor organization requesting the list.

19 15-10B-14.

20 The [Secretary] COMMISSIONER may establish reporting requirements to:

21 (1) Evaluate the effectiveness of private review agents; and

22 (2) Determine if the utilization review programs are in compliance with
23 the provisions of this section and applicable regulations.

24 15-10B-17.

25 (b) (1) In addition to the provisions of subsection (a) of this section, the
26 [Secretary] COMMISSIONER may impose an administrative penalty of up to $1,000
27 for a violation of any provision of this subtitle.

28 (2) The [Secretary] COMMISSIONER shall adopt regulations to provide
29 standards for the imposition of an administrative penalty under paragraph (1) of this
30 subsection.

1 15-10B-18.

2 (a) Any person aggrieved by a final decision of the [Secretary]
3 COMMISSIONER in a contested case under this subtitle may take a direct judicial
4 appeal.

5 SUBTITLE 10C. MEDICAL DIRECTORS.

6 15-10C-01.

7 (A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS
8 INDICATED.

9 (B) "CARRIER" MEANS:

10 (1) AN INSURER;

11 (2) A NONPROFIT HEALTH SERVICE PLAN;

12 (3) A HEALTH MAINTENANCE ORGANIZATION;

13 (4) A DENTAL PLAN ORGANIZATION; OR

14 (5) ANY OTHER PERSON THAT PROVIDES HEALTH BENEFIT PLANS
15 SUBJECT TO REGULATION BY THE STATE.

16 (C) "HEALTH CARE FACILITY" MEANS:

17 (1) A HOSPITAL AS DEFINED IN § 19-301 OF THE HEALTH - GENERAL
18 ARTICLE; OR

19 (2) AN AMBULATORY SURGICAL FACILITY AS DEFINED IN § 19-3B-01 OF
20 THE HEALTH - GENERAL ARTICLE.

21 (D) "HEALTH CARE SERVICE" MEANS ANY HEALTH OR MEDICAL PROCEDURE
22 OR SERVICE RENDERED BY A HEALTH CARE PROVIDER THAT:

23 (1) PROVIDES TESTING, DIAGNOSIS, OR TREATMENT OF A HUMAN
24 DISEASE OR DYSFUNCTION; OR

25 (2) DISPENSES DRUGS, MEDICAL DEVICES, MEDICAL APPLIANCES, OR
26 MEDICAL GOODS FOR THE TREATMENT OF A HUMAN DISEASE OR FUNCTION.

27 (E) "MEDICAL DIRECTOR" MEANS A PHYSICIAN WHO IS RESPONSIBLE FOR
28 ESTABLISHING OR SUPERVISING COMPLIANCE WITH PROTOCOLS OR PROCEDURES
29 USED IN THE HEALTH CARE SERVICE DELIVERY SYSTEM OF A CARRIER OR HEALTH
30 CARE FACILITY.

31 15-10C-02.

32 (A) THE COMMISSIONER SHALL:

1 (1) ESTABLISH AND ADOPT BY REGULATION STANDARDS FOR:

2 (I) THE CERTIFICATION OF MEDICAL DIRECTORS; AND

3 (II) THE RENEWAL, SUSPENSION, AND REVOCATION OF A
4 CERTIFICATE; AND

5 (2) PROVIDE ONGOING OVERSIGHT OF MEDICAL DIRECTORS TO ENSURE
6 COMPLIANCE WITH THIS SUBTITLE AND THE STANDARDS ESTABLISHED AND
7 ADOPTED UNDER THIS SUBTITLE.

8 (B) AS PART OF THE STANDARDS ESTABLISHED AND ADOPTED UNDER
9 SUBSECTION (A)(1) OF THIS SECTION, THE COMMISSIONER MAY ADOPT BY
10 REGULATION SEPARATE CERTIFICATION STANDARDS FOR A MEDICAL DIRECTOR OF
11 A HOSPITAL, A MEDICAL DIRECTOR OF AN AMBULATORY SURGICAL FACILITY, AND A
12 MEDICAL DIRECTOR OF A CARRIER.

13 15-10C-03.

14 (A) TO BE CERTIFIED AS A MEDICAL DIRECTOR UNDER THIS SUBTITLE, AN
15 APPLICANT SHALL:

16 (1) SUBMIT AN APPLICATION TO THE COMMISSIONER ON THE FORM
17 REQUIRED BY THE COMMISSIONER; AND

18 (2) PAY TO THE COMMISSIONER THE APPLICATION FEE SET BY THE
19 COMMISSIONER BY REGULATION.

20 (B) THE APPLICATION SHALL INCLUDE:

21 (1) A DESCRIPTION OF THE APPLICANT'S PROFESSIONAL
22 QUALIFICATIONS, INCLUDING MEDICAL EDUCATION INFORMATION, BOARD
23 CERTIFICATIONS, AND LICENSURE STATUS;

24 (2) IF APPLICABLE, A DESCRIPTION OF THE AREAS OF EXPERTISE OF
25 THE APPLICANT;

26 (3) THE PROTOCOLS OR PROCEDURES TO BE USED IN THE HEALTH CARE
27 SERVICE DELIVERY SYSTEM OF A CARRIER OR HEALTH CARE FACILITY THAT THE
28 APPLICANT HAS ESTABLISHED OR IS RESPONSIBLE FOR ENSURING COMPLIANCE;
29 AND

30 (4) ANY OTHER INFORMATION THE COMMISSIONER CONSIDERS
31 NECESSARY.

32 (C) (1) EACH YEAR, AN INDIVIDUAL CERTIFIED AS A MEDICAL DIRECTOR
33 UNDER THIS SUBTITLE SHALL SUBMIT THE INFORMATION REQUIRED UNDER
34 SUBSECTION (B) OF THIS SECTION.

35 (2) IF AT ANY TIME THERE IS A MATERIAL CHANGE IN THE
36 INFORMATION INCLUDED IN THE APPLICATION UNDER SUBSECTION (B) OF THIS

1 SECTION, THE MEDICAL DIRECTOR SHALL SUBMIT UPDATED INFORMATION TO THE
2 COMMISSIONER.

3 (D) IN CONJUNCTION WITH THE APPLICATION SUBMITTED UNDER
4 SUBSECTION (B) OF THIS SECTION, A MEDICAL DIRECTOR SHALL SUBMIT
5 INFORMATION THAT INCLUDES:

6 (1) THE POLICIES AND MECHANISMS THAT ARE TO BE USED BY THE
7 MEDICAL DIRECTOR WHEN ESTABLISHING OR SUPERVISING COMPLIANCE WITH THE
8 PROTOCOLS OR PROCEDURES TO BE USED IN THE HEALTH CARE SERVICE DELIVERY
9 SYSTEM OF A CARRIER OR HEALTH CARE FACILITY; AND

10 (2) THE CERTIFICATION BY THE MEDICAL DIRECTOR THAT THE
11 PROTOCOLS OR PROCEDURES ESTABLISHED OR FOR WHICH THE MEDICAL DIRECTOR
12 HAS RESPONSIBILITY FOR SUPERVISING COMPLIANCE WITH ARE:

13 (I) OBJECTIVE;

14 (II) CLINICALLY VALID;

15 (III) COMPATIBLE WITH ESTABLISHED PRINCIPLES OF HEALTH
16 CARE SERVICE DELIVERY; AND

17 (IV) FLEXIBLE ENOUGH TO ALLOW DEVIATIONS FROM THE NORMS
18 WHEN JUSTIFIED ON A CASE BY CASE BASIS.

19 (E) TO ENSURE THE VALIDITY OF THE INFORMATION PROVIDED TO THE
20 COMMISSIONER UNDER SUBSECTION (D)(2) OF THIS SECTION, THE COMMISSIONER
21 MAY CONTRACT WITH A THIRD PARTY THAT HAS THE NECESSARY MEDICAL
22 EXPERTISE TO DETERMINE VALIDITY OF THE INFORMATION.

23 27-304.

24 It is an unfair claim settlement practice and a violation of this subtitle for an
25 insurer or nonprofit health service plan, when committed with the frequency to
26 indicate a general business practice, to:

27 (1) misrepresent pertinent facts or policy provisions that relate to the
28 claim or coverage at issue;

29 (2) fail to acknowledge and act with reasonable promptness on
30 communications about claims that arise under policies;

31 (3) fail to adopt and implement reasonable standards for the prompt
32 investigation of claims that arise under policies;

33 (4) refuse to pay a claim without conducting a reasonable investigation
34 based on all available information;

35 (5) fail to affirm or deny coverage of claims within a reasonable time
36 after proof of loss statements have been completed;

1 (6) fail to make a prompt, fair, and equitable good faith attempt, to settle
2 claims for which liability has become reasonably clear;

3 (7) compel insureds to institute litigation to recover amounts due under
4 policies by offering substantially less than the amounts ultimately recovered in
5 actions brought by the insureds;

6 (8) attempt to settle a claim for less than the amount to which a
7 reasonable person would expect to be entitled after studying written or printed
8 advertising material accompanying, or made part of, an application;

9 (9) attempt to settle a claim based on an application that is altered
10 without notice to, or the knowledge or consent of, the insured;

11 (10) fail to include with each claim paid to an insured or beneficiary a
12 statement of the coverage under which the payment is being made;

13 (11) make known to insureds or claimants a policy of appealing from
14 arbitration awards in order to compel insureds or claimants to accept a settlement or
15 compromise less than the amount awarded in arbitration;

16 (12) delay an investigation or payment of a claim by requiring a claimant
17 or a claimant's licensed health care provider to submit a preliminary claim report and
18 subsequently to submit formal proof of loss forms that contain substantially the same
19 information;

20 (13) fail to settle a claim promptly whenever liability is reasonably clear
21 under one part of a policy, in order to influence settlements under other parts of the
22 policy;

23 (14) fail to provide promptly a reasonable explanation of the basis for
24 denial of a claim or the offer of a compromise settlement; [or]

25 (15) fail to meet the requirements of Title 19, Subtitle 13 of the Health -
26 General Article for preauthorization for a health care service; OR

27 (16) FAIL TO COMPLY WITH THE PROVISIONS OF TITLE 15, SUBTITLE 10A
28 OF THIS ARTICLE.

29 SECTION 3. AND BE IT FURTHER ENACTED, That the Health Education
30 and Advocacy Unit in the Division of Consumer Protection of the Office of the
31 Attorney General and the Maryland Insurance Commissioner shall enter into a
32 Memorandum of Understanding on or before October 1, 1998, with respect to
33 provisions enacted by Section 2 of this Act regarding: (1) the format and contents of
34 the annual report required under § 15-10A-08 of the Insurance Article; and (2)
35 funding from the Maryland Insurance Administration for the activities of the Health
36 Education and Advocacy Unit required under §§ 15-10A-02, 15-10A-07, and
37 15-10A-08 of the Insurance Article.

1 SECTION 4. AND BE IT FURTHER ENACTED, That the Health Education
2 and Advocacy Unit, in conjunction with other affected State government agencies,
3 shall study and make recommendations to the Legislative Policy Committee, the
4 Senate Finance Committee, the House Economic Matters Committee, and the House
5 Environmental Matters Committee by October 1, 1999, about the feasibility and
6 advisability of requiring all carriers to have a uniform internal grievance review
7 process for members in accordance with regulations adopted by the Maryland
8 Insurance Commissioner.

9 SECTION 5. AND BE IT FURTHER ENACTED, That the Maryland Insurance
10 Administration, as part of the annual report required under § 15-10A-06 of the
11 Insurance Article, shall report the number of complaints filed against carriers related
12 to a hospital length of stay or a requirement to have a service performed on an
13 outpatient basis, and the extent to which the complaints are related to a certain
14 clinical practice guideline.

15 SECTION 6. AND BE IT FURTHER ENACTED, That Section 3 of this Act shall
16 take effect June 1, 1998.

17 SECTION 7. AND BE IT FURTHER ENACTED, That Section 5 of this Act shall
18 remain in effect for a period of 2 years and, at the end of December 31, 2001, with no
19 further action required by the General Assembly, Section 5 of this Act shall be
20 abrogated and of no further force and effect.

21 SECTION 8. AND BE IT FURTHER ENACTED, That, except as provided in
22 Section 6 of this Act, this Act shall take effect January 1, 1999.