HOUSE BILL 3

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(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~~ Workman, DeCarlo, McHale, Miller, Valderrama, Gordon, Kach, McClenahan, Eckardt, Boston, Exum, Kirk, Pendergrass, Mohorovic, D. Davis, Ciliberti, Stup, Elliott, Stull, ~~and Klausmeier~~ Klausmeier, and Snodgrass**

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

Committee Report: Favorable with amendments
House action: Adopted with floor amendments
Read second time: February 24, 1998

CHAPTER_____

AN ACT concerning

Health Insurance - Complaint Process for Adverse Decisions and Grievances

FOR the purpose of requiring a carrier to establish a certain internal grievance process for its members; requiring a carrier to file a copy of its internal grievance process with the Maryland Insurance Commissioner and the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General; requiring a carrier to provide certain information about the internal grievance process to a member under certain circumstances; requiring a carrier to send a member or certain other individuals written notice of an adverse decision or grievance decision under certain circumstances; specifying the contents of the notice; requiring that certain information related to the internal grievance process be included in a policy, certificate, enrollment materials, or other evidence of coverage a carrier provides to a member; specifying that a carrier has the burden of persuasion that its grievance decision or adverse decision is correct during a certain review by the Commissioner;

authorizing the Commissioner to seek and receive certain advice from an independent review organization or certain other individuals under certain circumstances; requiring the Commissioner to make a final decision on all complaints filed that are within the Commissioner's jurisdiction; authorizing the Commissioner to issue certain orders under certain circumstances; requiring certain carriers to provide certain requested information to the Unit and the Commissioner within a certain time under certain circumstances; establishing a certain health care ~~complaint fee~~ regulatory assessment; transferring the responsibility for receiving complaints on health maintenance organizations from the Department of Health and Mental Hygiene to the Commissioner; requiring the Secretary of Health and Mental Hygiene to submit certain reports to the Commissioner concerning the investigation of certain complaints; requiring the Commissioner to adopt regulations; altering certain penalties; requiring certain persons to prepare and publish certain annual reports; providing that the failure of an insurer or nonprofit health service plan to satisfy the provisions of this Act is an unfair claim settlement practice; transferring the administrative and enforcement responsibility for private review agents to the Insurance Commissioner; altering certain provisions of law related to utilization review concerning the types of health care providers that may make an adverse determination or make a determination in the appeal of an adverse determination; requiring certain individuals to obtain a certification from the Commissioner in order to perform their responsibilities as a medical director for ~~certain persons~~ a health maintenance organization; requiring the Commissioner to adopt certain regulations related to the certification of medical directors; requiring a medical director of a health maintenance organization to be a physician licensed in this State and be certified in accordance with this Act; requiring the Health Education and Advocacy Unit and the Commissioner to enter into a certain Memorandum of Understanding by a certain date; requiring the Health Education and Advocacy Unit to make certain recommendations to certain committees of the General Assembly by a certain date; providing for the accurate codification of provisions of this Act; providing for the delayed effective date of certain provisions of this Act; providing for the termination of certain provisions of this Act; altering certain definitions; defining certain terms; and generally relating to a carrier's internal grievance process for members.

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

(1997 Volume)

BY repealing and reenacting, with amendments,
Article - Commercial Law
Section 13-4A-02(b)
Annotated Code of Maryland
(1990 Replacement Volume and 1997 Supplement)

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

BY adding to
Article - Health - General
Section ~~19-706(y)~~ 19-706(y) and (z)
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)

BY repealing and reenacting, without amendments,
Article - Health - General
Section 19-728
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section ~~19-729~~ 19-705.2, 19-708, 19-729, and 19-730
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
~~Section 15-1001 and 27-304~~ Section ~~4-113(d) and (e),~~ 15-112(e) and (g), 15-1001, 27-303, ~~27-304, and 27-305(a),~~ and 27-304
Annotated Code of Maryland
(1997 Volume)

BY adding to
Article - Insurance
Section 2-112.2; 15-10A-01 through 15-10A-09, inclusive, to be under the new subtitle "Subtitle 10A. Complaint Process for Adverse Decisions or Grievances"; and 15-10C-01 through ~~15-10C-03~~ 15-10C-04, inclusive, to

be under the new subtitle "Subtitle 10C. Medical Directors"
Annotated Code of Maryland
(1997 Volume)

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

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

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

Article - Commercial Law

13-4A-02.

(b) (1) (I) The Unit may assist health care consumers in understanding their health care bills and third party coverage, in identifying improper billing or coverage determinations, and in reporting any billing or coverage problems to appropriate entities, including the Division, the Attorney General or other governmental agencies, insurers, or providers.

(II) WHENEVER THE UNIT REQUESTS INFORMATION FROM AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION IN ORDER TO ASSIST A HEALTH CARE CONSUMER FOR THE PURPOSES PROVIDED IN THIS PARAGRAPH, THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION SHALL PROVIDE THE INFORMATION TO THE UNIT NO LATER THAN 7 WORKING DAYS FROM THE DATE THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION RECEIVED THE REQUEST.

(2) Whenever any billing or coverage question concerns the adequacy or propriety of any services or treatment, the Unit shall refer the matter to an appropriate professional, licensing, or disciplinary body, as applicable. The Unit may

monitor the progress of the concerns raised by health consumers through such referrals.

(3) Whenever any billing or coverage question concerns a matter within the jurisdiction of the Insurance Commissioner, the Unit shall refer the matter to the Commissioner. The Unit may monitor the progress of the concerns raised by health consumers through such referrals.

(4) The Unit shall work with the Department of Health and Mental Hygiene to assist with resolving any billing or coverage questions as necessary.

13-4A-04.

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

Article - Health - General

19-705.2.

(a) With the advice of the [Commissioner] SECRETARY, the [Secretary] COMMISSIONER shall adopt regulations to establish a system for the receipt and timely investigation of complaints of members and subscribers of health maintenance organizations concerning the operation of any health maintenance organization in this State.

(b) The complaint system shall include:

(1) A procedure for the timely acknowledgement of receipt of a complaint;

(2) Criteria THAT THE SECRETARY SHALL ADOPT BY REGULATION for determining the appropriate level of investigation for a complaint concerning quality of care, including:

(i) A determination as to whether the member or subscriber with the complaint previously attempted to have the complaint resolved; and

(ii) A determination as to whether a complaint should be sent to the member's or subscriber's health maintenance organization for resolution prior to investigation under the provisions of this section; and

(3) A procedure for the referral OF QUALITY OF CARE COMPLAINTS to the [Commissioner] SECRETARY [of all complaints, other than quality of care complaints,] for an appropriate investigation.

(c) If a determination is made to investigate a complaint under the provisions of this section prior to the member or subscriber attempting to otherwise resolve the complaint, the reasons for that determination shall be documented.

(d) Notice of the complaint system established under the provisions of this section shall be included in all contracts between a health maintenance organization and a member or subscriber of a health maintenance organization.

(E) FOR QUALITY OF CARE COMPLAINTS REFERRED TO THE SECRETARY FOR INVESTIGATION UNDER SUBSECTION (B)(3) OF THIS SECTION, THE SECRETARY SHALL REPORT TO THE COMMISSIONER IN A TIMELY MANNER ON THE RESULTS AND FINDINGS OF EACH INVESTIGATION.

19-706.

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

(Z) THE PROVISIONS OF § 2-112.2 OF THE INSURANCE ARTICLE SHALL APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

19-708.

(b) The application shall include or be accompanied by:

(1) A copy of the basic health maintenance organizational document and any amendments to it that, where applicable, are certified by the Department of Assessments and Taxation;

(2) A copy of the bylaws of the health maintenance organization, if any, that are certified by the appropriate officer;

(3) A list of the individuals who are to be responsible for the conduct of the affairs of the health maintenance organization, including all members of the governing body, the officers and directors if it is a corporation, and the partners or associates if it is a partnership or association;

(4) The addresses of those individuals and their official capacity with the health maintenance organization;

(5) A statement by each individual referred to in item (3) of this subsection that fully discloses the extent and nature of any contract or arrangement between the individual and the health maintenance organization and any possible conflict of interest;

(6) A resume of the qualifications of:

(i) The administrator;

(ii) The medical director, WHO SHALL BE A PHYSICIAN LICENSED IN THIS STATE AND CERTIFIED UNDER TITLE 15, SUBTITLE 10C OF THE INSURANCE ARTICLE;

(iii) The enrollment director; and

(iv) Any other individual who is associated with the health maintenance organization that the Commissioner and the Secretary request under their joint internal procedures;

(7) A statement that describes generally:

(i) The health maintenance organization, including:

1. Its operations;

2. Its enrollment process;

3. Its quality assurance mechanism; and

4. Its internal grievance procedures;

(ii) The methods the health maintenance organization proposes to use to offer its members and public representatives an opportunity to participate in matters of policy and operation;

(iii) The location of the facilities where health care services will be available regularly to members;

(iv) The type and specialty of physicians and health care personnel who are engaged to provide health care services;

(v) The number of physicians and personnel in each category; and

(vi) The health and medical records system to provide documentation of use by members;

(8) The form of each contract that the health maintenance organization proposes to offer to subscribers showing the benefits to which they are entitled and a table of the rates charged or proposed to be charged for each form of contract;

(9) A statement that describes with reasonable certainty each geographic area to be served by the health maintenance organization;

(10) A statement of the financial condition of the health maintenance organization, including:

(i) Sources of financial support;

(ii) A balance sheet showing assets, liabilities, and minimum tangible net worth; and

(iii) Any other financial information the Commissioner requires for adequate financial evaluation;

(11) Copies of any proposed advertising and proposed techniques and methods of selling the services of the health maintenance organization;

(12) A power of attorney that is executed by the health maintenance organization appointing the Commissioner as agent of the organization in this State to accept service of process in any action, proceeding, or cause of action arising in this State against the health maintenance organization; and

(13) Copies of the agreements proposed to be made between the health maintenance organizations and providers of health care services.

19-728.

(a) If, as to a matter that is within the jurisdiction of the Department under this subtitle, the Secretary finds that a health maintenance organization does not meet the requirements of this subtitle or the rules and regulations adopted under it and cannot or will not make corrective changes or new arrangements to meet these requirements, the Secretary may send to the Commissioner a written directive that sets out the findings of the Secretary and reasons for them and directs the Commissioner to suspend or revoke the certificate of authority of the health maintenance organization or to take any other appropriate action that the Secretary specifies. The Commissioner shall comply with the directive.

(b) The Commissioner is responsible for:

(1) Determining whether each health maintenance organization is or will be able to provide a fiscally sound operation and adequate provision against risk of insolvency and may adopt reasonable rules and regulations designed to achieve this goal; and

(2) Actuarial and financial evaluations and determinations of each health maintenance organization.

(c) (1) If the Commissioner determines that a health maintenance organization is not operating in a fiscally sound manner, the Commissioner shall notify the Department of the determination.

(2) After notifying the Department in accordance with the provisions of paragraph (1) of this subsection, the Commissioner shall monitor the health maintenance organization on a continuous basis until the Commissioner determines that the health maintenance organization is operating in a fiscally sound manner.

19-729.

(a) A health maintenance organization may not:

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

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

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

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

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

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

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

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

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

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

(11) FAIL TO COMPLY WITH ~~THE PROVISIONS OF TITLE 15, SUBTITLE 10A~~ § 15-10A-02(B) OR (E) OR § 15-10A-04(C) OF THE INSURANCE ARTICLE.

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

19-730.

If any person violates any provision of § 19-729 of this subtitle, the Commissioner may:

(1) Issue an administrative order that requires the health maintenance organization to:

(i) Cease inappropriate conduct or practices by it or any of the personnel employed or associated with it;

(ii) Fulfill its contractual obligations;

(iii) Provide a service that has been denied improperly;

(iv) Take appropriate steps to restore its ability to provide a service that is provided under a contract;

(v) Cease the enrollment of any additional enrollees except newborn children or other newly acquired dependents or existing enrollees; or

(vi) Cease any advertising or solicitation;

(2) Impose a penalty of not more than [$1,000] $5,000 for each unlawful act committed;

(3) Suspend or revoke the certificate of authority to do business as a health maintenance organization; or

(4) Apply to any court for legal or equitable relief considered appropriate by the Commissioner or the Department, in accordance with the joint internal procedures.

Article - Insurance

2-112.2.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "CARRIER" MEANS:

(I) AN INSURER;

(II) A NONPROFIT HEALTH SERVICE PLAN;

(III) A HEALTH MAINTENANCE ORGANIZATION;

(IV) A DENTAL PLAN ORGANIZATION; OR

(V) 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.

(3) (I) "PREMIUM" HAS THE MEANING STATED IN § 1-101 OF THIS ARTICLE TO THE EXTENT IT IS ALLOCABLE TO THIS STATE.

(II) "PREMIUM" INCLUDES ANY AMOUNTS PAID TO A HEALTH MAINTENANCE ORGANIZATION AS COMPENSATION FOR PROVIDING TO MEMBERS AND SUBSCRIBERS THE SERVICES SPECIFIED IN TITLE 19, SUBTITLE 7 OF THE HEALTH - GENERAL ARTICLE TO THE EXTENT IT IS ALLOCABLE TO THIS STATE.

(B) IN ADDITION TO THE FEES COLLECTED UNDER § 2-112 OF THIS SUBTITLE, THE COMMISSIONER SHALL COLLECT A HEALTH CARE ~~COMPLAINT FEE~~ REGULATORY ASSESSMENT FROM EACH CARRIER FOR THE COSTS ATTRIBUTABLE TO THE IMPLEMENTATION OF TITLE 15, SUBTITLES 10A, 10B, AND 10C OF THIS ARTICLE.

~~(C) THE HEALTH CARE COMPLAINT FEE SHALL BE CALCULATED BY DIVIDING THE GROSS DIRECT PREMIUMS WRITTEN BY THE CARRIER IN THE PRIOR CALENDAR YEAR BY THE TOTAL AMOUNT OF GROSS DIRECT PREMIUMS WRITTEN BY THE CARRIERS IN THE PRIOR CALENDAR YEAR.~~

(C) THE HEALTH CARE REGULATORY ASSESSMENT THAT IS PAYABLE BY EACH CARRIER SHALL BE CALCULATED BY TAKING THE TOTAL COSTS UNDER SUBSECTION (B) OF THIS SECTION MULTIPLIED BY THE PERCENTAGE OF GROSS DIRECT PREMIUMS WRITTEN IN THE STATE ATTRIBUTABLE TO THAT CARRIER IN THE PRIOR CALENDAR YEAR.

~~4-113.~~

~~(d) Instead of or in addition to suspending or revoking a certificate of authority, the Commissioner may:~~

~~(1) impose on the holder a penalty of not less than $100 but not exceeding [$50,000] $250,000 for each violation of this article; and~~

~~(2) require the holder to make restitution to any person who has suffered financial injury because of the violation of this article.~~

~~(e) The Commissioner shall adopt regulations TO ESTABLISH STANDARDS FOR THE IMPOSITION OF A PENALTY UNDER SUBSECTION (D) OF THIS SECTION AND to carry out the provisions of subsection (b) (11) of this section.~~

15-112.

(e) A carrier may not deny an application for participation or terminate participation on its provider panel on the basis of:

(1) gender, race, age, religion, national origin, or a protected category under the federal Americans with Disabilities Act;

(2) the type or number of appeals that the provider files under [Title 19, Subtitle 13 of the Health - General Article] SUBTITLE 10B OF THIS TITLE; [or]

(3) THE NUMBER OF GRIEVANCES OR COMPLAINTS THAT THE PROVIDER FILES ON BEHALF OF A PATIENT UNDER SUBTITLE 10A OF THIS TITLE; OR

[(3)] (4) the type or number of complaints or grievances that the provider files or requests for review under the carrier's internal review system established under subsection (h) of this section.

(g) A carrier may not terminate participation on its provider panel or otherwise penalize a provider for:

(1) advocating the interests of a patient through the carrier's internal review system established under subsection (h) of this section; [or]

(2) filing an appeal under [Title 19, Subtitle 13 of the Health - General Article] SUBTITLE 10B OF THIS TITLE; OR

(3) FILING A GRIEVANCE OR COMPLAINT ON BEHALF OF A PATIENT UNDER SUBTITLE 10A OF THIS TITLE.

15-1001.

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

(b) Each entity subject to this section shall:

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

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

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

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

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

15-10A-01.

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

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

(1) IS OR WAS NOT MEDICALLY NECESSARY<u>, APPROPRIATE, OR EFFICIENT</u>; AND

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

(C) "CARRIER" MEANS:

(1) AN INSURER;

(2) A NONPROFIT HEALTH SERVICE PLAN;

(3) A HEALTH MAINTENANCE ORGANIZATION;

(4) A DENTAL PLAN ORGANIZATION; OR

(5) 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) "GRIEVANCE" MEANS A PROTEST FILED BY A MEMBER 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.

~~(E)~~ (F) "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.

~~(F)~~ (G) "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.

~~(G)~~ (H) "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.

~~(H)~~ (I) "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.

~~(I)~~ (J) (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.

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

15-10A-02.

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

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

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

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

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

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

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

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

(3) FOR PURPOSES OF USING THE EXPEDITED PROCEDURE FOR AN EMERGENCY CASE THAT A CARRIER IS REQUIRED TO INCLUDE UNDER PARAGRAPH (2)(I) OF THIS SUBSECTION, THE COMMISSIONER SHALL DEFINE BY REGULATION THE STANDARDS REQUIRED FOR A GRIEVANCE TO BE CONSIDERED AN EMERGENCY CASE.

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

(D) (1) (I) A MEMBER OR A HEALTH CARE PROVIDER FILING A COMPLAINT ON BEHALF OF A MEMBER MAY FILE A COMPLAINT WITH THE

COMMISSIONER WITHOUT FIRST FILING A GRIEVANCE WITH A CARRIER AND RECEIVING A FINAL DECISION ON THE GRIEVANCE IF THE MEMBER OR THE HEALTH CARE PROVIDER PROVIDES SUFFICIENT INFORMATION AND SUPPORTING DOCUMENTATION IN THE COMPLAINT THAT DEMONSTRATES A COMPELLING REASON TO DO SO.

(II) THE COMMISSIONER SHALL DEFINE BY REGULATION THE STANDARDS THAT THE COMMISSIONER SHALL USE TO DECIDE WHAT DEMONSTRATES A COMPELLING REASON UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH.

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

(3) WHENEVER THE COMMISSIONER RECEIVES A COMPLAINT UNDER PARAGRAPH (1) OR (2) OF THIS SUBSECTION, THE COMMISSIONER SHALL NOTIFY THE CARRIER THAT IS THE SUBJECT OF THE COMPLAINT WITHIN 5 WORKING DAYS AFTER THE DATE THE COMPLAINT IS FILED WITH THE COMMISSIONER.

(E) EACH CARRIER SHALL:

(1) FILE FOR REVIEW WITH THE COMMISSIONER AND SUBMIT TO THE HEALTH ADVOCACY UNIT A COPY OF ITS INTERNAL GRIEVANCE PROCESS ESTABLISHED UNDER THIS SUBTITLE; AND

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

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

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

(2) INFORMATION STATING THAT:

(I) THE HEALTH ADVOCACY UNIT:

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

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

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

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

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

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

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

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

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

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

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

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

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

(II) WITHIN ~~2~~ 5 WORKING DAYS AFTER THE DECISION HAS BEEN MADE, SEND NOTICE OF THE ADVERSE DECISION OR GRIEVANCE DECISION TO:

1. THE MEMBER; AND

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

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

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

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

(III) STATE THE NAME, BUSINESS ADDRESS, AND BUSINESS TELEPHONE NUMBER OF THE PHYSICIAN THAT MADE THE ADVERSE DECISION OR GRIEVANCE DECISION;

(IV) BE SIGNED BY THE MEDICAL DIRECTOR IF THE CARRIER IS A HEALTH MAINTENANCE ORGANIZATION OR A DESIGNATED OFFICER OF THE CARRIER IF THE CARRIER IS NOT A HEALTH MAINTENANCE ORGANIZATION; AND

~~(III)~~ (V) INCLUDE THE FOLLOWING INFORMATION:

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

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

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

(3) A CARRIER MAY NOT USE IN A NOTICE SENT UNDER PARAGRAPH (1) OF THIS SUBSECTION GENERALIZED TERMS SUCH AS "EXPERIMENTAL PROCEDURE NOT COVERED", "COSMETIC PROCEDURE NOT COVERED", "SERVICE INCLUDED UNDER ANOTHER PROCEDURE", OR "NOT MEDICALLY NECESSARY" TO SATISFY THE REQUIREMENTS OF PARAGRAPH (2)(I) OR (II) OF THIS SUBSECTION.

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

(I) THE MEMBER; AND

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

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

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

15-10A-03.

(A) (1) WITHIN 30 DAYS AFTER THE DATE OF RECEIPT OF A GRIEVANCE DECISION, A MEMBER OR A HEALTH CARE PROVIDER, WHO FILED THE GRIEVANCE ON BEHALF OF THE MEMBER UNDER § 15-10A-02(B)(2)(III) OF THIS SUBTITLE, MAY FILE A COMPLAINT WITH THE COMMISSIONER FOR REVIEW OF THE GRIEVANCE DECISION.

(2) WHENEVER THE COMMISSIONER RECEIVES A COMPLAINT UNDER THIS SUBSECTION, THE COMMISSIONER SHALL NOTIFY THE CARRIER THAT IS THE SUBJECT OF THE COMPLAINT WITHIN 5 WORKING DAYS AFTER THE DATE THE COMPLAINT IS FILED WITH THE COMMISSIONER.

(3) EXCEPT FOR AN EMERGENCY CASE UNDER ~~SUBSECTION (B)(2)~~ SUBSECTION (B)(1)(II) OF THIS SECTION, THE CARRIER THAT IS THE SUBJECT OF A COMPLAINT FILED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL PROVIDE TO THE COMMISSIONER ANY INFORMATION REQUESTED BY THE COMMISSIONER NO LATER THAN 7 WORKING DAYS FROM THE DATE THE CARRIER RECEIVES THE REQUEST FOR INFORMATION.

(B) (1) IN DEVELOPING PROCEDURES TO BE USED IN REVIEWING AND DECIDING COMPLAINTS, THE COMMISSIONER SHALL:

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

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

(2) FOR PURPOSES OF USING THE EXPEDITED PROCEDURE FOR AN EMERGENCY CASE UNDER PARAGRAPH (1)(II) OF THIS SUBSECTION, THE COMMISSIONER SHALL DEFINE BY REGULATION THE STANDARDS REQUIRED FOR A GRIEVANCE TO BE CONSIDERED AN EMERGENCY CASE.

(C) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION AND EXCEPT FOR AN EMERGENCY CASE UNDER ~~SUBSECTION (B)(2)~~ SUBSECTION (B)(1)(II)

OF THIS SECTION, THE COMMISSIONER SHALL MAKE A FINAL DECISION ON A COMPLAINT WITHIN 30 WORKING DAYS AFTER THE COMPLAINT IS FILED.

(2) ONLY IF THE COMMISSIONER LACKS SUFFICIENT INFORMATION TO RENDER A FINAL DECISION ON A COMPLAINT WITHIN THE 30-DAY PERIOD REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION MAY THE COMMISSIONER EXTEND THE PERIOD IN WHICH A FINAL DECISION SHALL BE MADE UNDER PARAGRAPH (1) OF THIS SUBSECTION FOR UP TO 30 ADDITIONAL WORKING DAYS.

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

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

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

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

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

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

(II) THE COMMISSIONER MAY ALLOW A CARRIER, A MEMBER, OR A HEALTH CARE PROVIDER FILING A COMPLAINT ON BEHALF OF A MEMBER TO PROVIDE ADDITIONAL INFORMATION AS MAY BE RELEVANT FOR THE COMMISSIONER TO MAKE A FINAL DECISION ON THE COMPLAINT.

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

15-10A-04.

(A) THE COMMISSIONER SHALL:

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

(2) PROVIDE NOTICE IN WRITING TO ALL PARTIES TO A COMPLAINT OF THE OPPORTUNITY AND TIME PERIOD FOR REQUESTING A HEARING TO BE HELD IN ACCORDANCE WITH ~~TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE TO CONTEST A FINAL DECISION OF THE COMMISSIONER MADE AND ISSUED UNDER THIS SUBTITLE~~ § 2-210 OF THIS ARTICLE.

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

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

~~(C) IF THE COMMISSIONER DETERMINES THAT A GRIEVANCE DECISION OR ADVERSE DECISION MADE BY A CARRIER IS IMPROPER, THE COMMISSIONER MAY ORDER THE CARRIER TO PAY OR PROVIDE REIMBURSEMENT FOR THE HEALTH CARE SERVICE TO THE MEMBER OR OTHER PERSON DESIGNATED BY THE MEMBER.~~

(C) (1) IT IS A VIOLATION OF THIS SUBTITLE FOR A CARRIER TO FAIL TO FULFILL THE CARRIER'S OBLIGATIONS TO PROVIDE OR REIMBURSE FOR HEALTH CARE SERVICES SPECIFIED IN THE CARRIER'S POLICIES OR CONTRACTS WITH MEMBERS.

(2) IF, IN RENDERING AN ADVERSE DECISION OR GRIEVANCE DECISION, A CARRIER FAILS TO FULFILL THE CARRIER'S OBLIGATIONS TO PROVIDE OR REIMBURSE FOR HEALTH CARE SERVICES SPECIFIED IN THE CARRIER'S POLICIES OR CONTRACTS WITH MEMBERS, THE COMMISSIONER MAY:

(I) ISSUE AN ADMINISTRATIVE ORDER THAT REQUIRES THE CARRIER TO:

1. CEASE INAPPROPRIATE CONDUCT OR PRACTICES BY THE CARRIER OR ANY OF THE PERSONNEL EMPLOYED OR ASSOCIATED WITH THE CARRIER;

2. FULFILL THE CARRIER'S CONTRACTUAL OBLIGATIONS;

3. PROVIDE A HEALTH CARE SERVICE OR PAYMENT THAT HAS BEEN DENIED IMPROPERLY; OR

4. TAKE APPROPRIATE STEPS TO RESTORE THE CARRIER'S ABILITY TO PROVIDE A HEALTH CARE SERVICE OR PAYMENT THAT IS PROVIDED UNDER A CONTRACT; OR

(II) IMPOSE ANY PENALTY OR FINE OR TAKE ANY ACTION AS AUTHORIZED:

1. FOR AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR DENTAL PLAN ORGANIZATION, UNDER THIS ARTICLE; OR

2. FOR A HEALTH MAINTENANCE ORGANIZATION, UNDER THE HEALTH - GENERAL ARTICLE.

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

15-10A-05.

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

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

(C) ANY EXPERT REVIEWER ASSIGNED BY AN INDEPENDENT REVIEW ORGANIZATION OR MEDICAL EXPERT SHALL BE A PHYSICIAN OR OTHER APPROPRIATE HEALTH CARE PROVIDER WHO MEETS THE FOLLOWING MINIMUM REQUIREMENTS:

(1) BE AN EXPERT IN THE TREATMENT OF THE MEMBER'S MEDICAL CONDITION, AND KNOWLEDGEABLE ABOUT THE RECOMMENDED HEALTH CARE SERVICE OR TREATMENT THROUGH ACTUAL CLINICAL EXPERIENCE;

(2) HOLD:

(I) A NONRESTRICTED LICENSE IN A STATE OF THE UNITED STATES; AND

(II) IN ADDITION, FOR PHYSICIANS, A CURRENT CERTIFICATION BY A RECOGNIZED AMERICAN MEDICAL SPECIALTY BOARD IN THE AREA OR AREAS APPROPRIATE TO THE SUBJECT OF REVIEW; ~~AND~~

(3) HAVE NO HISTORY OF DISCIPLINARY ACTIONS OR SANCTIONS, INCLUDING, LOSS OF STAFF PRIVILEGES OR PARTICIPATION RESTRICTIONS THAT HAVE BEEN TAKEN OR ARE PENDING BY ANY HOSPITAL, GOVERNMENTAL AGENCY OR UNIT, OR REGULATORY BODY THAT THE COMMISSIONER, IN ACCORDANCE WITH REGULATIONS ADOPTED BY THE COMMISSIONER, CONSIDERS RELEVANT IN MEETING THE REQUIREMENTS OF THIS SUBSECTION; AND

(4) IN REVIEWING A COMPLAINT FOR THE COMMISSIONER UNDER THIS SECTION, USE THE STANDARD OF CARE THAT IS APPROPRIATE FOR THE GEOGRAPHIC AREA IN WHICH THE COMPLAINT ARISES.

(D) AN INDEPENDENT REVIEW ORGANIZATION MAY NOT BE A SUBSIDIARY OF, OR IN ANY WAY OWNED OR CONTROLLED BY, A HEALTH BENEFIT PLAN, OR A TRADE ASSOCIATION OF HEALTH BENEFIT PLANS OR A TRADE ASSOCIATION OF HEALTH CARE PROVIDERS.

(E) IN ADDITION TO SUBSECTION (D) OF THIS SECTION, TO BE INCLUDED ON THE LIST COMPILED UNDER SUBSECTION (B) OF THIS SECTION, AN INDEPENDENT REVIEW ORGANIZATION SHALL SUBMIT TO THE COMMISSIONER THE FOLLOWING INFORMATION:

(1) IF THE INDEPENDENT REVIEW ORGANIZATION IS A PUBLICLY HELD ORGANIZATION, THE NAMES OF ALL STOCKHOLDERS AND OWNERS OF MORE THAN 5% OF ANY STOCK OR OPTIONS OF THE INDEPENDENT REVIEW ORGANIZATION;

(2) THE NAMES OF ALL HOLDERS OF BONDS OR NOTES IN EXCESS OF $100,000, IF ANY;

(3) THE NAMES OF ALL CORPORATIONS AND ORGANIZATIONS THAT THE INDEPENDENT REVIEW ORGANIZATION CONTROLS OR IS AFFILIATED WITH, AND THE NATURE AND EXTENT OF ANY OWNERSHIP OR CONTROL, INCLUDING THE AFFILIATED ORGANIZATION'S TYPE OF BUSINESS; AND

(4) THE NAMES OF ALL DIRECTORS, OFFICERS, AND EXECUTIVES OF THE INDEPENDENT REVIEW ORGANIZATION AS WELL AS A STATEMENT REGARDING ANY RELATIONSHIPS THE DIRECTORS, OFFICERS, AND EXECUTIVES MAY HAVE WITH ANY CARRIER OR HEALTH CARE PROVIDER GROUP.

(F) NEITHER AN EXPERT REVIEWER ASSIGNED BY THE INDEPENDENT REVIEW ORGANIZATION NOR THE INDEPENDENT REVIEW ORGANIZATION NOR MEDICAL EXPERT SELECTED BY THE COMMISSIONER UNDER THIS SECTION MAY

HAVE A MATERIAL PROFESSIONAL, FAMILIAL, OR FINANCIAL CONFLICT OF INTEREST WITH ANY OF THE FOLLOWING:

(1) THE CARRIER THAT IS THE SUBJECT OF THE COMPLAINT;

(2) ANY OFFICER, DIRECTOR, OR MANAGEMENT EMPLOYEE OF THE CARRIER THAT IS THE SUBJECT OF THE COMPLAINT;

(3) THE HEALTH CARE PROVIDER, THE HEALTH CARE PROVIDER'S MEDICAL GROUP, OR THE INDEPENDENT PRACTICE ASSOCIATION THAT RENDERED OR IS PROPOSING TO RENDER THE HEALTH CARE SERVICE THAT IS UNDER REVIEW;

(4) THE HEALTH CARE FACILITY AT WHICH THE HEALTH CARE SERVICE WAS PROVIDED OR WILL BE PROVIDED; OR

(5) THE DEVELOPER OR MANUFACTURER OF THE PRINCIPAL DRUG, DEVICE, PROCEDURE, OR OTHER THERAPY THAT IS BEING PROPOSED FOR THE MEMBER.

(G) FOR ANY INDEPENDENT REVIEW ORGANIZATION SELECTED BY THE COMMISSIONER UNDER SUBSECTION (A) OF THIS SECTION, THE INDEPENDENT REVIEW ORGANIZATION SHALL HAVE A QUALITY ASSURANCE MECHANISM IN PLACE THAT ENSURES:

(1) THE TIMELINESS AND QUALITY OF THE REVIEWS;

(2) THE QUALIFICATIONS AND INDEPENDENCE OF THE EXPERT REVIEWERS; AND

(3) THE CONFIDENTIALITY OF MEDICAL RECORDS AND REVIEW MATERIALS.

~~(C)~~ (H) (1) THE CARRIER THAT IS THE SUBJECT OF THE COMPLAINT SHALL BE RESPONSIBLE FOR PAYING THE REASONABLE EXPENSES OF THE INDEPENDENT REVIEW ORGANIZATION OR MEDICAL EXPERT SELECTED BY THE COMMISSIONER IN ACCORDANCE WITH SUBSECTION (A) OF THIS SECTION.

~~(2) THE COMMISSIONER SHALL:~~

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

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

~~(3) THE CARRIER THAT IS THE SUBJECT OF A COMPLAINT MAY NOT PAY ANY PERSON ASSOCIATED WITH OR PART OF AN INDEPENDENT REVIEW ORGANIZATION THAT IS USED BY THE COMMISSIONER IN MAKING A FINAL DECISION ON THE COMPLAINT IN ACCORDANCE WITH SUBSECTION (A) OF THIS SECTION MAY~~

~~NOT ACCEPT ANY COMPENSATION FOR RENDERING A PROFESSIONAL JUDGMENT TO THE COMMISSIONER IN ADDITION TO THE EXPENSES PAID UNDER PARAGRAPH (1) OF THIS SUBSECTION.~~

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

(2) THE CARRIER THAT IS THE SUBJECT OF THE COMPLAINT MAY NOT PAY AND AN INDEPENDENT REVIEW ORGANIZATION OR MEDICAL EXPERT MAY NOT ACCEPT ANY COMPENSATION IN ADDITION TO THE PAYMENT FOR REASONABLE EXPENSES UNDER PARAGRAPH (1) OF THIS SUBSECTION.

15-10A-06.

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

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

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

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

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

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

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

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

(B) THE COMMISSIONER SHALL:

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

INFORMATION PROVIDED BY THE SECRETARY UNDER § 19-705.2(E) OF THE HEALTH - GENERAL ARTICLE; AND

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

(2) PROVIDE COPIES OF THE SUMMARY REPORT TO THE GOVERNOR AND, SUBJECT TO § 2-1246 OF THE STATE GOVERNMENT ARTICLE, TO THE GENERAL ASSEMBLY.

15-10A-07.

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

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

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

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

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

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

15-10A-08.

(A) ON OR BEFORE NOVEMBER 1, 1999, AND EACH NOVEMBER 1 THEREAFTER, THE HEALTH ADVOCACY UNIT SHALL PUBLISH AN ANNUAL SUMMARY REPORT AND PROVIDE COPIES OF THE REPORT TO THE ~~LEGISLATIVE POLICY COMMITTEE, THE SENATE FINANCE COMMITTEE, THE HOUSE ECONOMIC MATTERS COMMITTEE, AND THE HOUSE ENVIRONMENTAL MATTERS COMMITTEE~~ GOVERNOR AND, SUBJECT TO § 2-1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY.

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

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

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

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

15-10A-09.

THE COMMISSIONER SHALL ADOPT REGULATIONS TO CARRY OUT THIS SUBTITLE.

Subtitle 10B. Private Review Agents.

15-10B-01.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(F) "HEALTH CARE SERVICE" MEANS ANY HEALTH OR MEDICAL 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.

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

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

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

(i) A Maryland business entity; or

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

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

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

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

(i) Employed by the hospital; or

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

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

(1) 5 percent of the whole; or

(2) $5,000.

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

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

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

(j) "Commissioner" means the Insurance Commissioner.

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

15-10B-03.

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

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

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

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

[(e)] (D) (1) The [Secretary] COMMISSIONER, after consultation with [the Commissioner,] payors, including the Health Insurance Association of America, THE LEAGUE OF LIFE AND HEALTH INSURERS OF MARYLAND, and the Maryland Association of Health Maintenance Organizations, and providers of health care, including the Maryland Hospital Association, the Medical and Chirurgical Faculty of Maryland, and licensed or certified providers of treatment for a mental illness, emotional disorder, or a drug abuse or alcohol abuse disorder, shall adopt regulations to implement the provisions of this subtitle.

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

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

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

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

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

15-10B-04.

(a) An applicant for a certificate shall:

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

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

(b) The application shall:

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

(2) Be signed and verified by the applicant.

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

15-10B-05.

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

(1) A utilization review plan that includes:

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

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

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

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

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

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

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

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

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

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

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

(i) Objective;

(ii) Clinically valid;

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

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

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

(C) IT SHALL CONSTITUTE A VIOLATION OF THIS SUBTITLE IF THE COMMISSIONER, IN CONSULTATION WITH AN INDEPENDENT REVIEW ORGANIZATION, MEDICAL EXPERT, THE DEPARTMENT, OR OTHER APPROPRIATE ENTITY, DETERMINES THAT THE CRITERIA AND STANDARDS USED IN CONDUCTING UTILIZATION REVIEW ARE NOT:

(1) OBJECTIVE;

(2) CLINICALLY VALID;

(3) COMPATIBLE WITH ESTABLISHED PRINCIPLES OF HEALTH CARE; OR

(4) FLEXIBLE ENOUGH TO ALLOW DEVIATIONS FROM NORMS WHEN JUSTIFIED ON A CASE BY CASE BASIS.

15-10B-06.

(a) In this section, "utilization review" means a system for reviewing the appropriate and efficient allocation of health care resources and services given or proposed to be given to a patient or group of patients by a health care provider, including a hospital or an intermediate care facility described under § 8-403(e) of [this article] THE HEALTH - GENERAL ARTICLE.

(e) (1) In the event a patient or health care provider, including a physician, intermediate care facility described under § 8-403(e) of [this article] THE HEALTH - GENERAL ARTICLE, or hospital seeks reconsideration or appeal of an adverse decision by a private review agent, the final determination of the appeal of the adverse

decision shall be made based on the professional judgment of a physician, or a panel of other appropriate health care providers with at least 1 physician, selected by the private review agent who is:

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

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

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

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

(g) (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 drug abuse or alcohol abuse disorder:

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

15-10B-07.

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

(1) ~~All~~ EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, ALL adverse decisions shall be made by a physician or a panel of other appropriate health care providers with at least 1 physician on the panel.

(2) WHEN THE HEALTH CARE SERVICE UNDER REVIEW IS A DENTAL SERVICE, THE ADVERSE DECISION SHALL BE MADE BY A DENTIST OR A PANEL OF OTHER APPROPRIATE HEALTH CARE PROVIDERS WITH AT LEAST 1 DENTIST ON THE PANEL.

~~(2)~~ (3) In the event a patient or health care provider, including a physician, intermediate care facility described in § 8-403(e) of [this article] THE HEALTH - GENERAL ARTICLE, or hospital seeks reconsideration or appeal of an adverse decision by a private review agent, the final determination of the appeal of the adverse decision shall be made based on the professional judgment of ~~a~~:

(I) A physician or a panel of other appropriate health care providers with at least 1 physician on the panel WHO IS BOARD CERTIFIED OR ELIGIBLE IN THE SAME SPECIALITY AS THE TREATMENT UNDER REVIEW; OR

(II) WHEN THE ADVERSE DECISION INVOLVES A DENTAL SERVICE, A DENTIST OR A PANEL OF APPROPRIATE HEALTH CARE PROVIDERS WITH AT LEAST 1 DENTIST ON THE PANEL WHO IS A DENTIST LICENSED IN THIS STATE AND WHO IS BOARD CERTIFIED OR ELIGIBLE IN THE SAME SPECIALTY AS THE DENTIST PROVIDING THE SERVICE UNDER REVIEW.

~~(3)~~ (4) In the event a patient or health care provider, including a physician, intermediate care facility described in § 8-403(e) of [this article] THE HEALTH - GENERAL ARTICLE, or hospital seeks reconsideration or appeal of an adverse decision by a private review agent, the final determination of the appeal of the adverse decision shall:

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

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

15-10B-09.

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

15-10B-10.

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

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

(1) Otherwise is entitled to the certificate;

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

(3) Submits to the [Secretary] COMMISSIONER:

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

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

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

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

15-10B-11.

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

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

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

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

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

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

(b) The [Secretary] COMMISSIONER may revoke a certificate if the holder does not comply with performance assurances under this section, violates any

provision of this subtitle, or violates any regulation adopted under any provision of this subtitle.

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

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

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

15-10B-12.

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

15-10B-13.

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

~~(1) The Maryland Chamber of Commerce;~~

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

~~(3) The Maryland Hospital Association;~~

~~(4) All hospital utilization review programs; and~~

~~(5) Any other business or labor organization requesting the list~~ ANY PERSON ON REQUEST.

15-10B-14.

The [Secretary] COMMISSIONER may establish reporting requirements to:

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

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

15-10B-17.

(b) (1) In addition to the provisions of subsection (a) of this section, the [Secretary] COMMISSIONER may impose an administrative penalty of up to ~~$1,000~~ $5,000 for a violation of any provision of this subtitle.

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

15-10B-18.

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

~~SUBTITLE 10C. MEDICAL DIRECTORS.~~

~~15-10C-01.~~

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

~~(B) "CARRIER" MEANS:~~

~~(1) AN INSURER;~~

~~(2) A NONPROFIT HEALTH SERVICE PLAN;~~

~~(3) A HEALTH MAINTENANCE ORGANIZATION;~~

~~(4) A DENTAL PLAN ORGANIZATION; OR~~

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

~~(C) "HEALTH CARE FACILITY" MEANS:~~

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

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

~~(D) "HEALTH CARE SERVICE" MEANS ANY HEALTH OR MEDICAL 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 FUNCTION.~~

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

~~15-10C-02.~~

~~(A) THE COMMISSIONER SHALL:~~

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

~~(I) THE CERTIFICATION OF MEDICAL DIRECTORS; AND~~

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

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

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

~~15-10C-03.~~

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

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

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

~~(B) THE APPLICATION SHALL INCLUDE:~~

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

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

~~(3) THE PROTOCOLS OR PROCEDURES TO BE USED IN THE HEALTH CARE SERVICE DELIVERY SYSTEM OF A CARRIER OR HEALTH CARE FACILITY THAT THE~~

~~APPLICANT HAS ESTABLISHED OR IS RESPONSIBLE FOR ENSURING COMPLIANCE;~~
~~AND~~

~~(4) ANY OTHER INFORMATION THE COMMISSIONER CONSIDERS~~
~~NECESSARY.~~

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

~~(2) IF AT ANY TIME THERE IS A MATERIAL CHANGE IN THE~~
~~INFORMATION INCLUDED IN THE APPLICATION UNDER SUBSECTION (B) OF THIS~~
~~SECTION, THE MEDICAL DIRECTOR SHALL SUBMIT UPDATED INFORMATION TO THE~~
~~COMMISSIONER.~~

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

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

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

~~(I) OBJECTIVE;~~

~~(II) CLINICALLY VALID;~~

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

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

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

SUBTITLE 10C. MEDICAL DIRECTORS.

15-10C-01.

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

(B) "BOARD" MEANS THE STATE BOARD OF PHYSICIAN QUALITY ASSURANCE ESTABLISHED UNDER TITLE 14 OF THE HEALTH OCCUPATIONS ARTICLE.

(C) "CERTIFICATE" MEANS A CERTIFICATE ISSUED BY THE COMMISSIONER UNDER THIS SUBTITLE TO ACT AS A MEDICAL DIRECTOR.

(D) "DEPARTMENT" MEANS THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE.

(E) "HEALTH MAINTENANCE ORGANIZATION" HAS THE MEANING STATED IN § 19-701 OF THE HEALTH - GENERAL ARTICLE.

~~(F) "MEDICAL DIRECTOR" MEANS A PHYSICIAN WHO IS RESPONSIBLE FOR THE OVERALL COORDINATION OF PATIENT CARE AND THE DELIVERY OF HEALTH CARE SERVICES THROUGH:~~

~~(1) THE ESTABLISHMENT OR MAINTENANCE OF QUALITY ASSURANCE AND UTILIZATION MANAGEMENT STANDARDS AND PRACTICES AT A HEALTH MAINTENANCE ORGANIZATION;~~

~~(2) THE SUPERVISION OF HEALTH CARE PROVIDERS EMPLOYED BY OR UNDER CONTRACT WITH A HEALTH MAINTENANCE ORGANIZATION IN ORDER TO ENSURE COMPLIANCE WITH AND GUIDANCE ON COMPLYING WITH THE QUALITY ASSURANCE AND UTILIZATION MANAGEMENT STANDARDS AND PRACTICES; AND~~

~~(3) OVERSIGHT AND RESPONSIBILITY FOR THE UTILIZATION DECISIONS OF PRIVATE REVIEW AGENTS EMPLOYED BY OR UNDER CONTRACT WITH THE HEALTH MAINTENANCE ORGANIZATION.~~

(F) "MEDICAL DIRECTOR" MEANS A PHYSICIAN EMPLOYED BY OR UNDER CONTRACT WITH A HEALTH MAINTENANCE ORGANIZATION WHO IS RESPONSIBLE FOR:

(1) THE ESTABLISHMENT OR MAINTENANCE OF THE POLICIES AND PROCEDURES AT THE HEALTH MAINTENANCE ORGANIZATION FOR:

(I) QUALITY ASSURANCE; AND

(II) UTILIZATION MANAGEMENT;

(2) COMPLIANCE WITH THE QUALITY ASSURANCE AND UTILIZATION MANAGEMENT POLICIES AND PROCEDURES OF THE HEALTH MAINTENANCE ORGANIZATION; AND

(3) OVERSIGHT OF UTILIZATION REVIEW DECISIONS OF PRIVATE REVIEW AGENTS EMPLOYED BY OR UNDER CONTRACT WITH THE HEALTH MAINTENANCE ORGANIZATION.

15-10C-02.

THE COMMISSIONER, IN CONSULTATION WITH THE DEPARTMENT AND THE BOARD, SHALL ESTABLISH AND ADOPT BY REGULATION STANDARDS FOR:

(1) THE CERTIFICATION OF MEDICAL DIRECTORS; ~~AND~~

(2) THE RENEWAL, SUSPENSION, AND REVOCATION OF A CERTIFICATE; AND

(3) THE ISSUANCE OF A TEMPORARY CERTIFICATE.

15-10C-03.

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

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

(2) PAY TO THE COMMISSIONER AN APPLICATION FEE OF NO MORE THAN $100 ESTABLISHED BY THE COMMISSIONER BY REGULATION.

(B) THE APPLICATION SHALL INCLUDE:

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

(2) THE UTILIZATION MANAGEMENT PROCEDURES AND POLICIES; AND

(3) CERTIFICATION BY THE MEDICAL DIRECTOR THAT THE UTILIZATION MANAGEMENT PROCEDURES AND POLICIES ARE:

(I) OBJECTIVE;

(II) CLINICALLY VALID;

~~(III) COMPATIBLE WITH ESTABLISHED PRINCIPLES OF PATIENT CARE AND HEALTH CARE SERVICE DELIVERY; AND~~

(III) COMPATIBLE WITH ESTABLISHED PRINCIPLES OF HEALTH CARE; AND

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

15-10C-04.

(A) SUBJECT TO THE HEARING PROCEDURES IN §§ 2-210 THROUGH 2-214 OF THIS ARTICLE, THE COMMISSIONER MAY SUSPEND, REVOKE, OR REFUSE TO RENEW

A CERTIFICATE OF A MEDICAL DIRECTOR IF THE COMMISSIONER~~, IN CONSULTATION WITH AN INDEPENDENT REVIEW ORGANIZATION OR MEDICAL EXPERT THAT MEETS THE REQUIREMENTS OF § 15-10A-05 OF THIS TITLE, THE DEPARTMENT, THE BOARD, OR ANY OTHER APPROPRIATE ENTITY,~~ FINDS A PATTERN THAT THE UTILIZATION MANAGEMENT PROCEDURES AND POLICIES USED BY THE MEDICAL DIRECTOR IN MAKING UTILIZATION REVIEW DECISIONS OR USED BY A PRIVATE REVIEW AGENT EMPLOYED BY OR UNDER CONTRACT WITH THE HEALTH MAINTENANCE ORGANIZATION OVER WHOSE UTILIZATION REVIEW DECISIONS THE MEDICAL DIRECTOR HAS RESPONSIBILITY ARE NOT:

(1) OBJECTIVE;

(2) CLINICALLY VALID;

~~(3) COMPATIBLE WITH ESTABLISHED PRINCIPLES OF PATIENT CARE AND HEALTH CARE SERVICE DELIVERY; AND~~

(3) COMPATIBLE WITH ESTABLISHED PRINCIPLES OF HEALTH CARE; AND

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

(B) THE COMMISSIONER MAY CONSULT WITH AN INDEPENDENT REVIEW ORGANIZATION OR MEDICAL EXPERT THAT MEETS THE REQUIREMENTS OF § 15-10A-05 OF THIS TITLE, THE DEPARTMENT, THE BOARD, OR ANY OTHER APPROPRIATE ENTITY FOR PURPOSES OF TAKING AN ACTION DESCRIBED UNDER SUBSECTION (A) OF THIS SECTION.

27-303.

It is an unfair claim settlement practice and a violation of this subtitle for an insurer or nonprofit health service plan to:

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

(2) refuse to pay a claim for an arbitrary or capricious reason based on all available information;

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

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

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

(6) fail to provide promptly on request a reasonable explanation of the basis for a denial of a claim; [or]

(7) fail to meet the requirements of [Title 19, Subtitle 13 of the Health - General Article] TITLE 15, SUBTITLE 10B OF THIS ARTICLE for preauthorization for a health care service; OR

(8) FAIL TO COMPLY WITH ~~THE PROVISIONS OF TITLE 15, SUBTITLE 10A~~ § 15-10A-02(B) OR (E) OR § 15-10A-04(C) OF THIS ARTICLE.

27-304.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(15) fail to meet the requirements of ~~Title 19, Subtitle 13 of the Health - General Article~~ TITLE 15, SUBTITLE 10B OF THIS ARTICLE for preauthorization for a health care service; OR

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

~~27-305.~~

~~(a) The Commissioner may impose a penalty not exceeding [$500] $5,000 for each violation of § 27-303 of this subtitle or a regulation adopted under § 27-303 of this subtitle.~~

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

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

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

SECTION 6. AND BE IT FURTHER ENACTED, That, on or before January 1, 2001, the Insurance Commissioner shall submit a report to the Governor and, subject to § 2-1246 of the State Government Article, the General Assembly assessing the correlation between the health care regulatory assessment collected by the Insurance Commissioner from each carrier under § 2-112.2 of the Insurance Article, as enacted by this Act, and the number of complaints filed with the Commissioner and the costs incurred by the Insurance Commissioner in reviewing those complaints in accordance with Title 15, Subtitle 10A of the Insurance Article, as enacted by this Act.

SECTION 7. AND BE IT FURTHER ENACTED, That, subject to the approval of the Executive Director of the Department of Legislative Services, the publishers of the Annotated Code of Maryland shall correct any cross-references that are rendered incorrect by this Act.

SECTION ~~6.~~ 8. AND BE IT FURTHER ENACTED, That Section 3 of this Act shall take effect June 1, 1998.

SECTION ~~7.~~ 9. AND BE IT FURTHER ENACTED, That Section 5 of this Act shall remain in effect for a period of 2 years and, at the end of December 31, ~~2001~~ 2000, with no further action required by the General Assembly, Section 5 of this Act shall be abrogated and of no further force and effect.

SECTION ~~8.~~ 10. AND BE IT FURTHER ENACTED, That, except as provided in Section ~~6~~ 8 of this Act, this Act shall take effect January 1, 1999.