SENATE BILL 84

Unofficial Copy 1998 Regular Session
C3 8lr0217

(PRE-FILED)

By: **Senators Green, Hollinger, Dorman, Hafer, Madden, Teitelbaum, and Van Hollen**
Requested: August 7, 1997
Introduced and read first time: January 14, 1998
Assigned to: Judicial Proceedings

A BILL ENTITLED

AN ACT concerning

Managed Care Entities - Health Care Treatment and Benefit Determinations - Liability and Utilization Review Complaint and Appeal Processes and Procedures

FOR the purpose of establishing the liability of certain carriers and managed care entities for damages that an insured or enrollee suffers as a result of a health care treatment decision of the carrier or managed care entity under certain circumstances; establishing certain defenses; establishing a certain health care benefit utilization review complaint and appeal process; specifying the requirements of the utilization review process, including the method by which complaints may be initiated by enrollees, insureds, and health care providers and the method by which appeals may be made for adverse determinations; requiring the Insurance Commissioner to adopt certain regulations that relate to independent review organizations; specifying the standards that the Commissioner must include in the regulations; specifying the requirements for certification as an independent review organization; requiring carriers and health maintenance organizations to establish a certain complaint system; requiring carriers and health maintenance organizations to provide a certain notice to insureds and enrollees of the complaint system and procedures for filing an appeal of certain determinations; providing for the construction of certain provisions of this Act; providing for the application of provisions of this Act; making provisions of this Act severable; defining certain terms; and generally relating to managed care entities and liability and utilization review complaint and appeal process for health care treatment and benefit determinations.

BY renumbering
Article - Health - General
Section 19-705.3 through 19-705.7, respectively
to be Section 19-705.4 through 19-705.8, respectively
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)

BY adding to
Article - Courts and Judicial Proceedings
Section 3-2C-01 through 3-2C-05, inclusive, to be under the new subtitle "Subtitle 2C. Health Care Treatment Decisions - Liability"
Annotated Code of Maryland
(1995 Replacement Volume and 1997 Supplement)

BY repealing and reenacting, with amendments,
Article - Courts and Judicial Proceedings
Section 11-108(c)
Annotated Code of Maryland
(1995 Replacement Volume and 1997 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-112(e), (g), (h), and (j)
Annotated Code of Maryland
(1997 Volume)

BY adding to
Article - Insurance
Section 15-1601 through 15-1606, inclusive, to be under the new subtitle "Subtitle 16. Health Care Benefit Utilization Review Complaint and Appeal Process"; and Section 15-1701 through 15-1705, inclusive, to be under the new subtitle "Subtitle 17. Independent Review Organizations"
Annotated Code of Maryland
(1997 Volume)

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

BY adding to
Article - Health - General
Section 19-705.3 and 19-706(y)
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That Section(s) 19-705.3 through 19-705.7, respectively, of Article - Health - General of the Annotated Code of Maryland be renumbered to be Section(s) 19-705.4 through 19-705.8, respectively.

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

Article - Courts and Judicial Proceedings

SUBTITLE 2C. HEALTH CARE TREATMENT DECISIONS - LIABILITY.

3-2C-01.

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

(B) "APPROPRIATE AND MEDICALLY NECESSARY" MEANS THE STANDARD OF HEALTH CARE SERVICES AS DETERMINED BY A PHYSICIAN OR HEALTH CARE PROVIDER IN ACCORDANCE WITH THE PREVAILING PRACTICES AND STANDARDS OF THE MEDICAL PROFESSION AND COMMUNITY.

(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 BENEFITS PLANS SUBJECT TO STATE INSURANCE REGULATION.

(D) (1) "ENROLLEE" MEANS A PERSON WHO IS ENROLLED IN A HEALTH BENEFIT PLAN UNDER A POLICY, PLAN, CERTIFICATE, OR CONTRACT ISSUED OR DELIVERED IN THE STATE BY A CARRIER.

(2) "ENROLLEE" INCLUDES A MEMBER OF A GROUP.

(E) (1) "HEALTH BENEFIT PLAN" MEANS A PLAN OF BENEFITS THAT DEFINES COVERAGE PROVISIONS FOR HEALTH CARE FOR INSUREDS OR ENROLLEES.

(2) "HEALTH BENEFIT PLAN" INCLUDES:

(I) A POLICY OR CERTIFICATE FOR HOSPITAL OR MEDICAL BENEFITS;

(II) A NONPROFIT HEALTH SERVICE PLAN; OR

(III) A HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER OR GROUP MASTER CONTRACT.

(3) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE:

(I) ACCIDENT-ONLY INSURANCE;

(II) FIXED INDEMNITY INSURANCE;

(III) CREDIT HEALTH INSURANCE;

(IV) MEDICARE SUPPLEMENT POLICIES;

(V) CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS) SUPPLEMENT POLICIES;

(VI) LONG-TERM CARE INSURANCE;

(VII) DISABILITY INCOME INSURANCE;

(VIII) COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE;

(IX) WORKERS' COMPENSATION OR SIMILAR INSURANCE;

(X) DISEASE-SPECIFIC INSURANCE; OR

(XI) AUTOMOBILE MEDICAL PAYMENT INSURANCE.

(F) (1) "HEALTH CARE PROVIDER" MEANS:

(I) AN INDIVIDUAL WHO IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE SERVICES IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION OR IN AN APPROVED EDUCATION OR TRAINING PROGRAM; OR

(II) A HEALTH CARE FACILITY, AS DEFINED IN § 19-101 OF THE HEALTH - GENERAL ARTICLE, WHERE HEALTH CARE SERVICES ARE PROVIDED TO PATIENTS, INCLUDING:

1. A HEALTH MAINTENANCE ORGANIZATION, AS DEFINED IN § 19-701(E) OF THE HEALTH - GENERAL ARTICLE;

2. AN OUTPATIENT CLINIC; AND

3. A MEDICAL LABORATORY.

(2) "HEALTH CARE PROVIDER" INCLUDES:

(I) AN AGENT OR EMPLOYEE OF A HEALTH CARE FACILITY THAT IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED TO PROVIDE HEALTH CARE SERVICES;

(II) THE OFFICERS AND DIRECTORS OF A HEALTH CARE FACILITY; AND

(III) AN AGENT OR EMPLOYEE OF A HEALTH CARE PROVIDER WHO IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED TO PROVIDE HEALTH CARE SERVICES.

(G) "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.

(H) "HEALTH CARE TREATMENT DECISION" MEANS A DETERMINATION MADE WHEN HEALTH CARE SERVICES ARE ACTUALLY PROVIDED BY A CARRIER UNDER A HEALTH BENEFIT PLAN AND A DECISION WHICH AFFECTS THE QUALITY OF THE DIAGNOSIS, CARE, OR TREATMENT PROVIDED TO AN ENROLLEE OR INSURED OF THE PLAN.

(I) (1) "MANAGED CARE ENTITY" MEANS AN ENTITY THAT:

(I) DELIVERS, ADMINISTERS, OR ASSUMES RISK FOR THE DELIVERY OF HEALTH CARE SERVICES; AND

(II) HAS A SYSTEM OR TECHNIQUE TO CONTROL OR INFLUENCE THE QUALITY, ACCESSIBILITY, UTILIZATION, OR COSTS AND PRICES OF HEALTH CARE SERVICES DELIVERED OR TO BE DELIVERED TO A DEFINED ENROLLEE POPULATION.

(2) "MANAGED CARE ENTITY" DOES NOT INCLUDE:

(I) AN EMPLOYER PURCHASING COVERAGE OR ACTING ON BEHALF OF ITS EMPLOYEES OR THE EMPLOYEES OF ONE OR MORE SUBSIDIARIES OR AFFILIATED CORPORATIONS OF THE EMPLOYER; OR

(II) A PHARMACY ISSUED A PERMIT BY THE STATE BOARD OF PHARMACY UNDER TITLE 12 OF THE HEALTH OCCUPATIONS ARTICLE.

(J) "ORDINARY CARE" MEANS:

(1) FOR A CARRIER OR MANAGED CARE ENTITY, THAT DEGREE OF CARE THAT A CARRIER OR MANAGED CARE ENTITY OF ORDINARY PRUDENCE WOULD USE UNDER THE SAME OR SIMILAR CIRCUMSTANCES; OR

(2) FOR A PERSON THAT IS AN AGENT OR EMPLOYEE OF A CARRIER OR MANAGED CARE ENTITY, THAT DEGREE OF CARE THAT A PERSON OF ORDINARY PRUDENCE IN THE SAME PROFESSION, SPECIALTY, OR AREA OF PRACTICE AS THE PERSON WOULD USE IN THE SAME OR SIMILAR CIRCUMSTANCES.

(K) "PHYSICIAN" MEANS:

(1) AN INDIVIDUAL LICENSED TO PRACTICE MEDICINE IN THIS STATE UNDER TITLE 14 OF THE HEALTH OCCUPATIONS ARTICLE;

(2) A PROFESSIONAL ASSOCIATION ORGANIZED UNDER TITLE 5 OF THE CORPORATIONS AND ASSOCIATIONS ARTICLE; OR

(3) A PERSON OR ENTITY WHOLLY OWNED BY PHYSICIANS.

3-2C-02.

AN ACTION BROUGHT UNDER THIS SUBTITLE AGAINST A CARRIER OR MANAGED CARE ENTITY:

(1) IS NOT SUBJECT TO THE PROVISIONS OF SUBTITLE 2A OF THIS TITLE ("HEALTH CLAIMS ARBITRATION ACT"); AND

(2) IS SUBJECT TO THE PROVISIONS OF § 11-108 OF THIS ARTICLE.

3-2C-03.

(A) EACH CARRIER OR MANAGED CARE ENTITY FOR A HEALTH BENEFIT PLAN HAS THE DUTY TO EXERCISE ORDINARY CARE WHEN MAKING HEALTH CARE TREATMENT DECISIONS AND IS LIABLE FOR DAMAGES FOR HARM TO AN INSURED OR ENROLLEE PROXIMATELY CAUSED BY ITS FAILURE TO EXERCISE ORDINARY CARE.

(B) IN ADDITION TO SUBSECTION (A) OF THIS SECTION, EACH CARRIER OR MANAGED CARE ENTITY FOR A HEALTH BENEFIT PLAN IS LIABLE FOR DAMAGES FOR HARM TO AN INSURED OR ENROLLEE PROXIMATELY CAUSED BY THE HEALTH CARE TREATMENT DECISIONS MADE BY:

(1) ITS AGENTS OR EMPLOYEES; OR

(2) REPRESENTATIVES THAT ARE ACTING ON ITS BEHALF AND OVER WHOM IT HAS THE RIGHT TO EXERCISE INFLUENCE OR CONTROL OR HAS ACTUALLY EXERCISED INFLUENCE OR CONTROL WHICH RESULT IN THE FAILURE TO EXERCISE ORDINARY CARE.

(C) IT SHALL BE A DEFENSE TO ANY ACTION BROUGHT UNDER THIS SECTION AGAINST A CARRIER OR MANAGED CARE ENTITY FOR A HEALTH BENEFIT PLAN THAT:

(1) NEITHER THE CARRIER OR MANAGED CARE ENTITY NOR ANY AGENT OR EMPLOYEE FOR WHOM THE CARRIER OR MANAGED CARE ENTITY IS LIABLE UNDER SUBSECTION (B) OF THIS SECTION CONTROLLED, INFLUENCED, OR PARTICIPATED IN THE HEALTH CARE TREATMENT DECISION; AND

(2) THE CARRIER OR OTHER MANAGED CARE ENTITY DID NOT DENY OR DELAY PAYMENT FOR ANY TREATMENT OR HEALTH CARE SERVICE PRESCRIBED OR RECOMMENDED BY A PHYSICIAN OR HEALTH CARE PROVIDER TO THE INSURED OR ENROLLEE.

(D) IN AN ACTION BROUGHT UNDER THIS SECTION AGAINST A CARRIER OR MANAGED CARE ENTITY, A FINDING THAT A PHYSICIAN OR HEALTH CARE PROVIDER IS AN AGENT OR EMPLOYEE OF THE CARRIER OR MANAGED CARE ENTITY MAY NOT BE BASED SOLELY ON PROOF THAT THE PHYSICIAN OR HEALTH CARE PROVIDER APPEARS IN A LISTING OF APPROVED PHYSICIANS OR HEALTH CARE PROVIDERS MADE AVAILABLE TO INSUREDS OR ENROLLEES UNDER THE CARRIER'S OR OTHER MANAGED CARE ENTITY'S HEALTH BENEFIT PLAN.

(E) IN ANY ACTION BROUGHT UNDER THIS SUBTITLE AGAINST A CARRIER OR MANAGED CARE ENTITY, ANY LAW THAT PROHIBITS THE CORPORATE PRACTICE OF MEDICINE MAY NOT BE USED AS DEFENSE BY THE CARRIER OR OTHER MANAGED CARE ENTITY.

(F) THE PROVISIONS OF SUBSECTIONS (A) AND (B) OF THIS SECTION CREATE NO OBLIGATION ON THE PART OF A CARRIER OR MANAGED CARE ENTITY TO PROVIDE TO AN INSURED OR ENROLLEE A HEALTH CARE SERVICE OR TREATMENT THAT IS NOT COVERED UNDER ITS HEALTH BENEFIT PLAN.

3-2C-04.

(A) AN INSURED OR ENROLLEE OR AN INSURED'S OR ENROLLEE'S REPRESENTATIVE MAY NOT MAINTAIN A CAUSE OF ACTION UNDER THIS SUBTITLE AGAINST A CARRIER OR MANAGED CARE ENTITY THAT IS REQUIRED TO COMPLY WITH THE UTILIZATION REVIEW REQUIREMENTS OF SUBTITLE 16 OF THE INSURANCE ARTICLE OR TITLE 19, SUBTITLE 13 OF THE HEALTH - GENERAL ARTICLE, UNLESS THE INSURED OR ENROLLEE OR THE INSURED'S OR ENROLLEE'S REPRESENTATIVE:

(1) HAS EXHAUSTED THE APPEALS AND REVIEW PROCESS APPLICABLE UNDER UTILIZATION REVIEW; OR

(2) BEFORE INSTITUTING THE ACTION:

(I) GIVES WRITTEN NOTICE OF THE CLAIM AS PROVIDED BY SUBSECTION (B) OF THIS SECTION; AND

(II) AGREES TO SUBMIT THE CLAIM TO A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION UNDER SUBTITLE 16 OF THE INSURANCE ARTICLE, AS REQUIRED BY SUBSECTION (C) OF THIS SECTION.

(B) THE NOTICE REQUIRED UNDER SUBSECTION (A)(2) OF THIS SECTION SHALL BE DELIVERED OR MAILED TO THE CARRIER OR MANAGED CARE ENTITY AGAINST WHOM THE CLAIM IS FILED NO LATER THAN THE 30TH DAY BEFORE THE DATE THE CLAIM IS TO BE FILED.

(C) (1) THE INSURED OR ENROLLEE OR THE INSURED'S OR ENROLLEE'S REPRESENTATIVE SHALL SUBMIT THE CLAIM TO A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION IF THE CARRIER OR MANAGED CARE ENTITY AGAINST WHOM THE CLAIM IS MADE REQUESTS THE REVIEW NO LATER THAN THE 14TH DAY

AFTER THE DATE THE CARRIER OR MANAGED CARE ENTITY RECEIVES THE NOTICE REQUIRED UNDER SUBSECTION (A)(2) OF THIS SECTION.

(2) IF THE CARRIER OR MANAGED CARE ENTITY DOES NOT REQUEST A REVIEW WITHIN THE SPECIFIED TIME PERIOD REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION, THE INSURED OR ENROLLEE OR THE INSURED'S OR ENROLLEE'S REPRESENTATIVE IS NOT REQUIRED TO SUBMIT THE CLAIM TO INDEPENDENT REVIEW BEFORE MAINTAINING THE ACTION.

(D) (1) SUBJECT TO SUBSECTION (E) OF THIS SECTION, IF THE INSURED OR ENROLLEE OR THE INSURED'S OR ENROLLEE'S REPRESENTATIVE HAS NOT COMPLIED WITH SUBSECTION (A) OF THIS SECTION, A COURT MAY NOT DISMISS THE CAUSE OF ACTION, BUT MAY:

(I) ORDER THE PARTIES TO THE ACTION TO SUBMIT TO AN INDEPENDENT REVIEW OR MEDIATION OR OTHER NONBINDING ALTERNATIVE DISPUTE RESOLUTION; AND

(II) STAY THE ACTION FOR A PERIOD NOT EXCEEDING 30 DAYS FOR THE PURPOSE OF RESOLVING THE CLAIM.

(2) THE PROVISIONS OF PARAGRAPH (1) OF THIS SUBSECTION SHALL BE THE SOLE REMEDY AVAILABLE TO A PARTY COMPLAINING OF AN INSURED'S OR ENROLLEE'S OR THE INSURED'S OR ENROLLEE'S REPRESENTATIVE'S FAILURE TO COMPLY WITH SUBSECTION (A) OF THIS SECTION.

(E) (1) AN INSURED OR ENROLLEE OR THE INSURED'S OR ENROLLEE'S REPRESENTATIVE IS NOT REQUIRED TO COMPLY WITH SUBSECTION (C) OF THIS SECTION AND A COURT MAY NOT ISSUE AN ORDER STAYING THE COMMENCEMENT OF AN ACTION FOR FAILING TO COMPLY WITH SUBSECTION (A) OF THIS SECTION IF THE INSURED OR ENROLLEE OR THE INSURED'S OR ENROLLEE'S REPRESENTATIVE HAS FILED A PLEADING WITH THE COURT THAT ASSERTS THAT:

(I) HARM TO THE INSURED OR ENROLLEE HAS ALREADY OCCURRED BECAUSE OF:

1. THE CONDUCT OF THE CARRIER OR MANAGED CARE ENTITY THAT IS THE SUBJECT OF THE CLAIM; OR

2. AN ACT OR OMISSION OF AN AGENT OR EMPLOYEE OF THE CARRIER OR MANAGED CARE ENTITY FOR WHOSE CONDUCT THE CARRIER OR MANAGED CARE ENTITY IS LIABLE UNDER § 3-2C-03 OF THIS SUBTITLE; AND

(II) THE INDEPENDENT REVIEW WOULD NOT BE BENEFICIAL TO THE INSURED OR ENROLLEE.

(2) NOTWITHSTANDING PARAGRAPH (1) OF THIS SUBSECTION, A COURT MAY ISSUE AN ORDER IN ACCORDANCE WITH SUBSECTION (D) OF THIS SECTION IF ON A MOTION BY THE CARRIER OR MANAGED CARE ENTITY A HEARING IS HELD AND

AFTER THE HEARING THE COURT FINDS THAT THE PLEADING WAS NOT MADE IN GOOD FAITH.

(F) IF THE INSURED OR ENROLLEE OR THE INSURED'S OR ENROLLEE'S REPRESENTATIVE SEEKS TO EXHAUST THE APPEALS AND REVIEW REQUIREMENTS OF UTILIZATION REVIEW OR PROVIDES THE NOTICE, AS REQUIRED UNDER SUBSECTION (A) OF THIS SECTION, BEFORE THE STATUTE OF LIMITATIONS APPLICABLE TO THE CLAIM BROUGHT AGAINST THE CARRIER OR MANAGED CARE ENTITY HAS EXPIRED, THE STATUTE OF LIMITATIONS PERIOD IS TOLLED UNTIL THE LATER OF:

(1) THE 30TH DAY AFTER THE INSURED OR ENROLLEE OR THE INSURED'S OR ENROLLEE'S REPRESENTATIVE HAS EXHAUSTED THE APPEALS AND REVIEW PROCESS APPLICABLE UNDER UTILIZATION REVIEW; OR

(2) THE 40TH DAY AFTER THE DATE THE INSURED OR ENROLLEE OR THE INSURED'S OR ENROLLEE'S REPRESENTATIVE GIVES NOTICE UNDER SUBSECTION (A) OF THIS SECTION.

(G) THIS SECTION DOES NOT PROHIBIT AN INSURED OR ENROLLEE FROM PURSUING OTHER APPROPRIATE REMEDIES, INCLUDING INJUNCTIVE RELIEF, A DECLARATORY JUDGMENT, OR RELIEF AVAILABLE UNDER LAW, IF THE REQUIREMENT OF EXHAUSTING THE APPEALS AND REVIEW PROCESS OF UTILIZATION REVIEW PLACES THE INSURED'S OR ENROLLEE'S HEALTH IN SERIOUS JEOPARDY.

3-2C-05.

THIS SUBTITLE DOES NOT CREATE ANY LIABILITY ON THE PART OF AN EMPLOYER OR EMPLOYER GROUP PURCHASING ORGANIZATION THAT PURCHASES HEALTH CARE COVERAGE OR ASSUMES RISK ON BEHALF OF ITS EMPLOYEES OR A PHARMACY ISSUED A PERMIT BY THE STATE BOARD OF PHARMACY UNDER TITLE 12 OF THE HEALTH OCCUPATIONS ARTICLE.

11-108.

(c) (1) An award by the Health Claims Arbitration Panel in accordance with § 3-2A-06 of this article shall be considered an award for purposes of this section.

(2) AN AWARD MADE IN ACCORDANCE WITH TITLE 3, SUBTITLE 2C OF THIS ARTICLE SHALL BE CONSIDERED AN AWARD FOR PURPOSES OF THIS SECTION.

Article - Insurance

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 OR SUBTITLE 16 OF THIS TITLE; or

(3) 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 A PROVIDER'S participation on its provider panel or otherwise penalize a provider for:

(1) advocating the interests of a patient FOR APPROPRIATE AND MEDICALLY NECESSARY HEALTH CARE SERVICES 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 OR UNDER SUBTITLE 16 OF THIS TITLE.

(h) (1) Each carrier shall establish an internal review system to resolve grievances initiated by providers that participate on the carrier's provider panel, including grievances involving the termination of a provider from participation on the carrier's provider panel.

(2) (I) 1. IN THIS PARAGRAPH THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

2. "ADVERSE DETERMINATION" MEANS A DETERMINATION BY A CARRIER THAT HEALTH CARE SERVICES PROVIDED OR PROPOSED TO BE PROVIDED TO AN ENROLLEE ARE NOT APPROPRIATE AND MEDICALLY NECESSARY.

3. "INDEPENDENT REVIEW ORGANIZATION" MEANS AN ORGANIZATION SELECTED AS PROVIDED IN SUBTITLE 17 OF THIS TITLE.

4. "LIFE-THREATENING CONDITION" MEANS A DISEASE OR OTHER MEDICAL CONDITION WITH RESPECT TO WHICH DEATH IS PROBABLE UNLESS THE COURSE OF THE DISEASE OR CONDITION IS INTERRUPTED.

(II) EACH CARRIER SHALL ESTABLISH AND MAINTAIN A COMPLAINT SYSTEM TO PROVIDE PROCEDURES FOR THE RESOLUTION OF ORAL AND WRITTEN COMPLAINTS INITIATED BY ENROLLEES CONCERNING HEALTH CARE SERVICES.

(III) THE COMPLAINT SYSTEM SHALL INCLUDE:

1. NOTIFICATION TO THE ENROLLEE OF THE ENROLLEE'S RIGHT TO APPEAL AN ADVERSE DETERMINATION TO AN INDEPENDENT REVIEW ORGANIZATION;

2. NOTIFICATION TO THE ENROLLEE OF THE PROCEDURES FOR APPEALING AN ADVERSE DETERMINATION TO AN INDEPENDENT REVIEW ORGANIZATION; AND

3. NOTIFICATION TO AN ENROLLEE WHO HAS A LIFE-THREATENING CONDITION OF THE ENROLLEE'S RIGHT TO IMMEDIATE REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION AND THE PROCEDURES TO OBTAIN THAT REVIEW.

(IV) THE PROVISIONS OF SUBTITLE 16 OF THIS TITLE THAT RELATE TO INDEPENDENT REVIEW APPLY TO A CARRIER UNDER THIS SECTION AS IF THE CARRIER WAS A PRIVATE REVIEW AGENT.

(V) THE COMMISSIONER MAY EXAMINE THE COMPLAINT SYSTEM OF A CARRIER TO DETERMINE COMPLIANCE WITH THIS PARAGRAPH.

(j) (1) A carrier shall provide to prospective enrollees before enrollment and to existing enrollees at least once a year:

(i) a list of providers on the carrier's provider panel; and

(ii) information on providers that are no longer accepting new patients.

(2) The information provided under paragraph (1) of this subsection shall be updated at least once a year.

(3) A policy, certificate, or other evidence of coverage shall:

(i) indicate clearly the office in the administration that is responsible for receiving and responding to complaints from enrollees about carriers; [and]

(ii) include the telephone number of the office and the procedure for filing a complaint; AND

(III) INCLUDE INFORMATION ON AN ENROLLEE'S RIGHT TO APPEAL A DENIAL OF AN ADVERSE DETERMINATION, AS THAT TERM IS DEFINED IN SUBTITLE 16 OF THIS TITLE.

SUBTITLE 16. HEALTH CARE BENEFIT UTILIZATION REVIEW COMPLAINT AND APPEAL PROCESS.

15-1601.

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

(B) "ADVERSE DETERMINATION" MEANS A DETERMINATION BY A PRIVATE REVIEW AGENT THAT THE HEALTH CARE SERVICES PROVIDED OR PROPOSED TO BE PROVIDED TO A PATIENT ARE NOT APPROPRIATE AND MEDICALLY NECESSARY.

(C) "EMERGENCY CARE" MEANS HEALTH CARE SERVICES PROVIDED AFTER THE SUDDEN ONSET OF A MEDICAL CONDITION THAT MANIFESTS ITSELF BY SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING SEVERE PAIN, THAT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION COULD REASONABLY BE EXPECTED BY A PRUDENT LAYPERSON, WHO POSSESSES AN AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE, TO RESULT IN:

(1) PLACING THE PATIENT'S HEALTH IN SERIOUS JEOPARDY;

(2) SERIOUS IMPAIRMENT OF BODILY FUNCTIONS; OR

(3) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART.

(D) (1) "ENROLLEE" MEANS A PERSON WHO IS ENROLLED IN A HEALTH BENEFIT PLAN UNDER A POLICY, PLAN, CERTIFICATE, OR CONTRACT ISSUED OR DELIVERED IN THE STATE BY A PAYOR.

(2) "ENROLLEE" INCLUDES A MEMBER OF A GROUP.

(E) (1) "HEALTH BENEFIT PLAN" MEANS A PLAN OF BENEFITS THAT DEFINES COVERAGE PROVISIONS FOR HEALTH CARE FOR INSUREDS OR ENROLLEES.

(2) "HEALTH BENEFIT PLAN" INCLUDES:

(I) A POLICY OR CERTIFICATE FOR HOSPITAL OR MEDICAL BENEFITS;

(II) A NONPROFIT HEALTH SERVICE PLAN; OR

(III) A HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER OR GROUP MASTER CONTRACT.

(3) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE:

(I) ACCIDENT-ONLY INSURANCE;

(II) FIXED INDEMNITY INSURANCE;

(III) CREDIT HEALTH INSURANCE;

(IV) MEDICARE SUPPLEMENT POLICIES;

(V) CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS) SUPPLEMENT POLICIES;

(VI) LONG-TERM CARE INSURANCE;

(VII) DISABILITY INCOME INSURANCE;

(VIII) COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE;

(IX) WORKERS' COMPENSATION OR SIMILAR INSURANCE;

(X) DISEASE-SPECIFIC INSURANCE; OR

(XI) AUTOMOBILE MEDICAL PAYMENT INSURANCE.

(F) (1) "HEALTH CARE PROVIDER" MEANS:

(I) AN INDIVIDUAL WHO IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE SERVICES IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION OR IN AN APPROVED EDUCATION OR TRAINING PROGRAM; OR

(II) A HEALTH CARE FACILITY, AS DEFINED IN § 19-101 OF THE HEALTH - GENERAL ARTICLE, WHERE HEALTH CARE SERVICES ARE PROVIDED TO PATIENTS, INCLUDING:

1. A HEALTH MAINTENANCE ORGANIZATION, AS DEFINED IN § 19-701(E) OF THE HEALTH - GENERAL ARTICLE;

2. AN OUTPATIENT CLINIC; AND

3. A MEDICAL LABORATORY.

(2) "HEALTH CARE PROVIDER" INCLUDES:

(I) AN AGENT OR EMPLOYEE OF A HEALTH CARE FACILITY THAT IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED TO PROVIDE HEALTH CARE SERVICES;

(II) THE OFFICERS AND DIRECTORS OF A HEALTH CARE FACILITY; AND

(III) AN AGENT OR EMPLOYEE OF A HEALTH CARE PROVIDER THAT IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED TO PROVIDE HEALTH CARE SERVICES.

(G) "HEALTH CARE SERVICE" MEANS ANY 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.

(H) "PAYOR" MEANS:

(1) A HEALTH INSURER;

(2) A NONPROFIT HEALTH SERVICE PLAN;

(3) A HEALTH MAINTENANCE ORGANIZATION; OR

(4) ANY OTHER PERSON OR ENTITY THAT PROVIDES OR OFFERS TO PROVIDE OR ADMINISTERS HOSPITAL, OUTPATIENT, MEDICAL, OR OTHER BENEFITS TO PERSONS TREATED BY A HEALTH CARE PROVIDER UNDER A POLICY, PLAN, CONTRACT, OR CERTIFICATE ISSUED OR ISSUED FOR DELIVERY IN THE STATE.

(I) "PRIVATE REVIEW AGENT" MEANS A PERSON OR ENTITY THAT CONDUCTS UTILIZATION REVIEW FOR:

(1) AN EMPLOYER WITH EMPLOYEES IN THIS STATE WHO ARE COVERED UNDER A HEALTH BENEFIT PLAN OR POLICY;

(2) A PAYOR; OR

(3) A THIRD PARTY ADMINISTRATOR.

(J) "PROVIDER OF RECORD" MEANS A PHYSICIAN OR OTHER HEALTH CARE PROVIDER THAT HAS PRIMARY RESPONSIBILITY FOR THE CARE AND TREATMENT PROVIDED OR PROPOSED TO BE PROVIDED TO AN ENROLLEE OR INSURED.

(J) "UTILIZATION REVIEW" MEANS A SYSTEM FOR PROSPECTIVE OR CONCURRENT REVIEW OF THE MEDICAL NECESSITY AND APPROPRIATENESS OF HEALTH CARE SERVICES BEING PROVIDED OR PROPOSED TO BE PROVIDED TO AN INDIVIDUAL OR GROUP OF INDIVIDUALS.

15-1602.

THE REQUIREMENTS AND PROVISIONS OF THIS SUBTITLE SHALL BE CONSIDERED IN ADDITION TO THE REQUIREMENTS AND PROVISIONS OF TITLE 19, SUBTITLE 13 OF THE HEALTH - GENERAL ARTICLE FOR THE PURPOSE OF PROVIDING UTILIZATION REVIEW OF THE MEDICAL NECESSITY OR APPROPRIATENESS OF HEALTH CARE SERVICES PROVIDED OR TO BE PROVIDED TO AN INSURED OR ENROLLEE UNDER A HEALTH BENEFIT PLAN.

15-1603.

(A) EACH PRIVATE REVIEW AGENT SHALL:

(1) ESTABLISH AND MAINTAIN A COMPLAINT SYSTEM THAT PROVIDES REASONABLE PROCEDURES FOR THE RESOLUTION OF WRITTEN COMPLAINTS INITIATED BY ENROLLEES, INSUREDS, OR HEALTH CARE PROVIDERS CONCERNING THE UTILIZATION REVIEW BY A PRIVATE REVIEW AGENT; AND

(2) MAINTAIN RECORDS OF ALL WRITTEN COMPLAINTS RECEIVED FOR 2 YEARS FROM THE DATE A COMPLAINT WAS FILED WITH THE AGENT.

(B) THE COMPLAINT PROCEDURE SHALL REQUIRE THE AGENT TO RESPOND IN WRITING TO THE PERSON MAKING THE COMPLAINT WITHIN 60 DAYS AFTER THE COMPLAINT IS FILED.

(C) (1) EACH YEAR EACH PRIVATE REVIEW AGENT SHALL SUBMIT TO THE COMMISSIONER A SUMMARY REPORT OF ALL COMPLAINTS RECEIVED DURING THE YEAR AT THE TIME AND IN THE FORM THE COMMISSIONER MAY REQUIRE BY REGULATION.

(2) A PRIVATE REVIEW AGENT SHALL ALLOW THE COMMISSIONER TO EXAMINE THE COMPLAINTS AND ALL RELEVANT DOCUMENTS AT ANY REASONABLE TIME.

15-1604.

(A) A PRIVATE REVIEW AGENT SHALL NOTIFY THE ENROLLEE OR INSURED, THE PERSON ACTING ON BEHALF OF THE ENROLLEE OR INSURED, OR THE ENROLLEE'S OR INSURED'S PROVIDER OF RECORD OF A DETERMINATION MADE IN A UTILIZATION REVIEW.

(B) THE NOTIFICATION REQUIRED UNDER THIS SECTION MAY BE MAILED OR OTHERWISE TRANSMITTED NO LATER THAN 2 WORKING DAYS AFTER THE DATE OF THE REQUEST FOR UTILIZATION REVIEW AND ALL OF THE INFORMATION NECESSARY TO MAKE A DETERMINATION IS RECEIVED BY THE PRIVATE REVIEW AGENT.

(C) WHENEVER THE PRIVATE REVIEW AGENT MAKES AN ADVERSE DETERMINATION, THE PRIVATE REVIEW AGENT SHALL INCLUDE IN THE NOTIFICATION:

(1) THE PRINCIPAL REASON OR REASONS FOR THE ADVERSE DETERMINATION;

(2) A DESCRIPTION OR THE SOURCE OF THE SCREENING CRITERIA THAT WAS UTILIZED AS GUIDELINES IN MAKING THE DETERMINATION; AND

(3) A DESCRIPTION OF THE PROCEDURE FOR APPEAL.

(D) THE NOTIFICATION OF AN ADVERSE DETERMINATION SHALL BE PROVIDED BY THE PRIVATE REVIEW AGENT:

(1) WITHIN 1 WORKING DAY BY TELEPHONE OR OTHER ELECTRONIC TRANSMISSION TO THE PROVIDER OF RECORD IF THE ENROLLEE OR INSURED IS HOSPITALIZED AT THE TIME OF THE ADVERSE DETERMINATION; OR

(2) WITHIN 3 WORKING DAYS IN WRITING TO THE PROVIDER OF RECORD AND THE ENROLLEE OR INSURED OR THE PERSON ACTING ON BEHALF OF THE

ENROLLEE OR INSURED IF THE ENROLLEE OR INSURED IS NOT HOSPITALIZED AT THE TIME OF THE ADVERSE DETERMINATION.

15-1605.

(A) A PRIVATE REVIEW AGENT SHALL MAINTAIN AND MAKE AVAILABLE A WRITTEN DESCRIPTION OF THE APPEAL PROCEDURE OF AN ADVERSE DETERMINATION.

(B) THE PROCEDURE FOR APPEAL OF AN ADVERSE DETERMINATION SHALL INCLUDE THE FOLLOWING:

(1) A PROVISION THAT AN ENROLLEE, INSURED, THE PERSON ACTING ON BEHALF OF AN ENROLLEE OR INSURED, OR THE ENROLLEE'S OR INSURED'S HEALTH CARE PROVIDER MAY APPEAL THE ADVERSE DETERMINATION AND SHALL BE PROVIDED, ON REQUEST, A CLEAR AND CONCISE STATEMENT OF THE CLINICAL BASIS FOR THE ADVERSE DETERMINATION;

(2) A LIST OF DOCUMENTS NEEDED TO BE SUBMITTED BY THE APPEALING PARTY TO THE PRIVATE REVIEW AGENT FOR THE APPEAL;

(3) A PROVISION THAT APPEAL DECISIONS SHALL BE MADE BY A PHYSICIAN, PROVIDED THAT, IF THE APPEAL IS DENIED AND WITHIN 10 WORKING DAYS OF THE DECISION THE HEALTH CARE PROVIDER PROVIDES IN WRITING GOOD CAUSE FOR HAVING A PARTICULAR TYPE OF SPECIALTY PROVIDER REVIEW THE CASE, THE DENIAL SHALL BE REVIEWED BY A HEALTH CARE PROVIDER IN THE SAME OR SIMILAR SPECIALTY AS TYPICALLY MANAGES THE MEDICAL CONDITION, PROCEDURE, OR TREATMENT UNDER DISCUSSION FOR REVIEW OF THE ADVERSE DETERMINATION;

(4) IN ADDITION TO THE WRITTEN APPEAL, A METHOD FOR AN EXPEDITED APPEAL PROCEDURE FOR EMERGENCY CARE DENIALS THAT SHALL INCLUDE A HEALTH CARE PROVIDER THAT HAS NOT PREVIOUSLY REVIEWED THE CASE UNDER WHICH AN APPEAL IS COMPLETED WITHIN 1 WORKING DAY FOLLOWING THE DATE ON WHICH THE APPEAL AND ALL OF THE INFORMATION NECESSARY TO COMPLETE THE APPEAL IS RECEIVED BY THE PRIVATE REVIEW AGENT;

(5) A PROVISION FOR WRITTEN NOTIFICATION TO THE APPEALING PARTY OF THE DETERMINATION OF THE APPEAL, AS SOON AS PRACTICAL, BUT NO LATER THAN 30 DAYS AFTER THE DATE THE PRIVATE REVIEW AGENT RECEIVES THE APPEAL; AND

(6) IF THE APPEAL IS DENIED, A PROVISION FOR WRITTEN NOTIFICATION TO INCLUDE:

(I) A CLEAR AND CONCISE STATEMENT OF THE CLINICAL BASIS FOR THE APPEAL'S DENIAL;

(II) THE SPECIALTY OF THE HEALTH CARE PROVIDER THAT MADE THE DENIAL; AND

(III) NOTICE OF THE APPEALING PARTY'S RIGHT TO SEEK REVIEW OF THE DENIAL BY AN INDEPENDENT REVIEW ORGANIZATION UNDER § 15-1606 OF THIS SUBTITLE.

(C) (1) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, IN A CIRCUMSTANCE INVOLVING A LIFE-THREATENING CONDITION, AN ENROLLEE OR INSURED IS ENTITLED TO AN IMMEDIATE APPEAL TO AN INDEPENDENT REVIEW ORGANIZATION AS PROVIDED IN § 15-1606 OF THIS SUBTITLE AND IS NOT REQUIRED TO COMPLY WITH PROCEDURES UNDER THIS SECTION FOR AN INTERNAL REVIEW OF THE PRIVATE REVIEW AGENT'S ADVERSE DETERMINATION.

(2) FOR PURPOSES OF THIS SUBSECTION, "LIFE-THREATENING CONDITION" MEANS A DISEASE OR OTHER MEDICAL CONDITION WITH RESPECT TO WHICH DEATH IS PROBABLE UNLESS THE COURSE OF THE DISEASE OR CONDITION IS INTERRUPTED.

15-1606.

(A) A PRIVATE REVIEW AGENT SHALL:

(1) PERMIT ANY PARTY WHOSE APPEAL OF AN ADVERSE DETERMINATION IS DENIED BY THE PRIVATE REVIEW AGENT TO SEEK REVIEW OF THAT DETERMINATION BY AN INDEPENDENT REVIEW ORGANIZATION ASSIGNED TO THE APPEAL IN ACCORDANCE WITH SUBTITLE 17 OF THIS TITLE;

(2) PROVIDE TO THE APPROPRIATE INDEPENDENT REVIEW ORGANIZATION NO LATER THAN THE 3RD BUSINESS DAY AFTER THE DATE THE PRIVATE REVIEW AGENT RECEIVES A REQUEST FOR REVIEW A COPY OF:

(I) ANY MEDICAL RECORDS OF THE ENROLLEE OR INSURED THAT ARE RELEVANT TO THE REVIEW;

(II) ANY DOCUMENTS USED BY THE PRIVATE REVIEW AGENT IN MAKING THE DETERMINATION THAT IS TO BE REVIEWED BY THE INDEPENDENT REVIEW ORGANIZATION;

(III) THE WRITTEN NOTIFICATION DESCRIBED IN § 15-1605(B)(6) OF THIS SUBTITLE;

(IV) ANY DOCUMENTATION AND WRITTEN INFORMATION SUBMITTED TO THE PRIVATE REVIEW AGENT IN SUPPORT OF THE APPEAL; AND

(V) A LIST OF EACH PHYSICIAN OR HEALTH CARE PROVIDER THAT HAS PROVIDED HEALTH CARE SERVICES TO THE ENROLLEE OR INSURED AND MAY HAVE MEDICAL RECORDS RELEVANT TO THE APPEAL;

(3) COMPLY WITH THE INDEPENDENT REVIEW ORGANIZATION'S DETERMINATION WITH RESPECT TO THE MEDICAL NECESSITY OR APPROPRIATENESS OF THE HEALTH CARE SERVICES PROVIDED OR TO BE PROVIDED TO THE ENROLLEE OR INSURED; AND

(4) PAY FOR THE INDEPENDENT REVIEW.

(B) SUBJECT TO REGULATIONS ADOPTED BY THE COMMISSIONER UNDER SUBTITLE 17 OF THIS TITLE, A PRIVATE REVIEW AGENT MAY PROVIDE CONFIDENTIAL INFORMATION THAT IS IN THE CUSTODY OF THE AGENT TO AN INDEPENDENT REVIEW ORGANIZATION.

SUBTITLE 17. INDEPENDENT REVIEW ORGANIZATIONS.

15-1701.

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

(B) "LIFE-THREATENING CONDITION" MEANS A DISEASE OR OTHER MEDICAL CONDITION WITH RESPECT TO WHICH DEATH IS PROBABLE UNLESS THE COURSE OF THE DISEASE OR CONDITION IS INTERRUPTED.

(C) "PAYOR" HAS THE MEANING STATED IN § 15-1601 OF THIS TITLE.

15-1702.

(A) THE COMMISSIONER SHALL:

(1) ESTABLISH AND ADOPT BY REGULATION STANDARDS FOR:

(I) THE CERTIFICATION, SELECTION, AND OPERATION OF INDEPENDENT REVIEW ORGANIZATIONS TO PERFORM INDEPENDENT REVIEWS, AS DESCRIBED IN SUBTITLE 16 OF THIS TITLE; AND

(II) THE SUSPENSION AND REVOCATION OF A CERTIFICATION;

(2) DESIGNATE ANNUALLY EACH PERSON THAT MEETS THE STANDARDS AS AN INDEPENDENT REVIEW ORGANIZATION;

(3) ESTABLISH AND CHARGE PAYORS FEES THAT COVER THE NECESSARY COST OF OPERATING INDEPENDENT REVIEW ORGANIZATIONS; AND

(4) PROVIDE ONGOING OVERSIGHT OF INDEPENDENT REVIEW ORGANIZATIONS TO ENSURE THE CONTINUED COMPLIANCE WITH THIS SUBTITLE AND THE STANDARDS ESTABLISHED AND ADOPTED UNDER THIS SUBTITLE.

(B) THE STANDARDS REQUIRED TO BE ESTABLISHED AND ADOPTED BY REGULATION UNDER SUBSECTION (A) OF THIS SECTION MUST ENSURE:

(1) THE TIMELY RESPONSE OF AN INDEPENDENT REVIEW ORGANIZATION SELECTED UNDER THIS SUBTITLE;

(2) THE CONFIDENTIALITY OF MEDICAL RECORDS TRANSMITTED TO AN INDEPENDENT REVIEW ORGANIZATION FOR USE IN INDEPENDENT REVIEWS;

(3) THE QUALIFICATIONS AND INDEPENDENCE OF HEALTH CARE PROVIDERS OR PHYSICIANS MAKING REVIEW DETERMINATIONS FOR AN INDEPENDENT REVIEW ORGANIZATION;

(4) THE FAIRNESS OF PROCEDURES USED BY AN INDEPENDENT REVIEW ORGANIZATION IN MAKING DETERMINATIONS; AND

(5) TIMELY NOTICE TO AN ENROLLEE, INSURED, OR REPRESENTATIVE OF AN ENROLLEE OR INSURED OF THE RESULTS OF THE INDEPENDENT REVIEW, INCLUDING THE CLINICAL BASIS FOR THE DETERMINATION.

(C) IN ADDITION TO SUBSECTION (B) OF THIS SECTION, THE STANDARDS TO BE ESTABLISHED AND ADOPTED IN ACCORDANCE WITH SUBSECTION (A) OF THIS SECTION SHALL INCLUDE A REQUIREMENT THAT EACH INDEPENDENT REVIEW ORGANIZATION MAKE ITS DETERMINATION:

(1) NO LATER THAN THE EARLIER OF:

(I) THE 15TH DAY AFTER THE DATE THE INDEPENDENT REVIEW ORGANIZATION RECEIVES THE INFORMATION NECESSARY TO MAKE THE DETERMINATION; OR

(II) THE 20TH DAY AFTER THE DATE THE INDEPENDENT REVIEW ORGANIZATION RECEIVES THE REQUEST THAT THE DETERMINATION BE MADE; AND

(2) IN THE CASE OF A LIFE-THREATENING CONDITION, NO LATER THAN THE EARLIER OF:

(I) THE 5TH DAY AFTER THE DATE THE INDEPENDENT REVIEW ORGANIZATION RECEIVES INFORMATION NECESSARY TO MAKE THE DETERMINATION; OR

(II) THE 8TH DAY AFTER THE DATE THE INDEPENDENT REVIEW ORGANIZATION RECEIVES THE REQUEST THAT THE DETERMINATION BE MADE.

15-1703.

(A) TO BE CERTIFIED AS AN INDEPENDENT REVIEW ORGANIZATION UNDER THIS SUBTITLE, A PERSON MUST SUBMIT TO THE COMMISSIONER AN APPLICATION IN THE FORM REQUIRED BY THE COMMISSIONER.

(B) THE APPLICATION MUST INCLUDE:

(1) FOR AN APPLICANT THAT IS PUBLICLY HELD, THE NAME OF EACH STOCKHOLDER OR OWNER OF MORE THAN 5% OF ANY STOCK OR OPTIONS;

(2) THE NAME OF ANY HOLDER OF BONDS OR NOTES OF THE APPLICANT THAT EXCEED $100,000;

(3) THE NAME AND TYPE OF BUSINESS OF EACH CORPORATION OR OTHER ENTITY THAT THE APPLICANT CONTROLS OR IS AFFILIATED WITH AND THE NATURE AND EXTENT OF THE AFFILIATION OR CONTROL;

(4) THE NAME AND BIOGRAPHICAL SKETCH OF EACH DIRECTOR, OFFICER, AND EXECUTIVE OF THE APPLICANT AND ANY ENTITY LISTED UNDER ITEM (3) OF THIS SUBSECTION AND A DESCRIPTION OF ANY RELATIONSHIP THE NAMED INDIVIDUAL HAS WITH:

(I) A HEALTH BENEFIT PLAN;

(II) A HEALTH MAINTENANCE ORGANIZATION;

(III) AN INSURER;

(IV) A PRIVATE REVIEW AGENT;

(V) A NONPROFIT HEALTH PLAN;

(VI) A PAYOR;

(VII) A HEALTH CARE PROVIDER; OR

(VIII) A GROUP REPRESENTING ANY OF THE ENTITIES DESCRIBED BY ITEMS (I) THROUGH (VII) OF THIS ITEM;

(5) THE PERCENTAGE OF THE APPLICANT'S REVENUES THAT ARE ANTICIPATED TO BE DERIVED FROM REVIEWS CONDUCTED UNDER SUBTITLE 16 OF THIS TITLE;

(6) A DESCRIPTION OF THE AREAS OF EXPERTISE OF THE HEALTH CARE PROVIDERS MAKING REVIEW DETERMINATIONS FOR THE APPLICANT; AND

(7) THE PROCEDURES TO BE USED BY THE APPLICANT IN MAKING REVIEW DETERMINATIONS WITH RESPECT TO REVIEWS CONDUCTED UNDER SUBTITLE 16 OF THIS TITLE.

(C) (1) EACH YEAR, A PERSON CERTIFIED AS AN INDEPENDENT REVIEW ORGANIZATION 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 INDEPENDENT REVIEW ORGANIZATION SHALL SUBMIT THE UPDATED INFORMATION TO THE COMMISSIONER.

15-1704.

AN INDEPENDENT REVIEW ORGANIZATION MAY NOT BE A SUBSIDIARY OF, OR IN ANY WAY OWNED OR CONTROLLED BY, A PAYOR OR A TRADE OR PROFESSIONAL ASSOCIATION OF PAYORS.

15-1705.

(A) AN INDEPENDENT REVIEW ORGANIZATION CONDUCTING A REVIEW UNDER SUBTITLE 16 OF THIS TITLE IS NOT LIABLE FOR DAMAGES ARISING FROM A DETERMINATION MADE BY THE ORGANIZATION.

(B) THIS SECTION DOES NOT APPLY TO AN ACT OR OMISSION OF THE INDEPENDENT REVIEW ORGANIZATION THAT IS MADE IN BAD FAITH OR THAT INVOLVES GROSS NEGLIGENCE.

Article - Health - General

19-705.2.

(a) With the advice of the Commissioner, the Secretary 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 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 to the Commissioner 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, INCLUDING THE RIGHT OF A MEMBER OR SUBSCRIBER TO APPEAL A DENIAL OF AN ADVERSE DETERMINATION TO AN INDEPENDENT REVIEW ORGANIZATION AND

THE PROCEDURES FOR MAKING AN APPEAL TO AN INDEPENDENT REVIEW ORGANIZATION, shall be included in all contracts between a health maintenance organization and a member or subscriber of a health maintenance organization.

19-705.3.

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

(2) "ADVERSE DETERMINATION" MEANS A DETERMINATION BY A HEALTH MAINTENANCE ORGANIZATION THAT HEALTH CARE SERVICES PROVIDED OR PROPOSED TO BE PROVIDED TO A MEMBER OR SUBSCRIBER ARE NOT APPROPRIATE AND MEDICALLY NECESSARY.

(3) "INDEPENDENT REVIEW ORGANIZATION" MEANS AN ORGANIZATION SELECTED AS PROVIDED IN TITLE 15, SUBTITLE 17 OF THE INSURANCE ARTICLE.

(4) "LIFE-THREATENING CONDITION" MEANS A DISEASE OR OTHER MEDICAL CONDITION WITH RESPECT TO WHICH DEATH IS PROBABLE UNLESS THE COURSE OF THE DISEASE OR CONDITION IS INTERRUPTED.

(B) IN ADDITION TO § 19-703.2(B) OF THIS SUBTITLE, THE COMPLAINT SYSTEM OF A HEALTH MAINTENANCE ORGANIZATION SHALL INCLUDE:

(1) NOTIFICATION TO A MEMBER OR SUBSCRIBER OF THE MEMBER'S OR SUBSCRIBER'S RIGHT TO APPEAL AN ADVERSE DETERMINATION TO AN INDEPENDENT REVIEW ORGANIZATION;

(2) NOTIFICATION TO A MEMBER OR SUBSCRIBER OF THE PROCEDURES FOR APPEALING AN ADVERSE DETERMINATION TO AN INDEPENDENT REVIEW ORGANIZATION; AND

(3) NOTIFICATION TO A MEMBER OR SUBSCRIBER WHO HAS A LIFE-THREATENING CONDITION OF THE MEMBER'S OR SUBSCRIBER'S RIGHT TO AN IMMEDIATE REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION AND THE PROCEDURES TO OBTAIN THAT REVIEW.

(C) THE PROVISIONS OF TITLE 15, SUBTITLE 16 OF THE INSURANCE ARTICLE THAT RELATE TO INDEPENDENT REVIEW APPLY TO A HEALTH MAINTENANCE ORGANIZATION UNDER THIS SECTION AS IF THE HEALTH MAINTENANCE ORGANIZATION WAS A PRIVATE REVIEW AGENT.

19-706.

(Y) THE PROVISIONS OF TITLE 3, SUBTITLE 2C OF THE COURTS ARTICLE AND TITLE 15, SUBTITLES 16 AND 17 OF THE INSURANCE ARTICLE SHALL APPLY TO A HEALTH MAINTENANCE ORGANIZATION.

SECTION 3. AND BE IT FURTHER ENACTED, That the provisions of Title 3, Subtitle 2C of the Courts Article of this Act shall apply only to a cause of action arising on or after July 1, 1998.

SECTION 4. AND BE IT FURTHER ENACTED, That the provisions of Title 15, Subtitles 16 and 17 of the Insurance Article of this Act shall apply only to an adverse determination made by a private review agent, carrier, or health maintenance organization on or after July 1, 1998.

SECTION 5. AND BE IT FURTHER ENACTED, That § 15-112(j) of the Insurance Article and § 19-705.2(d) of the Health - General Article, as amended under this Act, shall apply to a new policy, contract, certificate, or other evidence of coverage issued or delivered in the State on or after July 1, 1998 and to the renewal of a policy, contract, certificate, or other evidence of coverage in effect before July 1, 1998, except that any policy, contract, certificate, or other evidence of coverage in effect before July 1, 1998 shall comply with the provisions of § 15-112(j) of the Insurance Article and § 19-705.2 of the Health - General Article, as amended under this Act, no later than July 1, 1999.

SECTION 6. AND BE IT FURTHER ENACTED, That this Act shall be construed only prospectively and may not be applied or interpreted to have any effect on or application to any cause of action arising before July 1, 1998.

SECTION 7. AND BE IT FURTHER ENACTED, That if any provision of this Act or the application thereof to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity does not affect other provisions or any other application of this Act which can be given effect without the invalid provision or application, and for this purpose the provisions of this Act are declared severable.

SECTION 8. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 1998.