

HOUSE BILL 412

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2000 Regular Session  
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By: **Chairman, Economic Matters Committee (Departmental - Insurance Administration, Maryland)**

Introduced and read first time: February 3, 2000

Assigned to: Economic Matters

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A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance - Private Review Agents**

3 FOR the purpose of altering certain provisions of law relating to administrative and  
4 enforcement oversight of private review agents; requiring certain entities to  
5 conduct utilization review in a certain manner; requiring private review agents  
6 to file a copy of their internal grievance process with the Maryland Insurance  
7 Commissioner; altering the time frame concerning when a representative of a  
8 private review agent must be accessible to patients and health care providers;  
9 requiring private review agents to submit certain information to the Insurance  
10 Commissioner; establishing certain requirements for when a private review  
11 agent must make certain determinations; requiring private review agents to  
12 notify certain health care providers within a certain time frame after a certain  
13 determination has been made; altering certain provisions of law related to  
14 utilization review concerning the types of health care providers that may make  
15 certain determinations; requiring certain private review agents to relinquish the  
16 private review agent's certificate of registration under certain circumstances;  
17 altering certain provisions of law relating to violations of this Act; altering  
18 certain provisions of law requiring the Commissioner to provide a hearing under  
19 certain circumstances; altering certain penalties; altering provisions of law  
20 relating to reporting requirements; defining certain terms; altering certain  
21 terms; making certain stylistic and technical changes; providing for a delayed  
22 effective date; and generally relating to administrative and enforcement  
23 oversight of private review agents.

24 BY repealing and reenacting, with amendments,  
25 Article - Insurance  
26 Section 15-1001, 15-10B-01, 15-10B-03(d), 15-10B-05, and 15-10B-06  
27 Annotated Code of Maryland  
28 (1997 Volume and 1999 Supplement)

29 BY repealing and reenacting, without amendments,  
30 Article - Insurance  
31 Section 15-10B-02, 15-10B-04, 15-10B-09, and 15-10B-10

1 Annotated Code of Maryland  
2 (1997 Volume and 1999 Supplement)

3 BY repealing

4 Article - Insurance  
5 Section 15-10B-07, 15-10B-08, 15-10B-11, 15-10B-12, 15-10B-13,  
6 15-10B-14, 15-10B-15, 15-10B-16, 15-10B-17, and 15-10B-18  
7 Annotated Code of Maryland  
8 (1997 Volume and 1999 Supplement)

9 BY adding to

10 Article - Insurance  
11 Section 15-10B-07, 15-10B-08, 15-10B-09.1, 15-10B-11, 15-10B-12,  
12 15-10B-13, 15-10B-14, 15-10B-15, 15-10B-16, 15-10B-17, and  
13 15-10B-18  
14 Annotated Code of Maryland  
15 (1997 Volume and 1999 Supplement)

16 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF  
17 MARYLAND, That the Laws of Maryland read as follows:

18 **Article - Insurance**

19 15-1001.

20 (a) This section applies to [insurers and nonprofit health service plans]  
21 ENTITIES that propose to issue or deliver individual, group, or blanket health  
22 insurance policies or contracts in the State or to administer health benefit programs  
23 that provide for the coverage of [hospital benefits] HEALTH CARE SERVICES and the  
24 utilization review of those [benefits] SERVICES, INCLUDING:

25 (1) AN AUTHORIZED INSURER THAT PROVIDES HEALTH INSURANCE IN  
26 THE STATE;

27 (2) A NONPROFIT HEALTH SERVICE PLAN;

28 (3) A HEALTH MAINTENANCE ORGANIZATION;

29 (4) A DENTAL PLAN ORGANIZATION; OR

30 (5) EXCEPT FOR A MANAGED CARE ORGANIZATION AS DEFINED IN TITLE  
31 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE, ANY OTHER PERSON THAT  
32 PROVIDES HEALTH BENEFIT PLANS SUBJECT TO REGULATION BY THE STATE.

33 (b) (1) [Each] SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, EACH  
34 entity subject to this section shall:

35 [(1)] (I) have a certificate issued under Subtitle 10B of this title; OR

1 [(2)] (II) contract with a private review agent that has a certificate  
2 issued under Subtitle 10B of this title[; or].

3 [(3)] (2) FOR HOSPITAL SERVICES, EACH ENTITY SUBJECT TO THIS  
4 SECTION MAY contract with or delegate utilization review to a hospital utilization  
5 review program approved under § 19-319(d) of the Health - General Article.

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

13 (1) THE TREATING PROVIDER; OR

14 (2) WHEN HOSPITAL SERVICES ARE PROVIDED, THE HOSPITAL  
15 UTILIZATION REVIEW PROGRAM APPROVED UNDER § 19-319(D) OF THE HEALTH -  
16 GENERAL ARTICLE.

17 15-10B-01.

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

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

21 (i) is or was not medically necessary, appropriate, or efficient; and

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

23 (2) [There is no adverse decision if the private review agent and the  
24 health care provider on behalf of the patient reach an agreement on the proposed or  
25 delivered health care services.] "ADVERSE DECISION" DOES NOT INCLUDE A  
26 DECISION CONCERNING A SUBSCRIBER'S STATUS AS A MEMBER.

27 (c) "Certificate" means a certificate of registration granted by the  
28 Commissioner to a private review agent.

29 (d) (1) "Employee assistance program" means a health care service plan  
30 that, in accordance with a contract with an employer or labor union:

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

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

35 2. refer the employee or the employee's family member to  
36 [health care providers] A PHYSICIAN OR PROVIDER LICENSED OR AUTHORIZED TO

1 PROVIDE HEALTH CARE SERVICES or other community resources for counseling,  
2 therapy, or treatment; and

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

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

9 (E) (1) "GRIEVANCE" MEANS A PROTEST FILED BY A PATIENT OR A HEALTH  
10 CARE PROVIDER ON BEHALF OF A PATIENT WITH A PRIVATE REVIEW AGENT  
11 THROUGH THE PRIVATE REVIEW AGENT'S INTERNAL GRIEVANCE PROCESS  
12 REGARDING AN ADVERSE DECISION CONCERNING A PATIENT.

13 (2) "GRIEVANCE" DOES NOT INCLUDE A VERBAL REQUEST FOR  
14 RECONSIDERATION OF A UTILIZATION REVIEW DETERMINATION.

15 (F) "GRIEVANCE DECISION" MEANS A FINAL DETERMINATION BY A PRIVATE  
16 REVIEW AGENT THAT ARISES FROM A GRIEVANCE FILED WITH THE PRIVATE REVIEW  
17 AGENT UNDER ITS INTERNAL GRIEVANCE PROCESS REGARDING AN ADVERSE  
18 DECISION CONCERNING A PATIENT.

19 [(e)] (G) "Health care facility" means:

20 (1) a hospital as defined in § 19-301 of the Health - General Article;

21 (2) a related institution as defined in § 19-301 of the Health - General  
22 Article;

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

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

29 (5) a home health agency as defined in § 19-401 of the Health - General  
30 Article;

31 (6) a hospice as defined in § 19-901 of the Health - General Article;

32 (7) a facility that provides radiological or other diagnostic imagery  
33 services;

34 (8) a medical laboratory as defined in § 17-201 of the Health - General  
35 Article; or

1 (9) an alcohol abuse and drug abuse treatment program as defined in §  
2 8-403 of the Health - General Article.

3 (H) "HEALTH CARE PROVIDER" MEANS:

4 (1) AN INDIVIDUAL WHO:

5 (I) IS LICENSED OR OTHERWISE AUTHORIZED IN THE STATE TO  
6 PROVIDE HEALTH CARE SERVICES IN THE ORDINARY COURSE OF BUSINESS OR  
7 PRACTICE OF A PROFESSION; AND

8 (II) IS A TREATING PROVIDER OF A MEMBER; OR

9 (2) A HOSPITAL, AS DEFINED IN § 19-301 OF THE HEALTH - GENERAL  
10 ARTICLE.

11 [(f)] (I) "Health care service" means [any] A health or medical CARE  
12 procedure or service rendered by a health care provider LICENSED OR AUTHORIZED  
13 TO PROVIDE HEALTH CARE SERVICES that:

14 (1) provides testing, diagnosis, or treatment of a human disease or  
15 dysfunction; or

16 (2) dispenses drugs, medical devices, medical appliances, or medical  
17 goods for the treatment of a human disease or dysfunction.

18 (J) "HEALTH CARE SERVICE REVIEWER" MEANS AN INDIVIDUAL WHO IS  
19 LICENSED OR OTHERWISE AUTHORIZED TO PROVIDE HEALTH CARE SERVICES IN  
20 THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION.

21 [(g)] (K) "Private review agent" means:

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

24 (i) a Maryland business entity; or

25 (ii) a third party that [provides] PAYS FOR, PROVIDES, or  
26 administers [hospital benefits] HEALTH CARE SERVICES to citizens of this State[,  
27 including:

28 1. a health maintenance organization issued a certificate of  
29 authority in accordance with Title 19, Subtitle 7 of the Health - General Article; or

30 2. a health insurer, nonprofit health service plan, health  
31 insurance service organization, or preferred provider organization authorized to offer  
32 health insurance policies or contracts in this State in accordance with this article]; or

33 (2) any person or entity including a hospital-affiliated person  
34 performing utilization review for the purpose of making claims or payment decisions  
35 FOR HEALTH CARE SERVICES on behalf of the employer's or labor union's health

1 insurance plan under an employee assistance program for employees other than the  
2 employees EMPLOYED BY:

3 (i) [employed by] the hospital; or

4 (ii) [employed by] a business wholly owned by the hospital.

5 [(h)] (L) "Significant beneficial interest" means the ownership of any financial  
6 interest that is greater than the lesser of:

7 (1) 5 percent of the whole; or

8 (2) \$5,000.

9 [(i)] (M) "Utilization review" means a system for reviewing the appropriate  
10 and efficient allocation of health care RESOURCES AND services given or proposed to  
11 be given to a patient or group of patients.

12 [(j)] (N) "Utilization review plan" means a description of the standards  
13 governing utilization review activities performed by a private review agent.

14 15-10B-02.

15 The purpose of this subtitle is to:

16 (1) promote the delivery of quality health care in a cost effective manner;

17 (2) foster greater coordination between payors and providers conducting  
18 utilization review activities;

19 (3) protect patients, business, and providers by ensuring that private  
20 review agents are qualified to perform utilization review activities and to make  
21 informed decisions on the appropriateness of medical care; and

22 (4) ensure that private review agents maintain the confidentiality of  
23 medical records in accordance with applicable State and federal laws.

24 15-10B-03.

25 (d) (1) The Commissioner, after consultation with payors, including the  
26 Health Insurance Association of America, the League of Life and Health Insurers of  
27 Maryland, and the Maryland Association of Health [Maintenance Organizations]  
28 PLANS, and providers of health care, including the [Maryland Hospital Association]  
29 MHA: THE ASSOCIATION OF MARYLAND HOSPITALS AND HEALTH SYSTEMS, the  
30 Medical and Chirurgical Faculty of Maryland, and licensed or certified providers of  
31 treatment for a mental illness, emotional disorder, or a drug abuse or alcohol abuse  
32 disorder, shall adopt regulations to implement the provisions of this subtitle.

33 (2) (i) Subject to the provisions of subparagraph (iii) of this paragraph,  
34 the regulations adopted by the Commissioner shall include a uniform treatment plan

1 form for utilization review of services for the treatment of a mental illness, emotional  
2 disorder, or a drug abuse or alcohol abuse disorder.

3 (ii) The uniform treatment plan form adopted by the  
4 Commissioner:

5 1. shall adequately protect the confidentiality of the patient;  
6 and

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

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

13 15-10B-04.

14 (a) An applicant for a certificate shall:

15 (1) submit an application to the Commissioner; and

16 (2) pay to the Commissioner the application fee established by the  
17 Commissioner through regulation.

18 (b) The application shall:

19 (1) be on a form and accompanied by any supporting documentation that  
20 the Commissioner requires; and

21 (2) be signed and verified by the applicant.

22 (c) The application fees required under subsection (a)(2) of this section or §  
23 15-10B-10(b)(2) of this subtitle shall be sufficient to pay for the administrative costs  
24 of the certificate program and any other costs associated with carrying out the  
25 provisions of this subtitle.

26 15-10B-05.

27 (a) In conjunction with the application, the private review agent shall submit  
28 information that the Commissioner requires including:

29 (1) a utilization review plan that includes:

30 (i) the specific criteria and standards to be used in conducting  
31 utilization review of proposed or delivered HEALTH CARE services;

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

1 (iii) [the] IF APPLICABLE, ANY provisions by which patients,  
2 physicians, or hospitals may seek reconsideration [or appeal of adverse decisions by  
3 the private review agent];

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

6 (3) A COPY OF THE PRIVATE REVIEW AGENT'S INTERNAL GRIEVANCE  
7 PROCESS IF A CARRIER DELEGATES ITS INTERNAL GRIEVANCE PROCESS TO THE  
8 PRIVATE REVIEW AGENT IN ACCORDANCE WITH § 15-10A-02(L) OF THIS TITLE;

9 [(3)] (4) the procedures and policies to ensure that a representative of  
10 the private review agent is reasonably accessible to patients and HEALTH CARE  
11 providers [5] 7 days a week [during normal business], 24 hours A DAY in this State;

12 [(4)] (5) the policies and procedures to ensure that all applicable State  
13 and federal laws to protect the confidentiality of individual medical records are  
14 followed;

15 [(5)] (6) a copy of the materials designed to inform applicable patients  
16 and providers of the requirements of the utilization review plan;

17 [(6)] (7) a list of the third party payors for which the private review  
18 agent is performing utilization review in this State;

19 [(7)] (8) the policies and procedures to ensure that the private review  
20 agent has a formal program for the orientation and training of the personnel either  
21 employed or under contract to perform the utilization review;

22 [(8)] (9) a list of the health care providers AS DEFINED IN § 15-10B-07 OF  
23 THIS SUBTITLE involved in establishing the specific criteria and standards to be used  
24 in conducting utilization review; and

25 [(9)] (10) certification by the private review agent that the criteria and  
26 standards to be used in conducting utilization review are:

27 (i) objective;

28 (ii) clinically valid;

29 (iii) compatible with established principles of health care; and

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

32 (b) (1) At least [10] 30 days before a private review agent requires any  
33 revisions or modifications to [the] EXISTING specific criteria and standards to be  
34 used in conducting utilization review of proposed or delivered services, the private  
35 review agent shall submit those revisions or modifications to the Commissioner.



1 (2) AT LEAST 10 DAYS BEFORE A PRIVATE REVIEW AGENT REQUIRES  
2 SPECIFIC CRITERIA AND STANDARDS TO BE USED IN CONDUCTING UTILIZATION  
3 REVIEW OF PROPOSED OR DELIVERED SERVICES IN WHICH THERE ARE NO EXISTING  
4 CRITERIA OR STANDARDS, THE PRIVATE REVIEW AGENT SHALL SUBMIT THE  
5 CRITERIA AND STANDARDS TO THE COMMISSIONER.

6 (c) On the written request of any person or health care facility, the private  
7 review agent shall provide 1 copy of the specific criteria and standards to be used in  
8 conducting utilization review of proposed or delivered services and any subsequent  
9 revisions or modifications to the specific criteria and standards to be used in  
10 conducting utilization review of proposed or delivered services to the person or health  
11 care facility making the request.

12 (d) The private review agent may charge a reasonable fee for a copy of the  
13 specific criteria and standards or any subsequent revisions or modifications to the  
14 specific criteria to any person or health care facility requesting a copy under  
15 subsection (c) of this section.

16 (e) [It shall constitute a violation of this subtitle if the Commissioner, in  
17 consultation with an independent review organization, medical expert, the  
18 Department of Health and Mental Hygiene, or other appropriate entity, determines  
19 that the criteria and standards used in conducting utilization review are not:

20 (1) objective;

21 (2) clinically valid;

22 (3) compatible with established principles of health care; or

23 (4) flexible enough to allow deviations from norms when justified on a  
24 case by case basis.]

25 A PRIVATE REVIEW AGENT SHALL ADVISE THE COMMISSIONER, IN WRITING, OF  
26 A CHANGE IN:

27 (1) CORPORATE OWNERSHIP, MEDICAL DIRECTOR, OR CHIEF EXECUTIVE  
28 OFFICER AT LEAST 60 DAYS BEFORE THE DATE OF THE CHANGE;

29 (2) THE NAME, ADDRESS, OR TELEPHONE NUMBER OF THE PRIVATE  
30 REVIEW AGENT WITHIN 30 DAYS OF THE DATE OF THE CHANGE; OR

31 (3) THE PRIVATE REVIEW AGENT'S SCOPE OF RESPONSIBILITY.

32 15-10B-06.

33 [(a) In this section, "utilization review" means a system for reviewing the  
34 appropriate and efficient allocation of health care resources and services given or  
35 proposed to be given to a patient or group of patients by a health care provider,  
36 including a hospital or an intermediate care facility described under § 8-403(e) of the  
37 Health - General Article.

1 (b) In addition to any other requirements under this subtitle, a private review  
2 agent performing utilization review of services related to the treatment of alcoholism,  
3 drug abuse, or mental illness shall meet the requirements of this section.

4 (c) All adverse decisions shall be made by a physician, or a panel of other  
5 appropriate health care providers with at least 1 physician, selected by the private  
6 review agent who is:

7 (1) (i) board certified or eligible in the same specialty as the treatment  
8 under review; or

9 (ii) actively practicing, or has demonstrated expertise, in the  
10 alcohol, drug abuse, or mental health service or treatment under review; and

11 (2) not compensated by the private review agent in a manner that  
12 provides a financial incentive directly or indirectly to deny or reduce coverage.

13 (d) If a course of treatment has been preauthorized or approved for a patient,  
14 a private review agent may not revise or modify the specific criteria or standards used  
15 for the utilization review to make an adverse decision regarding the services delivered  
16 to that patient.

17 (e) (1) In the event a patient or health care provider, including a physician,  
18 intermediate care facility described under § 8-403(e) of the Health - General Article,  
19 or hospital seeks reconsideration or appeal of an adverse decision by a private review  
20 agent, the final determination of the appeal of the adverse decision shall be made  
21 based on the professional judgment of a physician, or a panel of other appropriate  
22 health care providers with at least 1 physician, selected by the private review agent  
23 who is:

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

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

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

30 (2) In the event a patient or health care provider, including a physician,  
31 intermediate care facility described under § 8-403(e) of the Health - General Article,  
32 or hospital seeks reconsideration or appeal of an adverse decision by a private review  
33 agent, the final determination of the appeal of the adverse decision shall be stated in  
34 writing and shall reference the specific criteria and standards, including interpretive  
35 guidelines, upon which the denial or reduction in coverage is based.

36 (f) A private review agent may not charge a fee to a patient or health care  
37 provider for an appeal of an adverse decision.]

38 (A) (1) A PRIVATE REVIEW AGENT SHALL:

1 (I) MAKE ALL INITIAL DETERMINATIONS ON WHETHER TO  
2 AUTHORIZE OR CERTIFY A NONEMERGENCY COURSE OF TREATMENT FOR A PATIENT  
3 WITHIN 2 WORKING DAYS AFTER RECEIPT OF THE INFORMATION NECESSARY TO  
4 MAKE THE DETERMINATION;

5 (II) MAKE ALL DETERMINATIONS ON WHETHER TO AUTHORIZE OR  
6 CERTIFY AN EXTENDED STAY IN A HEALTH CARE FACILITY OR ADDITIONAL HEALTH  
7 CARE SERVICES WITHIN 1 WORKING DAY AFTER RECEIPT OF THE INFORMATION  
8 NECESSARY TO MAKE THE DETERMINATION; AND

9 (III) PROMPTLY NOTIFY THE HEALTH CARE PROVIDER OF THE  
10 DETERMINATION.

11 (2) IF WITHIN 3 DAYS AFTER RECEIPT OF THE INITIAL REQUEST FOR  
12 HEALTH CARE SERVICES THE PRIVATE REVIEW AGENT DOES NOT HAVE SUFFICIENT  
13 INFORMATION TO MAKE A DETERMINATION, THE PRIVATE REVIEW AGENT SHALL  
14 INFORM THE HEALTH CARE PROVIDER THAT ADDITIONAL INFORMATION MUST BE  
15 PROVIDED.

16 (B) IF AN INITIAL DETERMINATION IS MADE BY A PRIVATE REVIEW AGENT  
17 NOT TO AUTHORIZE OR CERTIFY A HEALTH CARE SERVICE AND THE HEALTH CARE  
18 PROVIDER BELIEVES THE DETERMINATION WARRANTS AN IMMEDIATE  
19 RECONSIDERATION, A PRIVATE REVIEW AGENT SHALL PROVIDE THE HEALTH CARE  
20 PROVIDER THE OPPORTUNITY TO SPEAK WITH THE PHYSICIAN THAT RENDERED THE  
21 DETERMINATION, BY TELEPHONE ON AN EXPEDITED BASIS, WITHIN A PERIOD OF  
22 TIME NOT TO EXCEED 24 HOURS OF THE HEALTH CARE PROVIDER SEEKING THE  
23 RECONSIDERATION.

24 (C) FOR EMERGENCY INPATIENT ADMISSIONS, A PRIVATE REVIEW AGENT  
25 MAY NOT RENDER AN ADVERSE DECISION SOLELY BECAUSE THE HOSPITAL DID NOT  
26 NOTIFY THE PRIVATE REVIEW AGENT OF THE EMERGENCY ADMISSION WITHIN 24  
27 HOURS OR OTHER PRESCRIBED PERIOD OF TIME AFTER THAT ADMISSION IF THE  
28 PATIENT'S MEDICAL CONDITION PREVENTED THE HOSPITAL FROM DETERMINING:

29 (1) THE PATIENT'S INSURANCE STATUS; AND

30 (2) IF APPLICABLE, THE PRIVATE REVIEW AGENT'S EMERGENCY  
31 ADMISSION NOTIFICATION REQUIREMENTS.

32 (D) A PRIVATE REVIEW AGENT MAY NOT RENDER AN ADVERSE DECISION AS  
33 TO AN ADMISSION OF A PATIENT DURING THE FIRST 24 HOURS AFTER ADMISSION  
34 WHEN:

35 (1) THE ADMISSION IS BASED ON A DETERMINATION THAT THE PATIENT  
36 IS IN IMMINENT DANGER TO SELF OR OTHERS;

37 (2) THE DETERMINATION HAS BEEN MADE BY THE PATIENT'S  
38 PHYSICIAN OR PSYCHOLOGIST IN CONJUNCTION WITH A MEMBER OF THE MEDICAL  
39 STAFF OF THE FACILITY WHO HAS PRIVILEGES TO MAKE THE ADMISSION; AND

1 (3) THE HOSPITAL IMMEDIATELY NOTIFIES THE PRIVATE REVIEW  
2 AGENT OF:

3 (I) THE ADMISSION OF THE PATIENT; AND

4 (II) THE REASONS FOR THE ADMISSION.

5 [(g)] (E) (1) A private review agent that requires a health care provider to  
6 submit a treatment plan in order for the private review agent to conduct utilization  
7 review of proposed or delivered services for the treatment of a mental illness,  
8 emotional disorder, or a drug abuse or alcohol abuse disorder:

9 (i) shall accept the uniform treatment plan form adopted by the  
10 Commissioner under § 15-10B-03(d) of this subtitle as a properly submitted  
11 treatment plan form; and

12 (ii) may not impose any requirement to:

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

14 2. submit additional treatment plan forms.

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

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

18 (ii) may be submitted by electronic transfer.

19 [15-10B-07.

20 (a) Except as specifically provided in § 15-10B-06 of this subtitle:

21 (1) except as provided in paragraph (2) of this subsection, all adverse  
22 decisions shall be made by a physician or a panel of other appropriate health care  
23 providers with at least 1 physician on the panel.

24 (2) when the health care service under review is a dental service, the  
25 adverse decision shall be made by a licensed dentist or a panel of other appropriate  
26 health care providers with at least 1 licensed dentist on the panel.

27 (3) in the event a patient or health care provider, including a physician,  
28 intermediate care facility described in § 8-403(e) of the Health - General Article, or  
29 hospital seeks reconsideration or appeal of an adverse decision by a private review  
30 agent, the final determination of the appeal of the adverse decision shall be made  
31 based on the professional judgment of:

32 (i) a physician or a panel of other appropriate health care  
33 providers with at least 1 physician on the panel who is board certified or eligible in  
34 the same specialty as the treatment under review; or

1 (ii) when the adverse decision involves a dental service, a licensed  
2 dentist, or a panel of appropriate health care providers with at least 1 dentist on the  
3 panel who is a licensed dentist, who shall consult with a dentist who is board certified  
4 or eligible in the same specialty as the service under review.

5 (4) in the event a patient or health care provider, including a physician,  
6 intermediate care facility described in § 8-403(e) of the Health - General Article, or  
7 hospital seeks reconsideration or appeal of an adverse decision by a private review  
8 agent, the final determination of the appeal of the adverse decision shall:

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

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

13 (b) A private review agent may not charge a fee to a patient or health care  
14 provider for an appeal of an adverse decision.

15 (c) (1) Except as provided in paragraph (2) of this subsection, if a course of  
16 treatment has been preauthorized or approved for a patient, a private review agent  
17 may not retrospectively render an adverse decision regarding the preauthorized or  
18 approved services delivered to that patient.

19 (2) A private review agent may retrospectively render an adverse  
20 decision regarding preauthorized or approved services delivered to a patient if:

21 (i) the information submitted to the private review agent  
22 regarding the services to be delivered to the patient was fraudulent or intentionally  
23 misrepresentative or critical information requested by the private review agent  
24 regarding services to be delivered to the patient was omitted such that the private  
25 review agent's determination would have been different had it known the critical  
26 information; or

27 (ii) the planned course of treatment for the patient that was  
28 approved by the private review agent was not substantially followed by the provider.]  
29 15-10B-07.

30 (A) (1) EXCEPT AS PROVIDED FOR IN PARAGRAPHS (2) AND (3) OF THIS  
31 SUBSECTION, ALL ADVERSE DECISIONS SHALL BE MADE BY A PHYSICIAN, OR A  
32 PANEL OF OTHER APPROPRIATE HEALTH CARE SERVICE REVIEWERS WITH AT LEAST  
33 ONE PHYSICIAN ON THE PANEL WHO IS BOARD CERTIFIED OR ELIGIBLE IN THE SAME  
34 SPECIALTY AS THE TREATMENT UNDER REVIEW.

35 (2) WHEN THE HEALTH CARE SERVICE UNDER REVIEW IS A MENTAL  
36 HEALTH OR SUBSTANCE ABUSE SERVICE, THE ADVERSE DECISION SHALL BE MADE  
37 BY A PHYSICIAN, OR A PANEL OF OTHER APPROPRIATE HEALTH CARE SERVICE  
38 REVIEWERS WITH AT LEAST ONE PHYSICIAN, SELECTED BY THE PRIVATE REVIEW  
39 AGENT WHO:

1 (I) IS BOARD CERTIFIED OR ELIGIBLE IN THE SAME SPECIALTY AS  
2 THE TREATMENT UNDER REVIEW; OR

3 (II) IS ACTIVELY PRACTICING OR HAS DEMONSTRATED EXPERTISE  
4 IN THE SUBSTANCE ABUSE OR MENTAL HEALTH SERVICE OR TREATMENT UNDER  
5 REVIEW.

6 (3) WHEN THE HEALTH CARE SERVICE UNDER REVIEW IS A DENTAL  
7 SERVICE, THE ADVERSE DECISION SHALL BE MADE BY A LICENSED DENTIST, OR A  
8 PANEL OF OTHER APPROPRIATE HEALTH CARE SERVICE REVIEWERS WITH AT LEAST  
9 ONE LICENSED DENTIST ON THE PANEL.

10 (B) ALL ADVERSE DECISIONS SHALL BE MADE BY A PHYSICIAN OR A PANEL OF  
11 OTHER APPROPRIATE HEALTH CARE SERVICE REVIEWERS WHO ARE NOT  
12 COMPENSATED BY THE PRIVATE REVIEW AGENT IN A MANNER THAT VIOLATES §  
13 19-705.1 OF THE HEALTH - GENERAL ARTICLE OR THAT DETERS THE DELIVERY OF  
14 MEDICALLY APPROPRIATE CARE.

15 (C) EXCEPT AS PROVIDED IN SUBSECTION (D) OF THIS SECTION, IF A COURSE  
16 OF TREATMENT HAS BEEN PREAUTHORIZED OR APPROVED FOR A PATIENT, A  
17 PRIVATE REVIEW AGENT MAY NOT RETROSPECTIVELY RENDER AN ADVERSE  
18 DECISION REGARDING THE PREAUTHORIZED OR APPROVED SERVICES DELIVERED  
19 TO THAT PATIENT.

20 (D) A PRIVATE REVIEW AGENT MAY RETROSPECTIVELY RENDER AN ADVERSE  
21 DECISION REGARDING PREAUTHORIZED OR APPROVED SERVICES DELIVERED TO A  
22 PATIENT IF:

23 (1) THE INFORMATION SUBMITTED TO THE PRIVATE REVIEW AGENT  
24 REGARDING THE SERVICES TO BE DELIVERED TO THE PATIENT WAS FRAUDULENT  
25 OR INTENTIONALLY MISREPRESENTATIVE;

26 (2) CRITICAL INFORMATION REQUESTED BY THE PRIVATE REVIEW  
27 AGENT REGARDING SERVICES TO BE DELIVERED TO THE PATIENT WAS OMITTED  
28 SUCH THAT THE PRIVATE REVIEW AGENT'S DETERMINATION WOULD HAVE BEEN  
29 DIFFERENT HAD THE AGENT KNOWN THE CRITICAL INFORMATION; OR

30 (3) THE PLANNED COURSE OF TREATMENT FOR THE PATIENT THAT WAS  
31 APPROVED BY THE PRIVATE REVIEW AGENT WAS NOT SUBSTANTIALLY FOLLOWED  
32 BY THE PROVIDER.

33 (E) IF A COURSE OF TREATMENT HAS BEEN PREAUTHORIZED OR APPROVED  
34 FOR A PATIENT, A PRIVATE REVIEW AGENT MAY NOT REVISE OR MODIFY THE  
35 SPECIFIC CRITERIA OR STANDARDS USED FOR THE UTILIZATION REVIEW TO MAKE  
36 AN ADVERSE DECISION REGARDING THE SERVICES DELIVERED TO THAT PATIENT.

37 [15-10B-08.

38 (a) Except as provided in subsection (b) of this section, a private review agent  
39 shall:

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

4 (2) promptly notify the attending health care provider and patient of the  
5 determination.

6 (b) A private review agent shall:

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

10 (2) promptly notify the attending health care provider of the  
11 determination.

12 (c) If an initial determination is made by the private review agent not to  
13 authorize or certify a course of treatment, an extended stay in a health care facility, or  
14 additional health care services and the attending health care provider believes the  
15 determination warrants an immediate reconsideration, the private review agent shall  
16 provide the attending health care provider an opportunity to seek a reconsideration of  
17 that determination by telephone on an expedited basis not to exceed 24 hours of the  
18 health care provider seeking the reconsideration.

19 (d) For emergency inpatient admissions, a private review agent may not  
20 render an adverse decision or deny coverage for medically necessary covered services  
21 solely because the hospital did not notify the private review agent of the emergency  
22 admission within 24 hours or other prescribed period of time after that admission if  
23 the patient's medical condition prevented the hospital from determining:

24 (1) the patient's insurance status; and

25 (2) the private review agent's emergency admission notification  
26 requirements.

27 (e) For an involuntary or voluntary inpatient admission of a patient  
28 determined by the patient's physician or psychologist in conjunction with a member of  
29 the medical staff of the hospital who has privileges to admit patients to be in  
30 imminent danger to self or others, a private review agent may not render an adverse  
31 decision as to the admission of a patient during the first 24 hours the patient is in an  
32 inpatient facility or until the next business day of the private review agent, whichever  
33 is later. The hospital shall immediately notify the private review agent that a patient  
34 has been admitted and shall state the reasons for the admission.]

35 15-10B-08.

36 (A) IF A CARRIER DELEGATES ITS INTERNAL GRIEVANCE PROCESS TO A  
37 PRIVATE REVIEW AGENT, THE PRIVATE REVIEW AGENT SHALL ESTABLISH AN  
38 INTERNAL GRIEVANCE PROCESS FOR ITS PATIENTS AND HEALTH CARE PROVIDERS  
39 ACTING ON BEHALF OF A PATIENT.

1 (B) A PRIVATE REVIEW AGENT'S INTERNAL GRIEVANCE PROCESS SHALL  
2 MEET THE SAME REQUIREMENTS ESTABLISHED UNDER §§ 15-10A-02 THROUGH  
3 15-10A-05 OF THIS TITLE.

4 (C) AN INTERNAL GRIEVANCE PROCESS ESTABLISHED BY A PRIVATE REVIEW  
5 AGENT UNDER THIS SECTION MAY NOT CHARGE A FEE TO A PATIENT OR HEALTH  
6 CARE PROVIDER FOR FILING A GRIEVANCE.

7 15-10B-09.

8 (a) In this section, "attending provider" means an obstetrician, pediatrician, or  
9 other physician or certified nurse midwife or pediatric nurse practitioner attending  
10 the mother or newborn child.

11 (b) Except as provided in subsections (c) and (d) of this section, the criteria  
12 and standards used by a private review agent or health maintenance organization in  
13 performing utilization review of hospital services related to maternity and newborn  
14 care, including length of stay, shall be in accordance with the medical criteria outlined  
15 in the most current version of the "Guidelines for Perinatal Care" prepared by the  
16 American Academy of Pediatrics and the American College of Obstetricians and  
17 Gynecologists.

18 (c) Subject to the provisions of subsection (d) of this section, a private review  
19 agent or health maintenance organization performing utilization review of hospital  
20 services related to maternity and newborn care shall authorize a minimum coverage  
21 of:

22 (1) 48 hours of inpatient hospitalization care following an uncomplicated  
23 vaginal delivery; and

24 (2) 96 hours of inpatient hospitalization care following an uncomplicated  
25 cesarean section.

26 (d) (1) The private review agent or health maintenance organization may  
27 authorize a shorter length of stay than that provided in subsection (c) of this section  
28 if the mother, in consultation with her attending provider, decides that less time is  
29 needed for recovery.

30 (2) For a mother and newborn child who have a hospital stay shorter in  
31 length than that provided under subsection (c) of this section, the private review  
32 agent or health maintenance organization performing utilization review shall  
33 authorize:

34 (i) one home visit scheduled to occur within 24 hours after hospital  
35 discharge; and

36 (ii) an additional home visit as may be prescribed by the attending  
37 provider.



1 (3) For a mother and newborn child who remain in the hospital for at  
2 least the period of time provided under subsection (c) of this section, the private  
3 review agent or health maintenance organization performing utilization review shall  
4 authorize a home visit as may be prescribed by the attending provider.

5 (4) A home visit under paragraph (2) or (3) of this subsection shall:

6 (i) be provided in accordance with generally accepted standards of  
7 nursing practice for home care of a mother and newborn child;

8 (ii) be provided by a registered nurse with at least 1 year of  
9 experience in maternal and child health nursing or in community health nursing with  
10 an emphasis on maternal and child health; and

11 (iii) include any services required by the attending provider.

12 (e) (1) The private review agent or health maintenance organization may  
13 not require additional documentation from, require additional utilization review of, or  
14 otherwise provide financial disincentives for an attending provider who orders care  
15 for which coverage is required to be provided under this section, § 19-703 of the  
16 Health - General Article, or § 15-811 of this article.

17 (2) The private review agent, hospital, or health maintenance  
18 organization may not deny, limit, or otherwise impair the participation of an  
19 attending provider under a contract or any privilege granted an attending provider  
20 who advocates more than 48 hours of inpatient hospital care following a complicated  
21 vaginal delivery or more than 96 hours of inpatient hospital care following a  
22 complicated cesarean section.

23 15-10B-09.1.

24 A GRIEVANCE DECISION SHALL BE MADE BASED ON THE PROFESSIONAL  
25 JUDGMENT OF:

26 (1) A PHYSICIAN, OR A PANEL OF OTHER APPROPRIATE HEALTH CARE  
27 SERVICE REVIEWERS WITH AT LEAST ONE PHYSICIAN ON THE PANEL WHO IS BOARD  
28 CERTIFIED OR ELIGIBLE IN THE SAME SPECIALTY AS THE TREATMENT UNDER  
29 REVIEW;

30 (2) WHEN THE ADVERSE DECISION INVOLVES A DENTAL SERVICE, A  
31 LICENSED DENTIST, OR A PANEL OF APPROPRIATE HEALTH CARE SERVICE  
32 REVIEWERS WITH AT LEAST ONE DENTIST ON THE PANEL WHO IS A LICENSED  
33 DENTIST WHO SHALL CONSULT WITH A DENTIST WHO IS BOARD CERTIFIED OR  
34 ELIGIBLE IN THE SAME SPECIALTY AS THE SERVICE UNDER REVIEW; OR

35 (3) WHEN THE ADVERSE DECISION INVOLVES A MENTAL HEALTH OR  
36 SUBSTANCE ABUSE SERVICE, A LICENSED PHYSICIAN, OR A PANEL OF OTHER  
37 APPROPRIATE HEALTH CARE SERVICE REVIEWERS WITH AT LEAST ONE PHYSICIAN,  
38 SELECTED BY THE PRIVATE REVIEW AGENT WHO IS ACTIVELY PRACTICING OR HAS

1 DEMONSTRATED EXPERTISE IN THE ALCOHOL, DRUG ABUSE, OR MENTAL HEALTH  
2 SERVICE OR TREATMENT UNDER REVIEW.

3 15-10B-10.

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

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

8 (1) otherwise is entitled to the certificate;

9 (2) pays to the Commissioner the renewal fee set by the Commissioner  
10 through regulation; and

11 (3) submits to the Commissioner:

12 (i) a renewal application on the form that the Commissioner  
13 requires; and

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

16 (c) If the requirements of this section are met, the Commissioner shall renew  
17 a certificate.

18 [15-10B-11.

19 (a) (1) The Commissioner shall deny a certificate to any applicant if, upon  
20 review of the application, the Commissioner finds that the applicant proposing to  
21 conduct utilization review does not:

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

25 (ii) meet any applicable regulations the Commissioner adopts  
26 under this subtitle relating to the qualifications of private review agents or the  
27 performance of utilization review.

28 (2) The Commissioner shall deny a certificate to any applicant that does  
29 not provide assurances satisfactory to the Commissioner that:

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

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

1 (b) The Commissioner may revoke a certificate if the holder does not comply  
2 with performance assurances under this section, violates any provision of this  
3 subtitle, or violates any regulation adopted under any provision of this subtitle.

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

8 (2) If an applicant or certificate holder requests a hearing, the  
9 Commissioner shall send a hearing notice by certified mail, return receipt requested,  
10 at least 30 days before the hearing.

11 (3) The Commissioner shall hold the hearing in accordance with Title 10,  
12 Subtitle 2 of the State Government Article.]

13 15-10B-11.

14 A PRIVATE REVIEW AGENT MAY NOT:

15 (1) VIOLATE ANY PROVISION OF THIS SUBTITLE OR ANY RULE OR  
16 REGULATION ADOPTED UNDER THIS SUBTITLE;

17 (2) FAIL TO MEET THE REQUIREMENTS FOR CERTIFICATION UNDER  
18 THIS SUBTITLE;

19 (3) OBTAIN OR ATTEMPT TO OBTAIN CERTIFICATION BASED ON  
20 INACCURATE INFORMATION;

21 (4) FRAUDULENTLY OR DECEPTIVELY OBTAIN OR USE A CERTIFICATE;

22 (5) FAIL TO MAKE AVAILABLE THE SERVICES OF SUFFICIENT NUMBERS  
23 OF REGISTERED NURSES, MEDICAL RECORDS TECHNICIANS, OR SIMILARLY  
24 QUALIFIED PERSONS SUPPORTED AND SUPERVISED BY APPROPRIATE PHYSICIANS  
25 TO CARRY OUT ITS UTILIZATION REVIEW ACTIVITIES;

26 (6) FAIL TO MEET ANY APPLICABLE REGULATIONS THE COMMISSIONER  
27 ADOPTS UNDER THIS SUBTITLE RELATING TO THE QUALIFICATIONS OF PRIVATE  
28 REVIEW AGENTS OR THE PERFORMANCE OF UTILIZATION REVIEW;

29 (7) FAIL TO PROTECT THE CONFIDENTIALITY OF MEDICAL RECORDS IN  
30 ACCORDANCE WITH APPLICABLE STATE AND FEDERAL LAWS; OR

31 (8) USE CRITERIA AND STANDARDS TO CONDUCT UTILIZATION REVIEW  
32 UNLESS THE CRITERIA AND STANDARDS USED BY THE PRIVATE REVIEW AGENT ARE:

33 (I) OBJECTIVE;

34 (II) CLINICALLY VALID;

1 (III) COMPATIBLE WITH ESTABLISHED PRINCIPLES OF HEALTH  
2 CARE; OR

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

5 [15-10B-12.

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

10 15-10B-12.

11 (A) (1) A PERSON WHO VIOLATES ANY PROVISION OF § 15-10B-11 OF THIS  
12 SUBTITLE IS GUILTY OF A MISDEMEANOR AND ON CONVICTION IS SUBJECT TO A  
13 PENALTY NOT EXCEEDING \$1,000.

14 (2) EACH DAY A VIOLATION IS CONTINUED AFTER THE FIRST  
15 CONVICTION IS A SEPARATE OFFENSE.

16 (B) IN ADDITION TO THE PROVISIONS OF SUBSECTION (A) OF THIS SECTION, IF  
17 ANY PERSON VIOLATES ANY PROVISION OF § 15-10B-11 OF THIS SUBTITLE, THE  
18 COMMISSIONER MAY:

19 (1) DENY, SUSPEND, OR REVOKE THE CERTIFICATE TO DO BUSINESS AS  
20 A PRIVATE REVIEW AGENT;

21 (2) REQUIRE A PRIVATE REVIEW AGENT TO MAKE RESTITUTION TO A  
22 PATIENT WHO HAS SUFFERED ACTUAL ECONOMIC DAMAGE BECAUSE OF THE  
23 VIOLATION; AND

24 (3) IMPOSE AN ADMINISTRATIVE PENALTY OF UP TO \$5,000 FOR EACH  
25 VIOLATION OF ANY PROVISION OF THIS SUBTITLE.

26 [15-10B-13.

27 The Commissioner shall periodically provide a list of private review agents  
28 issued certificates and the renewal date for those certificates to any person on  
29 request.]

30 15-10B-13.

31 ANY PERSON AGGRIEVED BY AN ORDER OF THE COMMISSIONER UNDER THIS  
32 SUBTITLE HAS THE RIGHT TO A HEARING AND THE RIGHT TO APPEAL FROM THE  
33 ACTION OF THE COMMISSIONER IN ACCORDANCE WITH §§ 2-210 THROUGH 2-215 OF  
34 THIS ARTICLE.

1 [15-10B-14.

2 The Commissioner may establish reporting requirements to:

3 (1) evaluate the effectiveness of private review agents; and

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

6 15-10B-14.

7 THE COMMISSIONER MAY WAIVE THE REQUIREMENTS OF THIS SUBTITLE FOR A  
8 PRIVATE REVIEW AGENT THAT OPERATES SOLELY UNDER CONTRACT WITH THE  
9 FEDERAL GOVERNMENT FOR UTILIZATION REVIEW OF PATIENTS ELIGIBLE FOR  
10 HOSPITAL SERVICES UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT.

11 [15-10B-15.

12 A private review agent may not disclose or publish individual medical records or  
13 any other confidential medical information obtained in the performance of utilization  
14 review activities.]

15 15-10B-15.

16 THE COMMISSIONER SHALL PERIODICALLY PROVIDE A LIST OF PRIVATE  
17 REVIEW AGENTS ISSUED CERTIFICATES AND THE RENEWAL DATE FOR THOSE  
18 CERTIFICATES TO ANY PERSON ON REQUEST.

19 [15-10B-16.

20 (a) (1) Except as provided in paragraph (2) of this subsection, this section  
21 does not apply to:

22 (i) a private review agent referring an individual to a health care  
23 provider or facility that participates in a health maintenance organization;

24 (ii) a preferred provider organization network of participating  
25 health care providers or facilities to which the individual would otherwise be referred  
26 as part of the individual's membership or insurance contract; or

27 (iii) an employee assistance program referring an individual to a  
28 network of participating health care providers or facilities in accordance with a  
29 contract with the individual's employer or labor union to provide comprehensive  
30 mental health and substance abuse services.

31 (2) A private review agent or any other individual who is either affiliated  
32 with, under contract with, or acting on behalf of a private review agent may not  
33 approve or fail to approve a course of treatment based on whether the treatment is  
34 delivered by a provider who is a participating or nonparticipating provider in the  
35 preferred provider organization or employee assistance program network.

1 (b) A private review agent or any individual who is either affiliated with,  
2 under contract with, or acting on behalf of a private review agent may not:

3 (1) refer a patient who has undergone utilization review by the private  
4 review agent to:

5 (i) a health care facility in which the private review agent owns a  
6 significant beneficial interest; or

7 (ii) the private review agent's own health care practice;

8 (2) pay or agree to pay any sum to, or accept or agree to accept any sum  
9 from, any person for bringing or referring a patient to the private review agent; or

10 (3) provide for different insurance coverage or benefits based on  
11 receiving the service from a health care facility or health care provider in which the  
12 private review agent owns a significant beneficial interest.

13 (c) A private review agent or any individual who is either affiliated with,  
14 under contract with, or acting on behalf of a private review agent may refer a patient  
15 who has undergone utilization review by the private review agent to another health  
16 care provider regulated under the Health Occupations Article if:

17 (1) (i) the patient or provider requests the private review agent to  
18 provide the patient with the name of a health care provider appropriate to meet the  
19 health care needs of the patient; or

20 (ii) the patient has no attending physician; and

21 (2) the private review agent provides the patient with the names of at  
22 least 2 health care providers appropriate to meet the health care needs of the  
23 patient.]

24 15-10B-16.

25 THE COMMISSIONER MAY ESTABLISH REPORTING REQUIREMENTS TO:

26 (1) EVALUATE THE EFFECTIVENESS OF PRIVATE REVIEW AGENTS; AND

27 (2) DETERMINE IF THE UTILIZATION REVIEW PROGRAMS ARE IN  
28 COMPLIANCE WITH THE PROVISIONS OF THIS SECTION AND APPLICABLE  
29 REGULATIONS.

30 [15-10B-17.

31 (a) A person who violates any provision of this subtitle or any regulation  
32 adopted under this subtitle is guilty of a misdemeanor and on conviction is subject to  
33 a penalty not exceeding \$1,000. Each day a violation is continued after the first  
34 conviction is a separate offense.

1 (b) (1) In addition to the provisions of subsection (a) of this section, the  
2 Commissioner may impose an administrative penalty of up to \$5,000 for a violation of  
3 any provision of this subtitle.

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

6 15-10B-17.

7 (A) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, THIS  
8 SECTION DOES NOT APPLY TO:

9 (I) A PRIVATE REVIEW AGENT REFERRING AN INDIVIDUAL TO A  
10 HEALTH CARE PROVIDER OR FACILITY THAT PARTICIPATES IN A HEALTH  
11 MAINTENANCE ORGANIZATION;

12 (II) A PREFERRED PROVIDER ORGANIZATION NETWORK OF  
13 PARTICIPATING HEALTH CARE PROVIDERS OR FACILITIES TO WHICH THE  
14 INDIVIDUAL WOULD OTHERWISE BE REFERRED AS PART OF THE INDIVIDUAL'S  
15 MEMBERSHIP OR INSURANCE CONTRACT; OR

16 (III) AN EMPLOYEE ASSISTANCE PROGRAM REFERRING AN  
17 INDIVIDUAL TO A NETWORK OF PARTICIPATING HEALTH CARE PROVIDERS OR  
18 FACILITIES IN ACCORDANCE WITH A CONTRACT WITH THE INDIVIDUAL'S EMPLOYER  
19 OR LABOR UNION TO PROVIDE COMPREHENSIVE MENTAL HEALTH AND SUBSTANCE  
20 ABUSE SERVICES.

21 (2) A PRIVATE REVIEW AGENT OR ANY OTHER INDIVIDUAL WHO IS  
22 EITHER AFFILIATED WITH, UNDER CONTRACT WITH, OR ACTING ON BEHALF OF A  
23 PRIVATE REVIEW AGENT MAY NOT APPROVE OR FAIL TO APPROVE A COURSE OF  
24 TREATMENT BASED ON WHETHER THE TREATMENT IS DELIVERED BY A PROVIDER  
25 WHO IS A PARTICIPATING OR NONPARTICIPATING PROVIDER IN THE PREFERRED  
26 PROVIDER ORGANIZATION OR EMPLOYEE ASSISTANCE PROGRAM NETWORK.

27 (B) A PRIVATE REVIEW AGENT OR ANY INDIVIDUAL WHO IS EITHER  
28 AFFILIATED WITH, UNDER CONTRACT WITH, OR ACTING ON BEHALF OF A PRIVATE  
29 REVIEW AGENT MAY NOT:

30 (1) REFER A PATIENT WHO HAS UNDERGONE UTILIZATION REVIEW BY  
31 THE PRIVATE REVIEW AGENT TO:

32 (I) A HEALTH CARE FACILITY IN WHICH THE PRIVATE REVIEW  
33 AGENT OWNS A SIGNIFICANT BENEFICIAL INTEREST; OR

34 (II) THE PRIVATE REVIEW AGENT'S OWN HEALTH CARE PRACTICE;

35 (2) PAY OR AGREE TO PAY ANY SUM TO, OR ACCEPT OR AGREE TO  
36 ACCEPT ANY SUM FROM, ANY PERSON FOR BRINGING OR REFERRING A PATIENT TO  
37 THE PRIVATE REVIEW AGENT; OR

1 (3) PROVIDE FOR DIFFERENT INSURANCE COVERAGE OR BENEFITS  
2 BASED ON RECEIVING THE SERVICE FROM A HEALTH CARE FACILITY OR HEALTH  
3 CARE PROVIDER IN WHICH THE PRIVATE REVIEW AGENT OWNS A SIGNIFICANT  
4 BENEFICIAL INTEREST.

5 (C) A PRIVATE REVIEW AGENT OR ANY INDIVIDUAL WHO IS EITHER  
6 AFFILIATED WITH, UNDER CONTRACT WITH, OR ACTING ON BEHALF OF A PRIVATE  
7 REVIEW AGENT MAY REFER A PATIENT WHO HAS UNDERGONE UTILIZATION REVIEW  
8 BY THE PRIVATE REVIEW AGENT TO ANOTHER HEALTH CARE PROVIDER REGULATED  
9 UNDER THE HEALTH OCCUPATIONS ARTICLE IF:

10 (1) (I) THE PATIENT OR PROVIDER REQUESTS THE PRIVATE REVIEW  
11 AGENT TO PROVIDE THE PATIENT WITH THE NAME OF A HEALTH CARE PROVIDER  
12 APPROPRIATE TO MEET THE HEALTH CARE NEEDS OF THE PATIENT; OR

13 (II) THE PATIENT HAS NO ATTENDING PHYSICIAN; AND

14 (2) THE PRIVATE REVIEW AGENT PROVIDES THE PATIENT WITH THE  
15 NAMES OF AT LEAST TWO HEALTH CARE PROVIDERS APPROPRIATE TO MEET THE  
16 HEALTH CARE NEEDS OF THE PATIENT.

17 [15-10B-18.

18 (a) Any person aggrieved by a final decision of the Commissioner in a  
19 contested case under this subtitle may take a direct judicial appeal.

20 (b) The appeal shall be made as provided for the judicial review of final  
21 decisions under Title 10, Subtitle 2 of the State Government Article.]

22 15-10B-18.

23 (A) A PRIVATE REVIEW AGENT SHALL ADVISE THE COMMISSIONER, IN  
24 WRITING, OF ITS INTENTION TO WITHDRAW ITS CERTIFICATE WITHIN 60 DAYS OF  
25 INTENTION TO CEASE OPERATIONS AS A PRIVATE REVIEW AGENT.

26 (B) A PRIVATE REVIEW AGENT SHALL SUBMIT ITS CERTIFICATE TO THE  
27 ADMINISTRATION WITHIN 30 DAYS AFTER THE DATE THAT THE PRIVATE REVIEW  
28 AGENT CEASED OPERATIONS.

29 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect  
30 January 1, 2001.