SENATE BILL 190

Unofficial Copy 2000 Regular Session
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CF 0lr0176

By: **Chairman, Finance Committee (Departmental - Insurance Administration, Maryland)**
Introduced and read first time: January 24, 2000
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Insurance - Private Review Agents

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

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

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

Annotated Code of Maryland
(1997 Volume and 1999 Supplement)

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

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

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

Article - Insurance

15-1001.

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

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

(2) A NONPROFIT HEALTH SERVICE PLAN;

(3) A HEALTH MAINTENANCE ORGANIZATION;

(4) A DENTAL PLAN ORGANIZATION; OR

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

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

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

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

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

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

(1) THE TREATING PROVIDER; OR

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

15-10B-01.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(H) "HEALTH CARE PROVIDER" MEANS:

(1) AN INDIVIDUAL WHO:

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

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

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

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

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

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

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

(i) a Maryland business entity; or

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

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

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

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

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

(i) [employed by] the hospital; or

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

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

(1) 5 percent of the whole; or

(2) $5,000.

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

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

15-10B-02.

The purpose of this subtitle is to:

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

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

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

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

15-10B-03.

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

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

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

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

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

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

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

15-10B-04.

(a) An applicant for a certificate shall:

(1) submit an application to the Commissioner; and

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

(b) The application shall:

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

(2) be signed and verified by the applicant.

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

15-10B-05.

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

(1) a utilization review plan that includes:

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

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

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

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

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

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

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

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

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

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

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

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

(i) objective;

(ii) clinically valid;

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

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

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

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

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

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

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

(1) objective;

(2) clinically valid;

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

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

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

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

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

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

15-10B-06.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) THE PATIENT'S INSURANCE STATUS; AND

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

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

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

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

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

(I) THE ADMISSION OF THE PATIENT; AND

(II) THE REASONS FOR THE ADMISSION.

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

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

(ii) may not impose any requirement to:

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

2. submit additional treatment plan forms.

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

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

(ii) may be submitted by electronic transfer.

[15-10B-07.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[15-10B-08.

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

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

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

(b) A private review agent shall:

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

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

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

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

(1) the patient's insurance status; and

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

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

15-10B-08.

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

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

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

15-10B-09.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15-10B-09.1.

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

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

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

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

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

15-10B-10.

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

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

(1) otherwise is entitled to the certificate;

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

(3) submits to the Commissioner:

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

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

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

[15-10B-11.

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

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

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

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

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

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

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

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

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

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

15-10B-11.

A PRIVATE REVIEW AGENT MAY NOT:

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

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

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

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

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

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

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

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

(I) OBJECTIVE;

(II) CLINICALLY VALID;

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

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

[15-10B-12.

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

15-10B-12.

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

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

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

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

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

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

[15-10B-13.

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

15-10B-13.

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

[15-10B-14.

The Commissioner may establish reporting requirements to:

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

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

15-10B-14.

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

[15-10B-15.

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

15-10B-15.

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

[15-10B-16.

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) the patient has no attending physician; and

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

15-10B-16.

THE COMMISSIONER MAY ESTABLISH REPORTING REQUIREMENTS TO:

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

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

[15-10B-17.

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

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

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

15-10B-17.

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

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

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

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

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

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

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

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

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

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

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

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

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

(II) THE PATIENT HAS NO ATTENDING PHYSICIAN; AND

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

[15-10B-18.

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

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

15-10B-18.

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

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

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