Unofficial Copy 2001 Regular Session
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By: **Senator Bromwell**
Introduced and read first time: February 21, 2001
Assigned to: Rules

A BILL ENTITLED

AN ACT concerning

Health Insurance - Appeals and Grievances Procedures - Modifications

FOR the purpose of establishing a certain minimum time period for a member or a health care provider on behalf of a member to file a grievance related to a carrier's adverse decision; extending the time period for a member or a health care provider on behalf of a member to file a complaint with the Insurance Commissioner for review of a carrier's grievance decision; altering certain notice requirements; requiring carriers to report certain information to the Insurance Commissioner on a quarterly basis; providing for the application of this Act; and generally relating to modifications of the procedures for appeals and grievances of adverse decisions and grievance decisions related to health insurance claims.

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-10A-02(b), (f), and (i), 15-10A-03(a), and 15-10A-06(a)
Annotated Code of Maryland
(1997 Volume and 2000 Supplement)

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

Article - Insurance

15-10A-02.

(b) (1) An internal grievance process shall meet the same requirements established under Subtitle 10B of this title.

(2) In addition to the requirements of Subtitle 10B of this title, an internal grievance process established by a carrier under this section shall:

(i) include an expedited procedure for use in an emergency case for purposes of rendering a grievance decision within 24 hours of the date a grievance is filed with the carrier;

(ii) provide that a carrier render a final decision in writing on a grievance within 30 working days after the date on which the grievance is filed unless:

1. the grievance involves an emergency case under item (i) of this paragraph;

2. the member or a health care provider filing a grievance on behalf of a member agrees in writing to an extension for a period of no longer than 30 working days; or

3. the grievance involves a retrospective denial under item (iv) of this paragraph;

(iii) allow a grievance to be filed on behalf of a member by a health care provider; [and]

(iv) provide that a carrier render a final decision in writing on a grievance within 45 working days after the date on which the grievance is filed when the grievance involves a retrospective denial; AND

(V) ALLOW A MEMBER OR A HEALTH CARE PROVIDER ON BEHALF OF A MEMBER TO FILE A GRIEVANCE FOR AT LEAST 180 DAYS AFTER THE MEMBER RECEIVES AN ADVERSE DECISION.

(3) For purposes of using the expedited procedure for an emergency case that a carrier is required to include under paragraph (2)(i) of this subsection, the Commissioner shall define by regulation the standards required for a grievance to be considered an emergency case.

(f) For nonemergency cases, when a carrier renders an adverse decision, the carrier shall:

(1) document the adverse decision in writing after the carrier has provided oral communication of the decision to the member or the health care provider acting on behalf of the member; and

(2) send, within 5 working days after the adverse decision has been made, a written notice to the member and a health care provider acting on behalf of the member that:

(i) states in detail in clear, understandable language the specific factual bases for the carrier's decision;

(ii) references the specific criteria and standards, including interpretive guidelines, on which the decision was based, and may not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary";

(iii) states the name, business address, and business telephone number of:

1. the medical director or associate medical director, as appropriate, who made the decision if the carrier is a health maintenance organization; or

2. the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process if the carrier is not a health maintenance organization;

(iv) gives written details of the carrier's internal grievance process and procedures under this subtitle; and

(v) includes the following information:

1. that the member or a health care provider on behalf of the member has a right to file a complaint with the Commissioner within 30 WORKING days after receipt of a carrier's grievance decision;

2. that a complaint may be filed without first filing a grievance if the member or a health care provider filing a grievance on behalf of the member can demonstrate a compelling reason to do so as determined by the Commissioner;

3. the Commissioner's address, telephone number, and facsimile number;

4. a statement that the Health Advocacy Unit is available to assist the member in both mediating and filing a grievance under the carrier's internal grievance process; and

5. the address, telephone number, facsimile number, and email address of the Health Advocacy Unit.

(i) (1) For nonemergency cases, when a carrier renders a grievance decision, the carrier shall:

(i) document the grievance decision in writing after the carrier has provided oral communication of the decision to the member or the health care provider acting on behalf of the member; and

(ii) send, within 5 working days after the grievance decision has been made, a written notice to the member and a health care provider acting on behalf of the member that:

1. states in detail in clear, understandable language the specific factual bases for the carrier's decision;

2. references the specific criteria and standards, including interpretive guidelines, on which the grievance decision was based;

3. states the name, business address, and business telephone number of:

A. the medical director or associate medical director, as appropriate, who made the grievance decision if the carrier is a health maintenance organization; or

B. the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process if the carrier is not a health maintenance organization; and

4. includes the following information:

A. that the member has a right to file a complaint with the Commissioner within 30 WORKING days after receipt of a carrier's grievance decision; and

B. the Commissioner's address, telephone number, and facsimile number.

(2) A carrier may not use solely in a notice sent under paragraph (1) of this subsection generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary" to satisfy the requirements of this subsection.

15-10A-03.

(a) (1) Within 30 WORKING days after the date of receipt of a grievance decision, a member or a health care provider, who filed the grievance on behalf of the member under § 15-10A-02(b)(2)(iii) of this subtitle, may file a complaint with the Commissioner for review of the grievance decision.

(2) Whenever the Commissioner receives a complaint under this subsection, the Commissioner shall notify the carrier that is the subject of the complaint within 5 working days after the date the complaint is filed with the Commissioner.

(3) Except for an emergency case under subsection (b)(1)(ii) of this section, the carrier that is the subject of a complaint filed under paragraph (1) of this subsection shall provide to the Commissioner any information requested by the Commissioner no later than 7 working days from the date the carrier receives the request for information.

15-10A-06.

(a) On a quarterly basis, each carrier shall submit to the Commissioner, on the form the Commissioner requires, a report that describes:

(1) the activities of the carrier under this subtitle, including:

(i) the outcome of each grievance filed with the carrier;

(ii) the number and outcomes of cases that were considered emergency cases under § 15-10A-02(b)(2)(i) of this subtitle;

(iii) the time within which the carrier made a grievance decision on each emergency case;

(iv) the time within which the carrier made a grievance decision on all other cases that were not considered emergency cases; [and]

(v) the number of grievances filed with the carrier that resulted from an adverse decision involving length of stay for inpatient hospitalization as related to the medical procedure involved; and

(VI) THE NUMBER OF ADVERSE DECISIONS ISSUED BY THE CARRIER UNDER § 15-10A-02(F) OF THIS SUBTITLE AND THE TYPE OF SERVICE AT ISSUE IN THE ADVERSE DECISIONS; AND

(2) the number and outcome of all other cases that are not subject to activities of the carrier under this subtitle that resulted from an adverse decision involving the length of stay for inpatient hospitalization as related to the medical procedure involved.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act applies to all adverse decisions and grievance decisions made on or after October 1, 2001.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2001.