SENATE BILL 842

Unofficial Copy 2002 Regular Session
C3 2lr2707
CF 2lr2706

By: **Senator Bromwell**
Introduced and read first time: February 18, 2002
Assigned to: Rules

A BILL ENTITLED

AN ACT concerning

Health and Disability Insurance - Appeals and Grievance Process - Modifications

FOR the purpose of altering the time periods of certain notice requirements for a certain grievance process relating to health insurance when the grievance involves an emergency case or a retrospective denial; altering the time periods for sending a certain notice of a certain adverse decision; altering the contents of a certain notice of an adverse decision; altering the time periods for sending a certain notice of a certain grievance decision; altering the contents of a certain notice of a grievance decision; requiring a carrier to provide certain notice of an adverse decision in a certain manner for an emergency case, for extension of a certain course of treatment, for a nonemergency case involving care that has not been provided, and for a retrospective denial of health care services; requiring a carrier to provide certain information about certain health care service reviewers to the Commissioner on request; altering the time periods in which and processes by which a private review agent is required to make certain determinations about certain courses of treatment or certain health care services; prohibiting a grievance decision from being made by certain physicians or reviewers; expanding a certain internal appeal process for coverage decisions to include denial of disability claims; requiring a carrier to send certain notice of a coverage decision within a certain period of time under certain circumstances; establishing a certain process for certain coverage decisions when the carrier does not have sufficient information to make the decision; altering the contents of a certain notice of a coverage decision; altering the time period for sending a certain notice of an appeal decision; altering the contents of a certain notice of an appeal decision; establishing a certain violation for failure of a carrier to provide or reimburse for disability benefits; altering certain definitions; and generally relating to the appeals and grievance process under health and disability insurance.

BY repealing and reenacting, with amendments,
Article - Insurance
Section 2-112.2(a)(3), 15-10A-02, 15-10A-03, 15-10B-06, 15-10B-08, 15-10B-09.1, 15-10D-01, 15-10D-02, and 15-10D-03
Annotated Code of Maryland

(1997 Volume and 2001 Supplement)

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

Article - Insurance

2-112.2.

(a) (3) (i) "Health benefit plan" means:

1. a hospital or medical policy, contract, or certificate, including those issued under multiple employer trusts or associations;

2. a hospital or medical policy, contract, or certificate issued by a nonprofit health service plan;

3. a health maintenance organization contract; [or]

4. a dental plan; OR

5. DISABILITY INSURANCE.

(ii) "Health benefit plan" does not include one or more, or any combination of the following:

1. long-term care insurance;

2. [disability insurance;

3.] accidental travel and accidental death and dismemberment insurance;

[4.] 3. credit health insurance;

[5.] 4. any insurance, medical policy, or certificate for which payment of benefits is conditioned on a determination of medical necessity made solely by the treating health care provider not acting on behalf of the carrier;

[6.] 5. any other insurance, medical policy, or certificate for which payment of benefits is not conditioned on a determination of medical necessity; or

[7.] 6. a health benefit plan issued by a managed care organization, as defined in Title 15, Subtitle 1 of the Health - General Article.

15-10A-02.

(a) Each carrier shall establish an internal grievance process for its members.

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

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

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

(ii) provide that a carrier [render] NOTIFY THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER OF 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, IN WHICH CASE THE CARRIER SHALL NOTIFY THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER OF THE DECISION:

A. ORALLY WITHIN 24 HOURS AFTER THE TIME THE GRIEVANCE IS FILED; AND

B. IN WRITING WITHIN 48 HOURS AFTER THE TIME THE GRIEVANCE IS FILED;

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;

(iv) provide that a carrier [render] NOTIFY THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER OF a final decision in writing on a grievance within [45 working] 60 days after the date on which the grievance is filed when the grievance involves a retrospective denial; and

(v) [for a retrospective denial,] 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.

(c) Except as provided in subsection (d) of this section, the carrier's internal grievance process shall be exhausted prior to filing a complaint with the Commissioner under this subtitle.

(d) (1) (i) A member or a health care provider filing a complaint on behalf of a member may file a complaint with the Commissioner without first filing a grievance with a carrier and receiving a final decision on the grievance if the member or the health care provider provides sufficient information and supporting documentation in the complaint that demonstrates a compelling reason to do so.

(ii) The Commissioner shall define by regulation the standards that the Commissioner shall use to decide what demonstrates a compelling reason under subparagraph (i) of this paragraph.

(2) Subject to subsections (b)(2)(ii) and (h) of this section, a member or a health care provider may file a complaint with the Commissioner if the member or the health care provider does not receive a grievance decision from the carrier on or before the 30th working day on which the grievance is filed.

(3) Whenever the Commissioner receives a complaint under paragraph (1) or (2) of this subsection, the Commissioner shall notify the carrier that is the subject of the complaint within 5 working days after the date the complaint is filed with the Commissioner.

(e) Each carrier shall:

(1) file for review with the Commissioner and submit to the Health Advocacy Unit a copy of its internal grievance process established under this subtitle; and

(2) update the initial filing annually to reflect any changes made.

(f) [For nonemergency cases, when] 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] THE TIME PERIODS DESCRIBED IN SUBSECTION (J) OF THIS SECTION, 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;

(VI) IF A CARRIER USES AN INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION TO MAKE THE ADVERSE DECISION, PROVIDES THE INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION;

(VII) IF THE ADVERSE DECISION IS A RESULT OF MEDICAL REVIEW OF EXPERIMENTAL OR INVESTIGATIONAL TREATMENTS OR SERVICES, PROVIDES AN EXPLANATION OF THE SCIENTIFIC OR CLINICAL JUDGMENT FOR THE ADVERSE DECISION; AND

(VIII) IF A CARRIER REQUIRES ADDITIONAL INFORMATION, PROVIDES A DESCRIPTION OF ANY ADDITIONAL MATERIAL OR INFORMATION REQUIRED FROM

THE MEMBER OR THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER AND AN EXPLANATION OF WHY THIS MATERIAL OR INFORMATION IS NECESSARY.

(g) If within 5 working days after a member or a health care provider, who has filed a grievance on behalf of a member, files a grievance with the carrier, and if the carrier does not have sufficient information to complete its internal grievance process, the carrier shall:

(1) notify the member or health care provider that it cannot proceed with reviewing the grievance unless additional information is provided; and

(2) assist the member or health care provider in gathering the necessary information without further delay.

(h) A carrier may extend the 30-day or [45-day] 60-DAY period required for making a final grievance decision under subsection [(b)(2)(ii)] (B)(2) of this section with the written consent of the member or the health care provider who filed the grievance on behalf of the member.

(i) (1) [For nonemergency cases, when] 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] THE TIME PERIODS SPECIFIED IN SUBSECTION (B)(2) OF THIS SECTION, 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;

5. STATES THAT THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER SHALL BE ENTITLED TO RECEIVE, FREE OF CHARGE, REASONABLE ACCESS TO, AND COPIES OF, ALL DOCUMENTS, RECORDS, AND OTHER INFORMATION RELEVANT TO THE GRIEVANCE DECISION;

6. IF A CARRIER USES AN INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION TO MAKE THE ADVERSE DECISION, PROVIDES THE INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION; AND

7. IF THE GRIEVANCE DECISION IS A RESULT OF MEDICAL REVIEW OF EXPERIMENTAL OR INVESTIGATIONAL TREATMENTS OR SERVICES, PROVIDES AN EXPLANATION OF THE SCIENTIFIC OR CLINICAL JUDGMENT FOR THE GRIEVANCE DECISION.

(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.

[(j) (1) For an emergency case under subsection (b)(2)(i) of this section, within 1 day after a decision has been orally communicated to the member or health care provider, the carrier shall send notice in writing of any adverse decision or grievance decision to:

(i) the member; and

(ii) if the grievance was filed on behalf of the member under subsection (b)(2)(iii) of this section, the health care provider.

(2) A notice required to be sent under paragraph (1) of this subsection shall include the following:

(i) for an adverse decision, the information required under subsection (f) of this section; and

(ii) for a grievance decision, the information required under subsection (i) of this section.]

(J) A CARRIER SHALL PROVIDE NOTICE OF AN ADVERSE DECISION AS FOLLOWS:

(1) EXCEPT AS PROVIDED IN ITEM (2) OF THIS SUBSECTION, FOR AN EMERGENCY CASE:

(I) UNLESS THE MEMBER OR THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION, THE CARRIER SHALL NOTIFY THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER:

1. ORALLY WITHIN 24 HOURS AFTER RECEIPT OF THE REQUEST FOR HEALTH CARE SERVICES; AND

2. IN WRITING WITHIN 48 HOURS AFTER RECEIPT OF THE REQUEST FOR HEALTH CARE SERVICES; OR

(II) IF THE MEMBER OR THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION, THE CARRIER SHALL:

1. NOTIFY THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER IN WRITING WITHIN 24 HOURS AFTER RECEIPT OF THE REQUEST FOR HEALTH CARE SERVICES OF THE SPECIFIC INFORMATION NECESSARY TO MAKE THE DECISION;

2. PERMIT THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER AT LEAST 48 HOURS TO PROVIDE THE SPECIFIC INFORMATION; AND

3. NOTIFY THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER IN WRITING OF THE CARRIER'S DECISION WITHIN THE EARLIER OF:

A. 48 HOURS AFTER RECEIPT OF THE SPECIFIC INFORMATION REQUIRED IN ITEM 1 OF THIS ITEM; OR

B. 48 HOURS FROM THE TIME THE SPECIFIC INFORMATION WAS REQUIRED TO BE PROVIDED TO THE CARRIER;

(2) FOR EXTENSION OF A COURSE OF TREATMENT BEYOND THE PERIOD OF TIME OR NUMBER OF TREATMENTS PREVIOUSLY APPROVED BY THE CARRIER, THE CARRIER SHALL PROVIDE WRITTEN NOTICE TO THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER WITHIN 24 HOURS AFTER RECEIPT OF THE REQUEST IF:

(I) THE DECISION INVOLVES AN EMERGENCY CASE; AND

(II) THE REQUEST FOR THE EXTENSION WAS PROVIDED TO THE CARRIER BY THE MEMBER OF THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER AT LEAST 24 HOURS BEFORE THE EXPIRATION OF THE PREVIOUSLY APPROVED PERIOD OF TIME OR NUMBER OF TREATMENTS;

(3) FOR A NONEMERGENCY CASE INVOLVING CARE THAT HAS NOT BEEN PROVIDED:

(I) THE CARRIER SHALL PROVIDE WRITTEN NOTICE TO THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER WITHIN 15 DAYS AFTER RECEIPT OF THE REQUEST FOR PREAUTHORIZATION OF HEALTH CARE SERVICES, UNLESS THE MEMBER OR THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION; OR

(II) IF THE MEMBER OR THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION, THE CARRIER SHALL:

1. NOTIFY THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER IN WRITING WITHIN 15 DAYS AFTER RECEIPT OF THE REQUEST FOR HEALTH CARE SERVICES OF THE SPECIFIC INFORMATION NECESSARY TO MAKE THE DECISION;

2. PERMIT THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER AT LEAST 45 DAYS TO PROVIDE THE SPECIFIC INFORMATION; AND

3. NOTIFY THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER IN WRITING OF THE CARRIER'S DECISION WITHIN 15 DAYS AFTER THE EARLIER OF:

A. THE DATE THE SPECIFIC INFORMATION REQUIRED UNDER ITEM 1 OF THIS ITEM IS PROVIDED TO THE CARRIER; OR

B. THE DATE THE SPECIFIC INFORMATION WAS REQUIRED TO BE PROVIDED TO THE CARRIER; AND

(4) FOR A RETROSPECTIVE DENIAL OF HEALTH CARE SERVICES:

(I) THE CARRIER SHALL PROVIDE WRITTEN NOTICE TO THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER WITHIN 30 DAYS AFTER RECEIPT OF THE REQUEST FOR PAYMENT FOR HEALTH CARE SERVICES, UNLESS THE MEMBER OR THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION; OR

(II) IF THE MEMBER OR THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION, THE CARRIER SHALL:

1. NOTIFY THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER WITHIN 30 DAYS AFTER RECEIPT OF THE REQUEST FOR PAYMENT OF HEALTH CARE SERVICES OF THE SPECIFIC INFORMATION NECESSARY TO MAKE THE DECISION;

2. PERMIT THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER AT LEAST 45 DAYS TO PROVIDE THE SPECIFIC INFORMATION; AND

3. NOTIFY THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER IN WRITING OF THE CARRIER'S DECISION WITHIN 45 DAYS AFTER THE DATE OF RECEIPT OF THE ORIGINAL REQUEST FOR PAYMENT OF HEALTH CARE SERVICES, IN ACCORDANCE WITH THE FOLLOWING:

A. THE PERIOD OF TIME WITHIN WHICH A DECISION IS REQUIRED TO BE MADE SHALL BEGIN ON THE DATE A REQUEST FOR PAYMENT IS RECEIVED BY THE CARRIER; AND

B. IF THE TIME PERIOD TO PROVIDE THE DECISION IS EXTENDED DUE TO THE FAILURE OF THE MEMBER OR THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION, THE PERIOD FOR MAKING THE DECISION SHALL BE TOLLED FROM THE DATE ON WHICH THE NOTICE IS SENT BY THE CARRIER REQUESTING ADDITIONAL INFORMATION TO THE DATE THE ADDITIONAL INFORMATION IS RECEIVED BY THE CARRIER.

(k) Each carrier shall include the information required by subsection (f)(2)(iii), (iv), and (v) of this section in the policy, plan, certificate, enrollment materials, or other evidence of coverage that the carrier provides to a member at the time of the member's initial coverage or renewal of coverage.

(l) (1) Nothing in this subtitle prohibits a carrier from delegating its internal grievance process to a private review agent that has a certificate issued under Subtitle 10B of this title and is acting on behalf of the carrier.

(2) If a carrier delegates its internal grievance process to a private review agent, the carrier shall be:

(i) bound by the grievance decision made by the private review agent acting on behalf of the carrier; and

(ii) responsible for a violation of any provision of this subtitle regardless of the delegation made by the carrier under paragraph (1) 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.

(b) (1) In developing procedures to be used in reviewing and deciding complaints, the Commissioner shall:

(i) allow a health care provider to file a complaint on behalf of a member; and

(ii) establish an expedited procedure for use in an emergency case for the purpose of making a final decision on a complaint within 24 hours after the complaint is filed with the Commissioner.

(2) For purposes of using the expedited procedure for an emergency case under paragraph (1)(ii) of this subsection, the Commissioner shall define by regulation the standards required for a grievance to be considered an emergency case.

(c) (1) Except as provided in paragraph (2) of this subsection and except for an emergency case under subsection (b)(1)(ii) of this section, the Commissioner shall make a final decision on a complaint:

(i) within 30 working days after a complaint regarding a pending health care service is filed; and

(ii) within 45 working days after a complaint is filed regarding a retrospective denial of services already provided.

(2) The Commissioner may extend the period within which a final decision is to be made under paragraph (1) of this subsection for up to an additional 30 working days if the Commissioner has not yet received:

(i) information requested by the Commissioner; and

(ii) the information requested is necessary for the Commissioner to render a final decision on the complaint.

(d) In cases considered appropriate by the Commissioner, the Commissioner may seek advice from an independent review organization or medical expert, as provided in § 15-10A-05 of this subtitle, for complaints filed with the Commissioner under this subtitle that involve a question of whether a health care service provided or to be provided to a member is medically necessary.

(e) (1) During the review of a complaint by the Commissioner or a designee of the Commissioner, a carrier shall have the burden of persuasion that its adverse decision or grievance decision, as applicable, is correct.

(2) As part of the review of a complaint, the Commissioner or a designee of the Commissioner may consider all of the facts of the case and any other evidence that the Commissioner or designee of the Commissioner considers appropriate.

(3) As required under § 15-10A-02(i) of this subtitle, the carrier's adverse decision or grievance decision shall state in detail in clear, understandable language the factual bases for the decision and reference the specific criteria and standards, including interpretive guidelines on which the decision was based.

(4) (i) Except as provided in subparagraph (ii) of this paragraph, in responding to a complaint, a carrier may not rely on any basis not stated in its adverse decision or grievance decision.

(ii) The Commissioner may allow a carrier, a member, or a health care provider filing a complaint on behalf of a member to provide additional information as may be relevant for the Commissioner to make a final decision on the complaint.

(iii) The Commissioner's use of additional information may not delay the Commissioner's decision on the complaint by more than 5 working days.

(f) The Commissioner may request the member that filed the complaint or a legally authorized designee of the member to sign a consent form authorizing the release of the member's medical records to the Commissioner or the Commissioner's designee that are needed in order for the Commissioner to make a final decision on the complaint.

(G) ON REQUEST BY THE COMMISSIONER, A CARRIER SHALL PROVIDE THE NAMES OF THE REVIEWING PHYSICIANS OR OTHER HEALTH CARE SERVICE REVIEWERS, INCLUDING THE MEDICAL SPECIALTY OF THE PHYSICIAN OR HEALTH CARE SERVICE REVIEWER, WHO MADE A PARTICULAR ADVERSE DECISION OR GRIEVANCE DECISION.

15-10B-06.

[(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 calendar 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 may 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.]

(A) (1) UNLESS THE PATIENT OR THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE PATIENT FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE A DETERMINATION, THE PRIVATE REVIEW AGENT SHALL, WITHIN 15 DAYS AFTER THE REQUEST FOR PROPOSED HEALTH CARE SERVICES:

(I) MAKE ALL INITIAL DETERMINATIONS TO AUTHORIZE OR CERTIFY A NONEMERGENCY COURSE OF TREATMENT INVOLVING CARE THAT HAS NOT BEEN PROVIDED; AND

(II) NOTIFY THE PATIENT OR HEALTH CARE PROVIDER ACTING ON BEHALF OF THE PATIENT IN WRITING OF THE INITIAL DETERMINATION.

(2) IF THE PATIENT, AUTHORIZED REPRESENTATIVE, OR HEALTH CARE PROVIDER ACTING ON BEHALF OF THE PATIENT FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DETERMINATION, THE PRIVATE REVIEW AGENT SHALL:

(I) NOTIFY THE PATIENT, AUTHORIZED REPRESENTATIVE, OR HEALTH CARE PROVIDER ACTING ON BEHALF OF THE PATIENT IN WRITING WITHIN 15 DAYS AFTER RECEIPT OF THE REQUEST FOR HEALTH CARE SERVICES OF THE SPECIFIC INFORMATION NECESSARY TO MAKE THE DETERMINATION;

(II) PERMIT THE PATIENT, AUTHORIZED REPRESENTATIVE, OR HEALTH CARE PROVIDER ACTING ON BEHALF OF THE PATIENT AT LEAST 45 DAYS TO PROVIDE THE SPECIFIC INFORMATION; AND

(III) NOTIFY THE PATIENT, AUTHORIZED REPRESENTATIVE, OR HEALTH CARE PROVIDER ACTING ON BEHALF OF THE PATIENT IN WRITING OF THE DETERMINATION WITHIN 15 DAYS AFTER THE EARLIER OF:

1. THE DATE THE SPECIFIC INFORMATION REQUIRED UNDER ITEM (I) OF THIS PARAGRAPH IS PROVIDED TO THE PRIVATE REVIEW AGENT; OR

2. THE DATE THE SPECIFIC INFORMATION WAS REQUIRED TO BE PROVIDED TO THE PRIVATE REVIEW AGENT.

(3) UNLESS THE PATIENT, AUTHORIZED REPRESENTATIVE, OR HEALTH CARE PROVIDER ACTING ON BEHALF OF THE PATIENT FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE A DETERMINATION, THE PRIVATE REVIEW AGENT SHALL:

(I) MAKE ALL DETERMINATIONS TO AUTHORIZE OR CERTIFY AN EXTENDED STAY IN A HEALTH CARE FACILITY OR ADDITIONAL HEALTH CARE SERVICES WITHIN 24 HOURS AFTER THE REQUEST FOR:

1. THE EXTENDED STAY IN A HEALTH CARE FACILITY; OR

2. THE ADDITIONAL HEALTH CARE SERVICES; AND

(II) NOTIFY THE PATIENT, AUTHORIZED REPRESENTATIVE, OR HEALTH CARE PROVIDER ACTING ON BEHALF OF THE PATIENT OF THE DETERMINATION:

1. ORALLY WITHIN 24 HOURS AFTER RECEIPT OF THE REQUEST; AND

2. IN WRITING WITHIN 48 HOURS AFTER RECEIPT OF THE REQUEST.

(4) THE PRIVATE REVIEW AGENT SHALL:

(I) MAKE ALL DETERMINATIONS ON WHETHER TO AUTHORIZE OR CERTIFY A REQUEST FOR URGENT HEALTH CARE SERVICES OR AN EMERGENCY COURSE OF TREATMENT INVOLVING CARE THAT HAS NOT BEEN PROVIDED WITHIN 24 HOURS AFTER RECEIPT OF THE REQUEST FOR HEALTH CARE SERVICES, UNLESS THE PATIENT, AUTHORIZED REPRESENTATIVE, OR HEALTH CARE PROVIDER ACTING ON BEHALF OF THE PATIENT FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DETERMINATION; OR

(II) IF THE PATIENT, AUTHORIZED REPRESENTATIVE, OR HEALTH CARE PROVIDER ACTING ON BEHALF OF THE PATIENT FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DETERMINATION:

1. NOTIFY THE PATIENT, AUTHORIZED REPRESENTATIVE, OR HEALTH CARE PROVIDER ACTING ON BEHALF OF THE PATIENT IN WRITING WITHIN 24 HOURS AFTER RECEIPT OF THE REQUEST FOR HEALTH CARE SERVICES OF THE SPECIFIC INFORMATION NECESSARY TO MAKE THE DECISION;

2. PERMIT THE PATIENT, AUTHORIZED REPRESENTATIVE, OR HEALTH CARE PROVIDER ACTING ON BEHALF OF THE PATIENT AT LEAST 48 HOURS TO PROVIDE THE SPECIFIC INFORMATION; AND

3. NOTIFY THE PATIENT, AUTHORIZED REPRESENTATIVE, OR HEALTH CARE PROVIDER ACTING ON BEHALF OF THE PATIENT IN WRITING OF THE DETERMINATION WITHIN:

A. 48 HOURS AFTER RECEIPT OF THE SPECIFIC INFORMATION REQUIRED UNDER ITEM 1 OF THIS ITEM; OR

B. 48 HOURS FROM THE TIME IN WHICH THE SPECIFIC INFORMATION WAS REQUIRED TO BE PROVIDED TO THE PRIVATE REVIEW AGENT.

[(c)] (B) 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)] (C) 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.

[(e)] (D) (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 substance 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-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] AGENT shall meet the same requirements established under §§ 15-10A-02 through 15-10A-05 of this title.

(c) A private review agent may not charge a fee to a patient or health care provider for filing a grievance.

15-10B-09.1.

(A) A grievance decision shall be made based on the professional judgment of:

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

(ii) 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 grievance 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 grievance decision involves a mental health or substance abuse service:

(i) a licensed physician who:

1. is board certified or eligible in the same specialty as the treatment under review; or

2. is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review; or

(ii) a panel of other appropriate health care service reviewers with at least one physician, selected by the private review agent who:

1. is board certified or eligible in the same specialty as the treatment under review; or

2. is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review.

(B) A GRIEVANCE DECISION MAY NOT BE MADE BY A PHYSICIAN OR OTHER HEALTH CARE SERVICE REVIEWER WHO:

(1) WAS CONSULTED IN CONNECTION WITH THE ADVERSE DECISION OR THE SAME HEALTH CARE SERVICE; OR

(2) IS A SUBORDINATE OF THE PHYSICIAN OR OTHER HEALTH CARE SERVICE REVIEWER WHO MADE THE ADVERSE DECISION FOR THE SAME HEALTH CARE SERVICE.

15-10D-01.

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

(b) "Appeal" means a protest filed by a member or a health care provider with a carrier under its internal appeal process regarding a coverage decision concerning a member.

(c) "Appeal decision" means a final determination by a carrier that arises from an appeal filed with the carrier under its appeal process regarding a coverage decision concerning a member.

(d) "Carrier" means a person that offers a health benefit plan and is:

(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 offers a health benefit plan subject to regulation by the State.

(e) "Complaint" means a protest filed with the Commissioner involving a coverage decision other than that which is covered by Subtitle 10A of this title.

(f) (1) "Coverage decision" means an initial determination by a carrier or a representative of the carrier that results in noncoverage of a health care service OR DENIAL OF A DISABILITY CLAIM.

(2) "Coverage decision" includes nonpayment of all or any part of a claim.

(3) "Coverage decision" does not include an adverse decision as defined in § 15-10A-01(b) of this title.

(g) (1) "Health Benefit Plan" means:

(i) a hospital or medical policy or contract, including a policy or contract issued under a multiple employer trust or association;

(ii) a hospital or medical policy or contract issued by a nonprofit health service plan;

(iii) a health maintenance organization contract; [or]

(iv) a dental plan organization contract; OR

(V) A DISABILITY POLICY OR CONTRACT.

(2) "Health Benefit Plan" does not include one or more, or any combination of the following:

(i) long-term care insurance;

(ii) [disability insurance;

(iii)] accidental travel and accidental death and dismemberment insurance;

[(iv)] (III) credit health insurance;

[(v)] (IV) a health benefit plan issued by a managed care organization, as defined in Title 15, Subtitle 1 of the Health - General Article;

[(vi)] (V) disease-specific insurance; or

[(vii)] (VI) fixed indemnity insurance.

(h) "Health care provider" means:

(1) an individual who is licensed under the Health Occupations Article to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the member; or

(2) a hospital, as defined in § 19-301 of the Health - General Article.

(i) "Health care service" means a health or medical care procedure or service rendered by a health care provider that:

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

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

(j) (1) "Member" means a person entitled to health care services OR DISABILITY BENEFITS under a policy, plan, or contract issued or delivered in the State by a carrier.

(2) "Member" includes:

(i) a subscriber; and

(ii) unless preempted by federal law, a Medicare recipient.

(3) "Member" does not include a Medicaid recipient.

15-10D-02.

(a) (1) Each carrier shall establish an internal appeal process for use by its members and health care providers to dispute coverage decisions made by the carrier.

(2) The carrier may use the internal grievance process established under Subtitle 10A of this title to comply with the requirement of paragraph (1) of this subsection.

(b) An internal appeal process established by a carrier under this section shall provide that a carrier render a final decision in writing to a member, and a health care provider acting on behalf of the member, within 60 [working] days after the date on which the appeal is filed.

(c) Except as provided in subsection (d) of this section, the carrier's internal appeal process shall be exhausted prior to filing a complaint with the Commissioner under this subtitle.

(d) A member or a health care provider filing a complaint on behalf of a member may file a complaint with the Commissioner without first filing an appeal with a carrier only if the coverage decision involves an urgent medical condition, as defined by regulation adopted by the Commissioner, for which care has not been rendered.

(e) (1) [Within 30 calendar days after a coverage decision has been made, a]

(I) A carrier shall send a written notice of the coverage decision to the member and, in the case of a health maintenance organization, the treating health care provider WITHIN 30 DAYS AFTER THE CLAIM FOR HEALTH CARE SERVICES OR DISABILITY BENEFITS IS RECEIVED BY THE CARRIER, UNLESS THE MEMBER OR HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION.

(II) IF THE MEMBER OR THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION, THE CARRIER SHALL:

1. NOTIFY THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER WITHIN 30 DAYS AFTER RECEIPT OF THE CLAIM FOR HEALTH CARE SERVICES OR DISABILITY BENEFITS OF THE SPECIFIC INFORMATION NECESSARY TO MAKE THE DECISION;

2. PERMIT THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER AT LEAST 45 DAYS TO PROVIDE THE SPECIFIC INFORMATION; AND

3. NOTIFY THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER OF THE CARRIER'S DECISION WITHIN 45 DAYS AFTER THE DATE OF RECEIPT OF THE ORIGINAL CLAIM FOR HEALTH CARE SERVICES OR DISABILITY BENEFITS, IN ACCORDANCE WITH THE FOLLOWING:

A. THE PERIOD OF TIME WITHIN WHICH A DECISION IS REQUIRED TO BE MADE SHALL BEGIN ON THE DATE A REQUEST FOR PAYMENT IS RECEIVED BY THE CARRIER; AND

B. IF THE TIME PERIOD TO PROVIDE THE DECISION IS EXTENDED DUE TO THE FAILURE OF A MEMBER OR HEALTH CARE PROVIDER ACTING ON BEHALF OF A MEMBER TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION, THE PERIOD FOR MAKING THE COVERAGE DECISION SHALL BE TOLLED FROM THE DATE ON WHICH THE NOTICE IS SENT BY THE CARRIER REQUESTING ADDITIONAL INFORMATION TO THE DATE THE ADDITIONAL INFORMATION IS RECEIVED BY THE CARRIER.

(2) Notice of the coverage decision required to be sent under paragraph (1) of this subsection shall:

(i) state in detail in clear, understandable language, the specific factual bases for the carrier's decision; [and]

(ii) include the following information:

1. that the member, or a health care provider acting on behalf of the member, has a right to file an appeal with the carrier;

2. that the member, or a health care provider acting on behalf of the member, may file a complaint with the Commissioner without first filing an appeal, if the coverage decision involves an urgent medical condition for which care has not been rendered;

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

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

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

(III) REFERENCE THE SPECIFIC PLAN PROVISIONS ON WHICH THE COVERAGE DECISION IS BASED;

(IV) INCLUDE A DESCRIPTION OF ANY ADDITIONAL MATERIAL OR INFORMATION REQUIRED FROM THE MEMBER OR THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER AND AN EXPLANATION OF WHY THIS MATERIAL OR INFORMATION IS NECESSARY;

(V) INCLUDE A DESCRIPTION OF THE CARRIER'S APPEAL PROCEDURES AND THE TIME LIMITS APPLICABLE TO THE CARRIER'S APPEAL PROCEDURES; AND

(VI) IF A CARRIER USES AN INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION TO MAKE THE COVERAGE DECISION, PROVIDE THE INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION.

(f) (1) [Within 30 calendar days after the appeal decision has been made, each] EACH carrier shall send to the member, and the health care provider acting on behalf of the member, a written notice of the appeal decision WITHIN 60 DAYS AFTER THE DATE THE CARRIER RECEIVES THE APPEAL.

(2) Notice of the appeal decision required to be sent under paragraph (1) of this subsection shall:

(i) state in detail in clear, understandable language the specific factual bases for the carrier's decision; [and]

(ii) include the following information:

1. that the member, or a health care provider acting on behalf of the member, has a right to file a complaint with the Commissioner within 60 working days after receipt of a carrier's appeal decision; and

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

(III) REFERENCE THE SPECIFIC PLAN PROVISIONS ON WHICH THE APPEAL DECISION IS BASED;

(IV) STATE THAT THE MEMBER AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER SHALL BE ENTITLED TO RECEIVE, FREE OF CHARGE, REASONABLE ACCESS TO, AND COPIES OF ALL DOCUMENTS, RECORDS, AND OTHER INFORMATION RELEVANT TO THE APPEAL DECISION; AND

(V) IF THE CARRIER USES AN INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION TO MAKE THE APPEAL DECISION,

PROVIDE THE INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION.

(g) The Commissioner may request the member that filed the complaint or a legally authorized designee of the member to sign a consent form authorizing the release of the member's medical records to the Commissioner or the Commissioner's designee that are needed in order for the Commissioner to make a final decision on the complaint.

(h) (1) During the review of a complaint by the Commissioner or a designee of the Commissioner, a carrier shall have the burden of persuasion that its coverage decision or appeal decision, as applicable, is correct.

(2) As part of the review of a complaint, the Commissioner or a designee of the Commissioner may consider all of the facts of the case and any other evidence that the Commissioner or designee of the Commissioner considers appropriate.

(i) The Commissioner shall:

(1) make and issue in writing a final decision on all complaints filed with the Commissioner under this subtitle that are within the Commissioner's jurisdiction; and

(2) provide notice in writing to all parties to a complaint of the opportunity and time period for requesting a hearing to be held in accordance with Title 10, Subtitle 2 of the State Government Article to contest a final decision of the Commissioner made and issued under this subtitle.

15-10D-03.

(a) It is a violation of this subtitle for a carrier to fail to fulfill the carrier's obligations to provide or reimburse for health care services OR DISABILITY BENEFITS specified in the carrier's policies or contracts with members.

(b) If, in rendering a coverage decision or appeal decision, a carrier fails to fulfill the carrier's policies or contracts with members, the Commissioner may:

(1) Issue an administrative order that requires the carrier to:

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

(ii) fulfill the carrier's contractual obligations;

(iii) provide a health care service or payment that has been denied improperly; or

(iv) take appropriate steps to restore the carrier's ability to provide a health care service or payment that is provided under a contract; or

(2) Impose any penalty or fine or take any action as authorized:

(i) for an insurer, nonprofit health service plan, or dental plan organization, under this article; or

(ii) for a health maintenance organization, under the Health - General Article or under this article.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2002.