HOUSE BILL 1361

Unofficial Copy 2004 Regular Session
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By: **Chairman, Health and Government Operations Committee (By Request - Departmental - Insurance Administration, Maryland)**
Introduced and read first time: February 19, 2004
Assigned to: Rules and Executive Nominations

A BILL ENTITLED

AN ACT concerning

Health Insurance - Appeals and Grievances

FOR the purpose of altering certain provisions governing the submission of a claim by a health care provider to a carrier for payment; requiring a carrier to accept the filing of an appeal from certain individuals; requiring carriers and private review agents to make certain determinations within certain time periods; requiring carriers and private review agents to provide notice of the carrier's determination under certain circumstances; requiring the Insurance Commissioner to accept the filing of a complaint from certain individuals; defining certain terms; altering certain definitions; providing for a delayed effective date; and generally relating to the claims handling and appeals and grievance processes with respect to the payment of claims by insurance carriers for health care services.

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-123(j)(1), 15-1005(d), (e), and (f)(1), 15-10A-01, 15-10A-02, 15-10A-03, 15-10A-04, 15-10B-01, 15-10B-06, 15-10B-08, 15-10B-09.1, 15-10D-01, and 15-10D-02
Annotated Code of Maryland
(2002 Replacement Volume and 2003 Supplement)

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

Article - Insurance

15-123.

(j) (1) A carrier's [coverage] decision on an emerging medical or surgical treatment shall be in compliance with [§ 15-10B-07] TITLE 15, SUBTITLES 10A AND 10B of this article[, when being appealed by an enrollee].

15-1005.

(d) (1) An insurer, nonprofit health service plan, or health maintenance organization shall permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement for the service.

(2) If an insurer, nonprofit health service plan, or health maintenance organization wholly or partially denies a claim for reimbursement, the insurer, nonprofit health service plan, or health maintenance organization shall permit a provider a minimum of [90 working days] 180 DAYS after [the date] THE PROVIDER RECEIVES NOTICE of denial of the claim to appeal the denial.

(e) (1) If an insurer, nonprofit health service plan, or health maintenance organization provides notice under subsection (c)(2)(i) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall pay any undisputed portion of the claim within 30 days of receipt of the claim, in accordance with this section.

(2) If an insurer, nonprofit health service plan, or health maintenance organization provides notice under subsection (c)(2)(ii) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall:

(i) pay any undisputed portion of the claim in accordance with this section; and

(ii) comply with subsection (c)(1) or (2)(i) of this section within [30] 15 days after receipt of the requested additional information.

(3) If an insurer, nonprofit health service plan, or health maintenance organization provides notice under subsection (c)(2)(iii) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall comply with subsection (c)(1) or (2)(i) of this section within [30] 15 days after receipt of the requested additional information.

(f) (1) If an insurer, nonprofit health service plan, or health maintenance organization fails to comply with subsection (c) OR (E) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall pay interest on the amount of the claim that remains unpaid 30 days after the claim is received at the monthly rate of:

(i) 1.5% from the 31st day through the 60th day;

(ii) 2% from the 61st day through the 120th day; and

(iii) 2.5% after the 120th day.

15-10A-01.

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

(b) (1) "Adverse decision" means a utilization review determination by a private review agent, a carrier, or a health care provider acting on behalf of a carrier that:

(i) a proposed or delivered health care service covered under the member's contract is or was not medically necessary, appropriate, or efficient; and

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

(2) "Adverse decision" does not include a decision concerning a subscriber's status as a member.

(C) (1) "AUTHORIZED REPRESENTATIVE" MEANS A PERSON, INCLUDING A HEALTH CARE PROVIDER, AUTHORIZED BY THE MEMBER TO ACT ON BEHALF OF THE MEMBER.

(2) "AUTHORIZED REPRESENTATIVE" INCLUDES, IN AN EMERGENCY CASE, A HEALTH CARE PROVIDER WITH KNOWLEDGE OF THE MEMBER'S MEDICAL CONDITION.

[(c)] (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 provides health benefit plans subject to regulation by the State.

[(d)] (E) "Complaint" means a protest filed with the Commissioner involving an adverse decision or grievance decision concerning the member.

(F) "DESIGNEE OF THE COMMISSIONER" MEANS ANY PERSON TO WHOM THE COMMISSIONER HAS DELEGATED THE AUTHORITY TO REVIEW AND DECIDE COMPLAINTS FILED UNDER THIS SUBTITLE, INCLUDING AN ADMINISTRATIVE LAW JUDGE TO WHOM THE AUTHORITY TO CONDUCT A HEARING HAS BEEN DELEGATED FOR RECOMMENDED OR FINAL DECISION.

(G) (1) "EMERGENCY CASE" MEANS ANY CLAIM OR REQUEST FOR MEDICAL CARE OR TREATMENT IN WHICH THE APPLICATION OF THE TIME PERIODS FOR MAKING NONEMERGENCY CASE DETERMINATIONS:

(I) IN THE JUDGMENT OF A PRUDENT LAYPERSON WHO POSSESSES AN AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE, MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE ABILITY OF THE MEMBER TO REGAIN MAXIMUM FUNCTION; OR

(II) IN THE OPINION OF A PHYSICIAN WITH KNOWLEDGE OF THE MEMBER'S MEDICAL CONDITION:

1. MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE ABILITY OF THE MEMBER TO REGAIN MAXIMUM FUNCTION; OR

2. MAY SUBJECT THE MEMBER TO SEVERE PAIN THAT CANNOT BE ADEQUATELY MANAGED WITHOUT THE CARE OR TREATMENT THAT IS THE SUBJECT OF THE CLAIM OR REQUEST.

(2) "EMERGENCY CASE" DOES NOT INCLUDE A RETROSPECTIVE DENIAL OF HEALTH CARE SERVICES.

[(e)] (H) "Grievance" means a protest filed by a member or [a health care provider on behalf of a member] AN AUTHORIZED REPRESENTATIVE with a carrier through the carrier's internal grievance process regarding an adverse decision concerning the member.

[(f)] (I) "Grievance decision" means a final determination by a carrier that arises from a grievance filed with the carrier under its internal grievance process regarding an adverse decision concerning a member.

[(g)] (J) "Health Advocacy Unit" means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General established under Title 13, Subtitle 4A of the Commercial Law Article.

[(h)] (K) "Health benefit plan" has the meaning stated in § 2-112.2(a) of this article.

[(i)] (L) "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.

[(j)] (M) "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.

[(k)] (N) (1) "Member" means a person entitled to health care benefits under a policy, HEALTH BENEFIT plan, or certificate 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.

[(l)] (O) "Private review agent" has the meaning stated in § 15-10B-01 of this title.

15-10A-02.

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

(B) THE CARRIER'S INTERNAL GRIEVANCE PROCESS SHALL ALLOW AN AUTHORIZED REPRESENTATIVE TO FILE A GRIEVANCE ON BEHALF OF A MEMBER.

[(b)] (C) (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] NOTIFY THE MEMBER AND THE AUTHORIZED REPRESENTATIVE OF a [final] GRIEVANCE decision in writing [on a grievance] within 30 [working] days after the date on which the grievance is [filed] RECEIVED BY THE CARRIER 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 AUTHORIZED REPRESENTATIVE OF THE DECISION IN WRITING AS SOON AS POSSIBLE DEPENDING ON THE MEDICAL EXIGENCY BUT NO LATER THAN 72 HOURS AFTER THE TIME THE GRIEVANCE IS RECEIVED BY THE CARRIER;

2. the member or [a health care provider] AN AUTHORIZED REPRESENTATIVE filing a grievance on behalf of a member agrees in writing to an extension for a period of no longer than [30 working days] 60 DAYS AFTER RECEIPT BY THE CARRIER OF THE GRIEVANCE; or

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

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

(iv)] (III) provide that a carrier [render] NOTIFY THE MEMBER AND THE AUTHORIZED REPRESENTATIVE OF a final decision in writing on a grievance

within [45 working days] 60 DAYS after the date on which the grievance is [filed] RECEIVED BY THE CARRIER when the grievance involves a retrospective denial; and

[(v)] (IV) [for a retrospective denial,] allow a member or [a health care provider on behalf of a member] AN AUTHORIZED REPRESENTATIVE to file a grievance for at least 180 days after the member OR THE AUTHORIZED REPRESENTATIVE 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)] (D) Except as provided in subsection [(d)] (E) of this section, the carrier's internal grievance process shall be exhausted prior to filing a complaint with the Commissioner under this subtitle.

[(d)] (E) (1) (i) A member or [a health care provider filing a complaint on behalf of a member] AN AUTHORIZED REPRESENTATIVE 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] AUTHORIZED REPRESENTATIVE 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)] SUBSECTION (C)(2)(II) of this section, a member or [a health care provider] AN AUTHORIZED REPRESENTATIVE may file a complaint with the Commissioner if the member or the [health care provider] AUTHORIZED REPRESENTATIVE does not receive a grievance decision from the carrier on or before the 30th [working] day on which the grievance is [filed] RECEIVED BY THE CARRIER.

(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] 7 days after the date the complaint is filed with the Commissioner.

[(e)] (F) 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] FILE ANY REVISIONS TO THE INTERNAL GRIEVANCE PROCESS WITH THE COMMISSIONER AT LEAST 30 DAYS BEFORE ITS INTENDED USE.

[(f)] (G) [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] AUTHORIZED REPRESENTATIVE; and

(2) send, [within 5 working days after the adverse decision has been made] WITHIN THE TIME PERIODS DESCRIBED IN SUBSECTION (I) OF THIS SECTION, a written notice to the member and [a health care provider acting on behalf of the member] THE AUTHORIZED REPRESENTATIVE 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] THE AUTHORIZED REPRESENTATIVE ACTING on behalf of the member has a right to file a complaint with the Commissioner within [30 working] 45 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] THE AUTHORIZED REPRESENTATIVE 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 electronic mail address of the Health Advocacy [Unit.] UNIT;

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

1. PROVIDES THE INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION; OR

2. INFORMS THE MEMBER AND THE AUTHORIZED REPRESENTATIVE THAT A COPY OF THE INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION WILL BE PROVIDED FREE OF CHARGE ON REQUEST OF THE MEMBER OR THE AUTHORIZED REPRESENTATIVE;

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

(VIII) IF A CARRIER REQUIRES ADDITIONAL INFORMATION:

1. PROVIDES A DESCRIPTION OF ANY ADDITIONAL MATERIAL OR INFORMATION REQUIRED FROM THE MEMBER OR AUTHORIZED REPRESENTATIVE; AND

2. PROVIDES AN EXPLANATION OF WHY THE ADDITIONAL 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 period required for making a final grievance decision under subsection (b)(2)(ii) 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)] (H) (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] AUTHORIZED REPRESENTATIVE; and

(ii) send, within [5 working days after the grievance decision has been made] THE TIME PERIODS SPECIFIED IN SUBSECTION (C)(2) OF THIS SECTION, a written notice to the member and [a health care provider acting on behalf of the member] THE AUTHORIZED REPRESENTATIVE 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 OR THE AUTHORIZED REPRESENTATIVE has a right to file a complaint with the Commissioner within [30 working] 45 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 AUTHORIZED REPRESENTATIVE ARE 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 THE CARRIER USES AN INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION TO MAKE THE GRIEVANCE DECISION:

A. PROVIDES THE INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION; OR

B. INFORMS THE MEMBER AND THE AUTHORIZED REPRESENTATIVE THAT A COPY OF THE INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION WILL BE PROVIDED FREE OF CHARGE ON REQUEST FROM THE MEMBER OR AUTHORIZED REPRESENTATIVE; AND

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

(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.]

(I) (1) A CARRIER SHALL PROVIDE NOTICE OF AN ADVERSE DECISION AS PROVIDED IN THIS SUBSECTION.

(2) EXCEPT AS PROVIDED IN PARAGRAPH (3) OF THIS SUBSECTION, FOR AN EMERGENCY CASE:

(I) THE CARRIER SHALL PROVIDE WRITTEN NOTICE TO THE MEMBER AND THE AUTHORIZED REPRESENTATIVE WITHIN 72 HOURS AFTER RECEIPT OF THE REQUEST FOR HEALTH CARE SERVICES, UNLESS THE MEMBER OR THE AUTHORIZED REPRESENTATIVE FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION; OR

(II) IF THE MEMBER OR THE AUTHORIZED REPRESENTATIVE FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION, THE CARRIER SHALL:

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

2. ALLOW THE MEMBER OR THE AUTHORIZED REPRESENTATIVE AT LEAST 48 HOURS TO PROVIDE THE SPECIFIC INFORMATION; AND

3. NOTIFY THE MEMBER AND THE AUTHORIZED REPRESENTATIVE 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 SUBPARAGRAPH; OR

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

(3) FOR AN EXTENSION OF A COURSE OF TREATMENT BEYOND THE PERIOD OF TIME OR NUMBER OF TREATMENTS PREVIOUSLY APPROVED BY THE CARRIER, THE CARRIER SHALL PROVIDE NOTICE TO THE MEMBER AND THE AUTHORIZED REPRESENTATIVE WITHIN 24 HOURS AFTER RECEIPT OF THE REQUEST, IF:

(I) THE DECISION ADDRESSES AN EMERGENCY CASE; AND

(II) THE REQUEST FOR THE EXTENSION WAS PROVIDED TO THE CARRIER BY THE MEMBER OR THE AUTHORIZED REPRESENTATIVE AT LEAST 24 HOURS BEFORE THE EXPIRATION OF THE PREVIOUSLY APPROVED PERIOD OF TIME OR NUMBER OF TREATMENTS.

(4) (I) FOR A NONEMERGENCY CASE INVOLVING CARE THAT HAS NOT BEEN PROVIDED, THE CARRIER SHALL PROVIDE WRITTEN NOTICE TO THE MEMBER AND THE AUTHORIZED REPRESENTATIVE WITHIN 15 DAYS AFTER THE REQUEST FOR PREAUTHORIZATION OF HEALTH CARE SERVICES HAS BEEN RECEIVED BY THE CARRIER, UNLESS:

1. THE MEMBER OR THE AUTHORIZED REPRESENTATIVE FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION; OR

2. THE CARRIER DETERMINES THAT DUE TO CIRCUMSTANCES BEYOND THE CONTROL OF THE CARRIER, A 15-DAY EXTENSION IS NECESSARY.

(II) IF THE MEMBER OR THE AUTHORIZED REPRESENTATIVE FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION, THE CARRIER SHALL:

1. NOTIFY THE MEMBER AND THE AUTHORIZED REPRESENTATIVE IN WRITING WITHIN 15 DAYS AFTER RECEIPT OF THE REQUEST FOR SERVICES OF THE SPECIFIC INFORMATION NECESSARY TO MAKE THE DECISION;

2. ALLOW THE MEMBER OR THE AUTHORIZED REPRESENTATIVE AT LEAST 45 DAYS TO PROVIDE THE SPECIFIC INFORMATION; AND

3. NOTIFY THE MEMBER AND THE AUTHORIZED REPRESENTATIVE IN WRITING OF THE CARRIER'S DECISION WITHIN THE EARLIER OF:

A. 15 DAYS AFTER RECEIPT OF THE SPECIFIC INFORMATION REQUIRED IN ITEM 1 OF THIS SUBPARAGRAPH; OR

B. 15 DAYS AFTER THE DATE THE SPECIFIC INFORMATION WAS REQUIRED TO BE PROVIDED TO THE CARRIER.

(III) IF THE CARRIER DETERMINES THAT A 15-DAY EXTENSION IS NECESSARY DUE TO CIRCUMSTANCES BEYOND THE CONTROL OF THE CARRIER, THE CARRIER SHALL NOTIFY THE MEMBER AND AUTHORIZED REPRESENTATIVE BEFORE THE EXPIRATION OF THE INITIAL 15-DAY PERIOD OF:

1. THE CIRCUMSTANCES REQUIRING THE EXTENSION OF TIME; AND

2. THE DATE BY WHICH THE CARRIER EXPECTS TO RENDER A DECISION.

(5) (I) FOR A RETROSPECTIVE DENIAL OF HEALTH CARE SERVICES, THE CARRIER SHALL PROVIDE WRITTEN NOTICE TO THE MEMBER AND THE AUTHORIZED REPRESENTATIVE WITHIN 30 DAYS AFTER THE REQUEST FOR PAYMENT FOR HEALTH CARE SERVICES IS RECEIVED BY THE CARRIER, SUBJECT TO SUBPARAGRAPHS (II) AND (III) OF THIS PARAGRAPH.

(II) IF THE MEMBER OR THE AUTHORIZED REPRESENTATIVE FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION ON THE PAYMENT OF HEALTH CARE SERVICES, THE CARRIER SHALL:

1. NOTIFY THE MEMBER AND THE AUTHORIZED REPRESENTATIVE IN WRITING WITHIN 30 DAYS AFTER RECEIPT OF THE REQUEST FOR PAYMENT OF HEALTH CARE SERVICES OF THE SPECIFIC INFORMATION NECESSARY TO MAKE THE DECISION;

2. ALLOW THE MEMBER OR THE AUTHORIZED REPRESENTATIVE ACTING ON BEHALF OF THE MEMBER AT LEAST 45 DAYS TO PROVIDE THE SPECIFIC INFORMATION; AND

3. PROVIDE WRITTEN NOTICE OF THE CARRIER'S DECISION TO THE MEMBER AND THE AUTHORIZED REPRESENTATIVE WITHIN THE EARLIER OF:

A. 15 DAYS AFTER RECEIPT OF THE SPECIFIC INFORMATION REQUIRED IN ITEM 1 OF THIS SUBPARAGRAPH; OR

B. 15 DAYS AFTER THE DATE THE SPECIFIC INFORMATION WAS REQUIRED TO BE PROVIDED TO THE CARRIER.

(III) THE CARRIER MAY BE ALLOWED A 15-DAY EXTENSION IF THE CARRIER:

1. DETERMINES THE EXTENSION IS NECESSARY DUE TO CIRCUMSTANCES BEYOND THE CONTROL OF THE CARRIER; AND

2. PROVIDES NOTICE TO THE MEMBER AND THE AUTHORIZED REPRESENTATIVE BEFORE THE EXPIRATION OF THE INITIAL 30-DAY PERIOD OF:

A. THE CIRCUMSTANCES REQUIRING THE EXTENSION OF TIME; AND

B. THE DATE BY WHICH THE CARRIER EXPECTS TO RENDER A DECISION.

[(k)] (J) Each carrier shall include the information required by subsection [(f)(2)(iii)] (G)(2)(III), (iv), and (v) of this section in the policy, HEALTH BENEFIT 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)] (K) (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] 45 days after the date of receipt of a grievance decision, a member or [a health care provider] THE AUTHORIZED REPRESENTATIVE, who filed the grievance on behalf of the member under § [15-10A-02(b)(2)(iii)] 15-10A-02(B)(1) 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] 7 days after the date the complaint is filed with the Commissioner.

(3) Except for an emergency case under subsection [(b)(1)(ii)] (B)(2) 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] 10 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)] (1) allow [a health care provider] AN AUTHORIZED REPRESENTATIVE to file a complaint on behalf of a member; and

[(ii)] (2) 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)] (B)(2) of this section, the Commissioner shall make a final decision on a complaint:

(i) within [30 working] 45 days after a complaint regarding a pending health care service is filed; and

(ii) within [45 working] 60 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] 45 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)] 15-10A-02(H) 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] AN AUTHORIZED REPRESENTATIVE 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] 7 days.

(f) The Commissioner may request the member that filed the complaint or [a legally authorized designee of the member] AN AUTHORIZED REPRESENTATIVE 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 OF THE COMMISSIONER, THE PATIENT, OR THE AUTHORIZED REPRESENTATIVE, 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.

15-10A-04.

(a) The Commissioner shall:

(1) notwithstanding the provisions of § 15-10A-03(c)(1)(ii) of this subtitle, for the purpose of making final decisions on complaints, prioritize complaints regarding pending health care services over complaints regarding health care services already delivered;

(2) 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

(3) 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 § 2-210 of this article.

(B) THE PROVISIONS OF § 15-10A-02(E) SHALL BE APPLIED IN ANY HEARING REQUESTED IN ACCORDANCE WITH SUBSECTION (A) OF THIS SECTION.

[(b)] (C) (1) For emergency cases, the Commissioner shall send written notification of the Commissioner's final decision within [1 working day] 3 DAYS after the Commissioner or the Commissioner's designee has informed the member or [a health care provider] AN AUTHORIZED REPRESENTATIVE who filed the complaint on behalf of the member of the final decision through an oral communication.

(2) The Commissioner shall include in the notice the information required under subsection (a)(3) of this section.

[(c)] (D) (1) 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 specified in the carrier's policies or contracts with members.

(2) If, in rendering an adverse decision or grievance decision, a carrier fails to fulfill the carrier's obligations to provide or reimburse for health care services specified in the carrier's policies or contracts with members, the Commissioner may:

(i) issue an administrative order that requires the carrier to:

1. cease inappropriate conduct or practices by the carrier or any of the personnel employed or associated with the carrier;

2. fulfill the carrier's contractual obligations;

3. provide a health care service or payment that has been denied improperly; or

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

(ii) impose any penalty or fine or take any action as authorized:

1. for an insurer, nonprofit health service plan, or dental plan organization, under this article; or

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

(3) In addition to paragraph (1) of this subsection, it is a violation of this subtitle, if the Commissioner, in consultation with an independent review organization, medical expert, the Department, or other appropriate entity, determines that the criteria and standards used by a health maintenance organization to conduct utilization review are not:

(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.

[(d)] (E) The Commissioner may refer complaints not within the Commissioner's jurisdiction to the Health Advocacy Unit or any other appropriate federal or State government agency or unit for disposition or resolution.

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) "Adverse decision" does not include a decision concerning a subscriber's status as a member.

(C) "AUTHORIZED REPRESENTATIVE" MEANS A PERSON, INCLUDING A HEALTH CARE PROVIDER, AUTHORIZED BY THE PATIENT TO ACT ON BEHALF OF THE PATIENT.

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

[(d)] (E) (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 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)] (F) (1) "Grievance" means a protest filed by a patient or [a health care provider on behalf of a patient] AN AUTHORIZED REPRESENTATIVE 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)] (G) "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.

[(g)] (H) "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)] (I) "Health care provider" means:

(1) an individual who:

(i) is licensed or otherwise authorized to provide health care services in the ordinary course of business or practice of a profession; and

(ii) is a treating provider of a patient; or

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

[(i)] (J) "Health care service" means 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;

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

(3) provides any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well-being of human beings.

[(j)] (K) "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.

[(k)] (L) "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 pays for, provides, or administers health care services to citizens of this State; 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) the hospital; or

(ii) a business wholly owned by the hospital.

[(l)] (M) "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.

[(m)] (N) "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.

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

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.] SHALL PROVIDE NOTICE OF ALL DETERMINATIONS TO THE PATIENT AND THE AUTHORIZED REPRESENTATIVE, WHETHER ADVERSE OR NOT, WITHIN THE TIME PERIODS SPECIFIED IN § 15-10A-02(I) OF THIS TITLE.

(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.

(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)] (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] AND THE AUTHORIZED REPRESENTATIVES.

(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] THE AUTHORIZED REPRESENTATIVE 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 FOR 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] AN AUTHORIZED REPRESENTATIVE 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) "AUTHORIZED REPRESENTATIVE" MEANS A PERSON, INCLUDING A HEALTH CARE PROVIDER, AUTHORIZED BY THE MEMBER TO ACT ON BEHALF OF THE MEMBER.

[(d)] (E) "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)] (F) "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)] (G) (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.

(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.

(H) "DESIGNEE OF THE COMMISSIONER" MEANS ANY PERSON TO WHOM THE COMMISSIONER HAS DELEGATED THE AUTHORITY TO REVIEW AND DECIDE COMPLAINTS FILED UNDER THIS SUBTITLE, INCLUDING AN ADMINISTRATIVE LAW JUDGE TO WHOM THE AUTHORITY TO CONDUCT A HEARING HAS BEEN DELEGATED FOR RECOMMENDED OR FINAL DECISION.

(I) (1) "EMERGENCY CASE" MEANS ANY CLAIM OR REQUEST FOR MEDICAL CARE OR TREATMENT IN WHICH THE APPLICATION OF THE TIME PERIODS FOR MAKING NONEMERGENCY CASE DETERMINATIONS MAY:

(I) IN THE JUDGMENT OF A PRUDENT LAYPERSON WHO POSSESSES AN AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE, SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE ABILITY OF THE MEMBER TO REGAIN MAXIMUM FUNCTION; OR

(II) IN THE OPINION OF A PHYSICIAN WITH KNOWLEDGE OF THE MEMBER'S MEDICAL CONDITION:

1. SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE ABILITY OF THE MEMBER TO REGAIN MAXIMUM FUNCTION; OR

2. SUBJECT THE MEMBER TO SEVERE PAIN THAT CANNOT BE ADEQUATELY MANAGED WITHOUT THE CARE OR TREATMENT THAT IS THE SUBJECT OF THE CLAIM OR REQUEST.

(2) "EMERGENCY CASE" DOES NOT INCLUDE A RETROSPECTIVE DENIAL OF HEALTH CARE SERVICES.

[(g)] (J) (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.

(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) credit health insurance;

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

(vi) disease-specific insurance; or

(vii) fixed indemnity insurance.

[(h)] (K) "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)] (L) "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)] (M) (1) "Member" means a person entitled to health care services under a policy, HEALTH BENEFIT 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] OR THEIR AUTHORIZED REPRESENTATIVES 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) THE CARRIER'S INTERNAL APPEAL PROCESS SHALL ALLOW:

(1) AN AUTHORIZED REPRESENTATIVE TO FILE AN APPEAL; OR

(2) IN AN EMERGENCY CASE, A HEALTH CARE PROVIDER WITH KNOWLEDGE OF THE MEMBER'S MEDICAL CONDITION TO FILE AN APPEAL.

[(b)] (C) An internal appeal process established by a carrier under this section shall provide that a carrier render [a final] AN APPEAL decision in writing to a [member, and a health care provider acting on behalf of the member,] MEMBER AND AUTHORIZED REPRESENTATIVE within 60 [working] days after the date on which the [appeal is filed] CARRIER RECEIVES THE APPEAL OF A RETROSPECTIVE DENIAL.

(D) 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 AUTHORIZED REPRESENTATIVE WITHIN 30 DAYS AFTER THE DATE THE CARRIER RECEIVES THE APPEAL OF A HEALTH CARE SERVICE NOT YET PROVIDED.

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

[(d)] (F) A member or [a health care provider filing a complaint on behalf of a member] AN AUTHORIZED REPRESENTATIVE 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,] EMERGENCY CASE for which care has not been rendered.

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

(G) (1) FOR A COVERAGE DECISION INVOLVING A NONEMERGENCY CASE FOR WHICH CARE HAS NOT BEEN PROVIDED, A CARRIER SHALL COMPLY WITH § 15-10A-02(I)(4) OF THIS TITLE.

(2) FOR A COVERAGE DECISION INVOLVING A RETROSPECTIVE DENIAL OF HEALTH CARE SERVICES, A CARRIER SHALL COMPLY WITH § 15-10A-02(I)(5) OF THIS TITLE.

(3) FOR A COVERAGE DECISION INVOLVING AN EXTENSION OF A COURSE OF TREATMENT BEYOND THE PERIOD OF TIME OR NUMBER OF TREATMENTS PREVIOUSLY APPROVED BY THE CARRIER, THE CARRIER SHALL COMPLY WITH § 15-10A-02(I)(3) OF THIS TITLE.

(4) FOR A COVERAGE DECISION INVOLVING AN EMERGENCY CASE, THE CARRIER SHALL COMPLY WITH § 15-10A-02(I)(2) OF THIS TITLE.

[(2)] (5) Notice of the coverage decision required to be sent under [paragraph (1)] PARAGRAPHS (1) THROUGH (4) 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,] MEMBER OR THE AUTHORIZED REPRESENTATIVE 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,] MEMBER OR THE AUTHORIZED REPRESENTATIVE may file a complaint with the Commissioner without first filing an appeal, if the coverage decision involves an [urgent medical condition] EMERGENCY CASE 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 electronic mail address of the Health Advocacy Unit;

(III) REFERENCE THE SPECIFIC HEALTH BENEFIT 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 AUTHORIZED REPRESENTATIVE AND AN EXPLANATION OF THE NECESSITY OF THE MATERIAL OR INFORMATION;

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

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

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

2. INFORM THE MEMBER AND THE AUTHORIZED REPRESENTATIVE THAT A COPY OF THE INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION WILL BE PROVIDED FREE OF CHARGE ON REQUEST FROM THE MEMBER OR AUTHORIZED REPRESENTATIVE.

[(f)] (H) [(1) Within 30 calendar days after the appeal decision has been made, 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.

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

[(i)] (1) state in detail in clear, understandable language the specific factual bases for the carrier's decision; [and]

[(ii)] (2) include the following information:

[1.] (I) that the [member, or a health care provider acting on behalf of the member,] MEMBER OR AUTHORIZED REPRESENTATIVE has a right to file a complaint with the Commissioner within 60 working days after receipt of a carrier's appeal decision; and

[2.] (II) the Commissioner's address, telephone number, and facsimile [number.] NUMBER;

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

(4) INCLUDE A STATEMENT THAT THE MEMBER OR THE AUTHORIZED REPRESENTATIVE IS ENTITLED TO RECEIVE, FREE OF CHARGE, REASONABLE ACCESS TO AND COPIES OF ALL DOCUMENTS, RECORDS, AND OTHER INFORMATION RELEVANT TO THE APPEAL DECISION; AND

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

(I) PROVIDE THE INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION; OR

(II) INFORM THE MEMBER OR THE AUTHORIZED REPRESENTATIVE THAT A COPY OF THE INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION WILL BE PROVIDED FREE OF CHARGE ON REQUEST FROM THE MEMBER OR AUTHORIZED REPRESENTATIVE.

[(g)] (I) The Commissioner may request the member that filed the complaint or [a legally] AN authorized [designee] REPRESENTATIVE 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)] (J) (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)] (K) (1) The Commissioner shall:

[(1)] (I) 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)] (II) 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.

(2) THE PROVISIONS OF SUBSECTION (J) OF THIS SECTION SHALL APPLY IN A HEARING REQUESTED IN ACCORDANCE WITH PARAGRAPH (1) OF THIS SUBSECTION.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 2005.