Unofficial Copy C3 2004 Regular Session 4lr0121

### 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

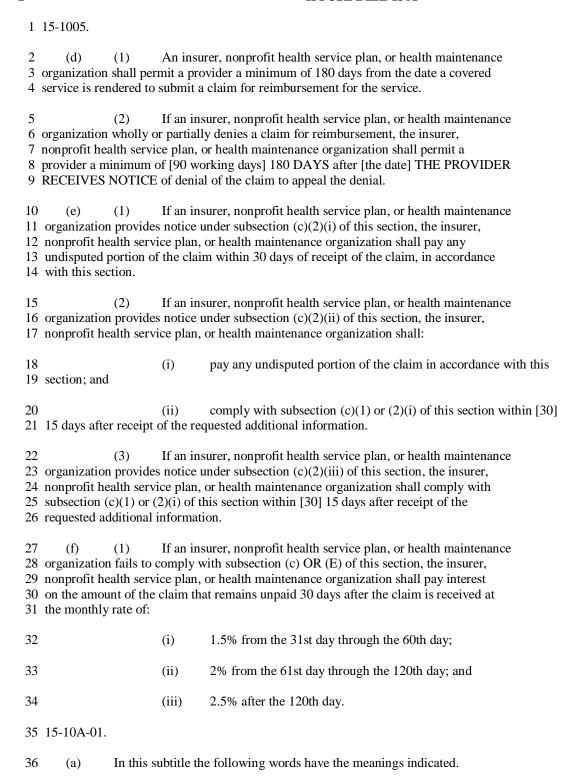
1	$\Delta N$	$\Delta CT$	concerning
1	7 11 1	1101	concerning

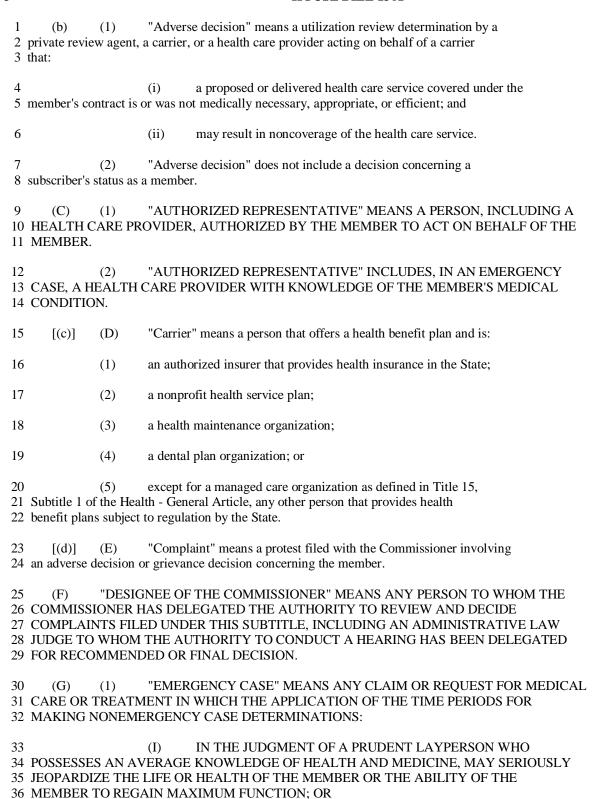
### 2 Health Insurance - Appeals and Grievances

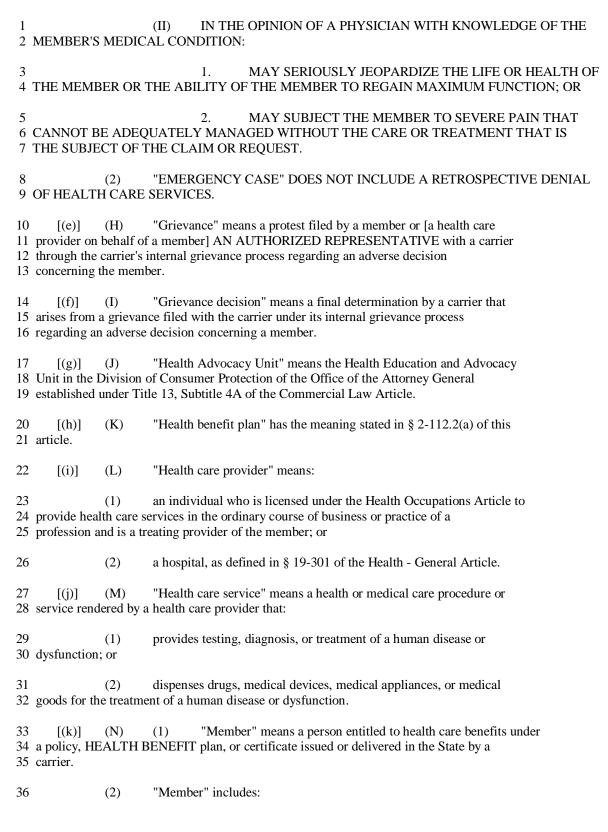
- 3 FOR the purpose of altering certain provisions governing the submission of a claim by
- 4 a health care provider to a carrier for payment; requiring a carrier to accept the
- 5 filing of an appeal from certain individuals; requiring carriers and private
- 6 review agents to make certain determinations within certain time periods;
- 7 requiring carriers and private review agents to provide notice of the carrier's
  - determination under certain circumstances; requiring the Insurance
- 9 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
- 12 grievance processes with respect to the payment of claims by insurance carriers
- 13 for health care services.
- 14 BY repealing and reenacting, with amendments,
- 15 Article Insurance
- 16 Section 15-123(j)(1), 15-1005(d), (e), and (f)(1), 15-10A-01, 15-10A-02,
- 17 15-10A-03, 15-10A-04, 15-10B-01, 15-10B-06, 15-10B-08,
- 18 15-10B-09.1, 15-10D-01, and 15-10D-02
- 19 Annotated Code of Maryland
- 20 (2002 Replacement Volume and 2003 Supplement)
- 21 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF
- 22 MARYLAND, That the Laws of Maryland read as follows:
- 23 Article Insurance
- 24 15-123.

8

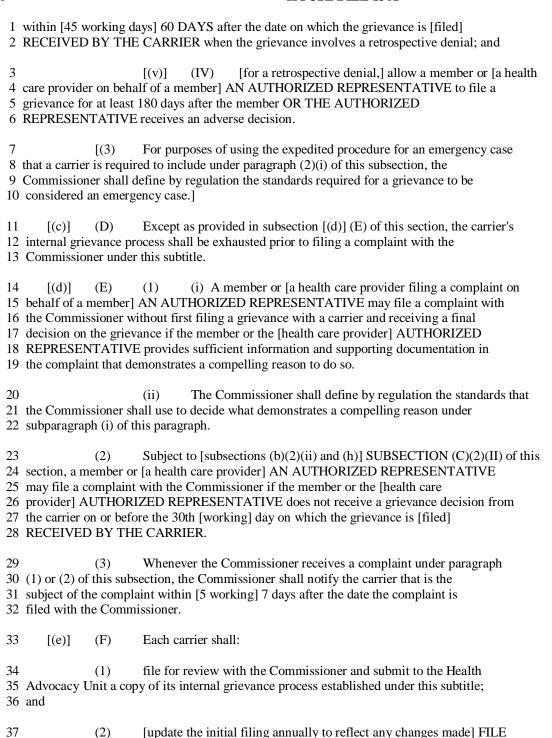
- 25 (j) A carrier's [coverage] decision on an emerging medical or surgical
- 26 treatment shall be in compliance with [§ 15-10B-07] TITLE 15, SUBTITLES 10A AND
- 27 10B of this article, when being appealed by an enrollee.







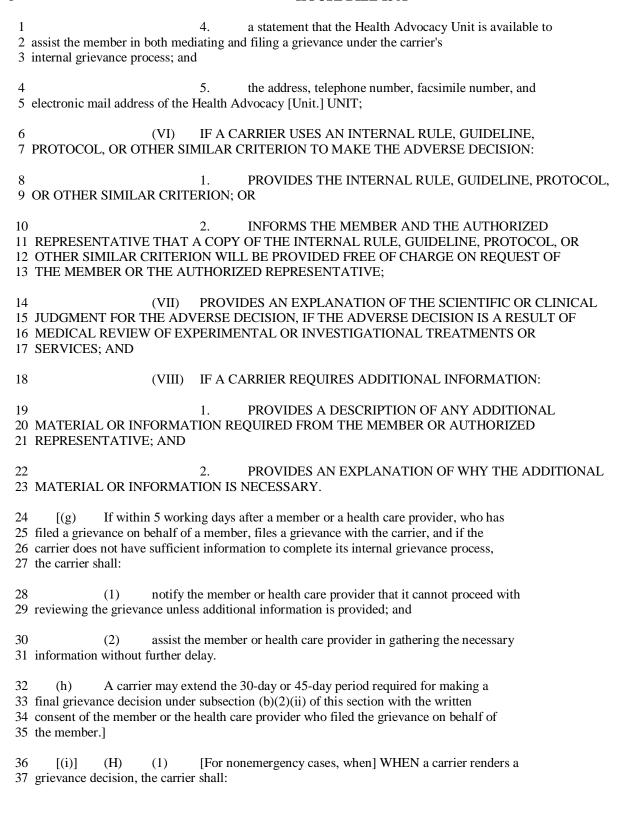
1			(i)	a subscriber; and
2			(ii)	unless preempted by federal law, a Medicare recipient.
3		(3)	"Membe	r" does not include a Medicaid recipient.
4 5	[(l)] title.	(O)	"Private	review agent" has the meaning stated in § 15-10B-01 of this
6	15-10A-02.			
7	(a)	Each ca	rrier shall	establish an internal grievance process for its members.
8 9	(B) AUTHORIZ			S INTERNAL GRIEVANCE PROCESS SHALL ALLOW AN ATIVE TO FILE A GRIEVANCE ON BEHALF OF A MEMBER.
10 11	[(b)] requirement	(C) s establis	(1) shed unde	An internal grievance process shall meet the same r Subtitle 10B of this title.
12 13	internal grie	(2) evance pro		on to the requirements of Subtitle 10B of this title, an blished by a carrier under this section shall:
	[for purpose grievance is			include an expedited procedure for use in an emergency case ievance decision within 24 hours of the date a ier];
19		vithin 30	[working	provide that a carrier [render] NOTIFY THE MEMBER AND THE CATIVE OF a [final] GRIEVANCE decision in writing [on a days after the date on which the grievance is [filed] ER unless:
23 24	AUTHORIZ DEPENDIN	ZED REP IG ON T	RESENT HE MED	1. the grievance involves an emergency case under item (i) of ASE THE CARRIER SHALL NOTIFY THE MEMBER AND THE CATIVE OF THE DECISION IN WRITING AS SOON AS POSSIBLE ICAL EXIGENCY BUT NO LATER THAN 72 HOURS AFTER THE RECEIVED BY THE CARRIER;
28	extension fo	r a perio	d of no lo	2. the member or [a health care provider] AN AUTHORIZED grievance on behalf of a member agrees in writing to an nger than [30 working days] 60 DAYS AFTER RECEIPT GRIEVANCE; or
30 31	[(iv)] (III) o	f this par	agraph;	3. the grievance involves a retrospective denial under item
32 33	care provide	er;	[(iii)	allow a grievance to be filed on behalf of a member by a health
34 35	THE AUTH	IORIZED	(iv)] REPRE	(III) provide that a carrier [render] NOTIFY THE MEMBER AND SENTATIVE OF a final decision in writing on a grievance



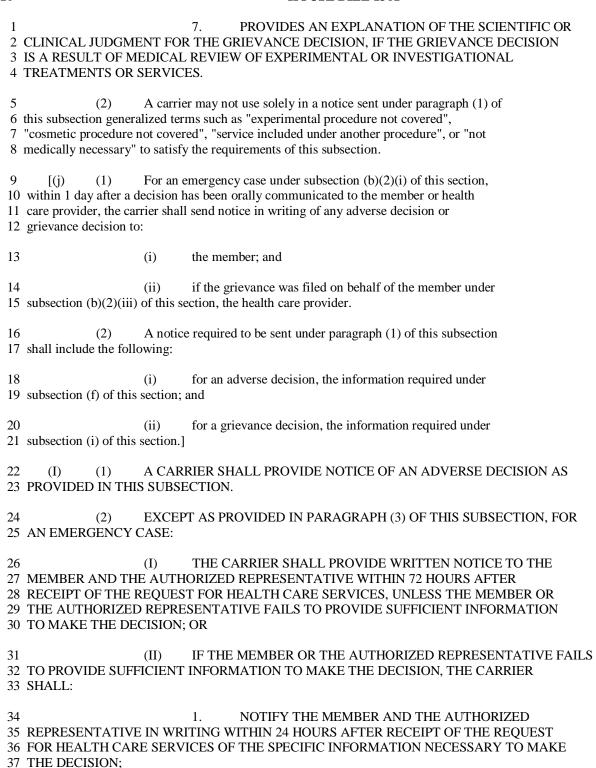
38 ANY REVISIONS TO THE INTERNAL GRIEVANCE PROCESS WITH THE COMMISSIONER

39 AT LEAST 30 DAYS BEFORE ITS INTENDED USE.

2	[(f)] (G) decision, the carrier sh	-	nemergency cases, when WHEN a carrier renders an adverse
		nication o	nt the adverse decision in writing after the carrier has of the decision to the member or the [health care e member] AUTHORIZED REPRESENTATIVE; and
8	a written notice to the	TIME PI member	rithin 5 working days after the adverse decision has been ERIODS DESCRIBED IN SUBSECTION (I) OF THIS SECTION, and [a health care provider acting on behalf of the PREPRESENTATIVE that:
10 11	factual bases for the c	(i) carrier's d	states in detail in clear, understandable language the specific lecision;
14 15	generalized terms suc	ch as "exp	references the specific criteria and standards, including ich the decision was based, and may not solely use perimental procedure not covered", "cosmetic procedure d under another procedure", or "not medically
17 18	number of:	(iii)	states the name, business address, and business telephone
	appropriate, who mac organization; or	le the dec	1. the medical director or associate medical director, as cision if the carrier is a health maintenance
	who has responsibilit a health maintenance	•	2. the designated employee or representative of the carrier carrier's internal grievance process if the carrier is not ation;
25 26	and procedures under	(iv) this subt	gives written details of the carrier's internal grievance process title; [and]
27		(v)	includes the following information:
30		ommissio	1. that the member or [a health care provider] THE TATIVE ACTING on behalf of the member has a right to file a oner within [30 working] 45 days after receipt of a
34	REPRESENTATIVE	filing a	2. that a complaint may be filed without first filing a health care provider] THE AUTHORIZED grievance on behalf of the member can demonstrate a determined by the Commissioner;
36 37	facsimile number;		3. the Commissioner's address, telephone number, and



		of the dec	nt the grievance decision in writing after the carrier has ision to the member or the [health care r] AUTHORIZED REPRESENTATIVE; and
6		DDS SPE	thin [5 working days after the grievance decision has CIFIED IN SUBSECTION (C)(2) OF THIS SECTION, a lth care provider acting on behalf of the SENTATIVE that:
8 9	specific factual bases for the ca	1. arrier's de	states in detail in clear, understandable language the cision;
10 11	interpretive guidelines, on wh	2. ich the gr	references the specific criteria and standards, including ievance decision was based;
12 13	number of:	3.	states the name, business address, and business telephone
		A. evance de	the medical director or associate medical director, as ecision if the carrier is a health maintenance
			the designated employee or representative of the carrier internal grievance process if the carrier is not
20		4.	includes the following information:
	has a right to file a complaint after receipt of a carrier's griev		that the member OR THE AUTHORIZED REPRESENTATIVE Commissioner within [30 working] 45 days ision; and
24 25	facsimile number;	B.	the Commissioner's address, telephone number, and
28	REPRESENTATIVE ARE EN	OF, ALL	STATES THAT THE MEMBER AND THE AUTHORIZED TO RECEIVE, FREE OF CHARGE, REASONABLE DOCUMENTS, RECORDS, AND OTHER INFORMATION DECISION;
30 31		6. MILAR C	IF THE CARRIER USES AN INTERNAL RULE, GUIDELINE, CRITERION TO MAKE THE GRIEVANCE DECISION:
32 33	OR OTHER SIMILAR CRITI	A. ERION; (	PROVIDES THE INTERNAL RULE, GUIDELINE, PROTOCOL OR
36	REPRESENTATIVE THAT A OTHER SIMILAR CRITERIO	ON WILI	INFORMS THE MEMBER AND THE AUTHORIZED OF THE INTERNAL RULE, GUIDELINE, PROTOCOL, OR L BE PROVIDED FREE OF CHARGE ON REQUEST IZED REPRESENTATIVE; AND



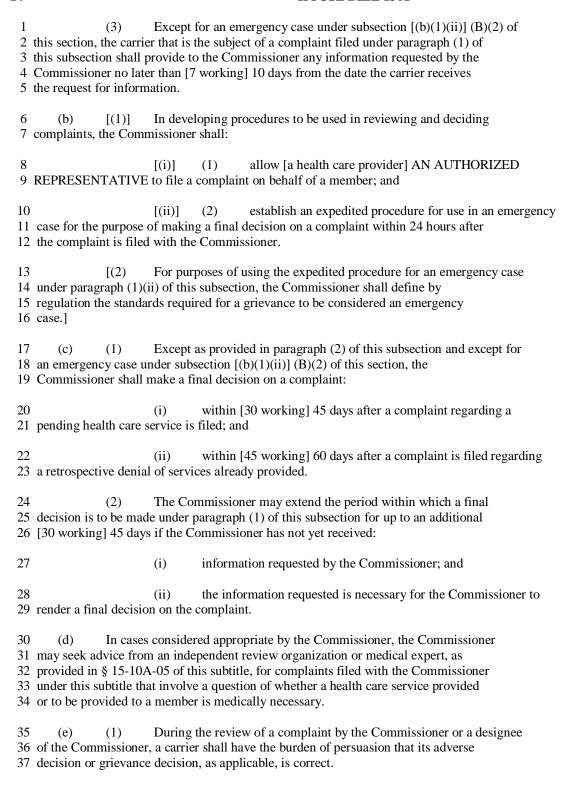
ALLOW THE MEMBER OR THE AUTHORIZED 1 2 REPRESENTATIVE AT LEAST 48 HOURS TO PROVIDE THE SPECIFIC INFORMATION; 3 AND NOTIFY THE MEMBER AND THE AUTHORIZED 3. 5 REPRESENTATIVE IN WRITING OF THE CARRIER'S DECISION WITHIN THE EARLIER 6 OF: 7 48 HOURS AFTER RECEIPT OF THE SPECIFIC A. 8 INFORMATION REOUIRED IN ITEM 1 OF THIS SUBPARAGRAPH: OR 9 48 HOURS FROM THE TIME THE SPECIFIC INFORMATION B. 10 WAS REOUIRED TO BE PROVIDED TO THE CARRIER. 11 FOR AN EXTENSION OF A COURSE OF TREATMENT BEYOND THE 12 PERIOD OF TIME OR NUMBER OF TREATMENTS PREVIOUSLY APPROVED BY THE 13 CARRIER, THE CARRIER SHALL PROVIDE NOTICE TO THE MEMBER AND THE 14 AUTHORIZED REPRESENTATIVE WITHIN 24 HOURS AFTER RECEIPT OF THE REQUEST, 15 IF: (I) THE DECISION ADDRESSES AN EMERGENCY CASE; AND 16 17 (II)THE REQUEST FOR THE EXTENSION WAS PROVIDED TO THE 18 CARRIER BY THE MEMBER OR THE AUTHORIZED REPRESENTATIVE AT LEAST 24 19 HOURS BEFORE THE EXPIRATION OF THE PREVIOUSLY APPROVED PERIOD OF TIME 20 OR NUMBER OF TREATMENTS. FOR A NONEMERGENCY CASE INVOLVING CARE THAT HAS NOT 21 (I) 22 BEEN PROVIDED, THE CARRIER SHALL PROVIDE WRITTEN NOTICE TO THE MEMBER 23 AND THE AUTHORIZED REPRESENTATIVE WITHIN 15 DAYS AFTER THE REQUEST FOR 24 PREAUTHORIZATION OF HEALTH CARE SERVICES HAS BEEN RECEIVED BY THE 25 CARRIER, UNLESS: THE MEMBER OR THE AUTHORIZED REPRESENTATIVE 26 1. 27 FAILS TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION; OR 28 THE CARRIER DETERMINES THAT DUE TO 2. 29 CIRCUMSTANCES BEYOND THE CONTROL OF THE CARRIER, A 15-DAY EXTENSION IS 30 NECESSARY. IF THE MEMBER OR THE AUTHORIZED REPRESENTATIVE FAILS 31 (II)32 TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION, THE CARRIER 33 SHALL: 34 1. NOTIFY THE MEMBER AND THE AUTHORIZED 35 REPRESENTATIVE IN WRITING WITHIN 15 DAYS AFTER RECEIPT OF THE REQUEST 36 FOR SERVICES OF THE SPECIFIC INFORMATION NECESSARY TO MAKE THE DECISION; ALLOW THE MEMBER OR THE AUTHORIZED 38 REPRESENTATIVE AT LEAST 45 DAYS TO PROVIDE THE SPECIFIC INFORMATION; AND

1 NOTIFY THE MEMBER AND THE AUTHORIZED 2 REPRESENTATIVE IN WRITING OF THE CARRIER'S DECISION WITHIN THE EARLIER 3 OF: 15 DAYS AFTER RECEIPT OF THE SPECIFIC INFORMATION A. 5 REQUIRED IN ITEM 1 OF THIS SUBPARAGRAPH; OR 15 DAYS AFTER THE DATE THE SPECIFIC INFORMATION 6 B. 7 WAS REQUIRED TO BE PROVIDED TO THE CARRIER. IF THE CARRIER DETERMINES THAT A 15-DAY EXTENSION IS (III)9 NECESSARY DUE TO CIRCUMSTANCES BEYOND THE CONTROL OF THE CARRIER, THE 10 CARRIER SHALL NOTIFY THE MEMBER AND AUTHORIZED REPRESENTATIVE BEFORE 11 THE EXPIRATION OF THE INITIAL 15-DAY PERIOD OF: 12 THE CIRCUMSTANCES REQUIRING THE EXTENSION OF 13 TIME; AND 14 2. THE DATE BY WHICH THE CARRIER EXPECTS TO RENDER 15 A DECISION. FOR A RETROSPECTIVE DENIAL OF HEALTH CARE SERVICES. (I)17 THE CARRIER SHALL PROVIDE WRITTEN NOTICE TO THE MEMBER AND THE 18 AUTHORIZED REPRESENTATIVE WITHIN 30 DAYS AFTER THE REQUEST FOR 19 PAYMENT FOR HEALTH CARE SERVICES IS RECEIVED BY THE CARRIER, SUBJECT TO 20 SUBPARAGRAPHS (II) AND (III) OF THIS PARAGRAPH. IF THE MEMBER OR THE AUTHORIZED REPRESENTATIVE FAILS 21 22 TO PROVIDE SUFFICIENT INFORMATION TO MAKE THE DECISION ON THE PAYMENT 23 OF HEALTH CARE SERVICES, THE CARRIER SHALL: 24 NOTIFY THE MEMBER AND THE AUTHORIZED 25 REPRESENTATIVE IN WRITING WITHIN 30 DAYS AFTER RECEIPT OF THE REQUEST 26 FOR PAYMENT OF HEALTH CARE SERVICES OF THE SPECIFIC INFORMATION 27 NECESSARY TO MAKE THE DECISION: ALLOW THE MEMBER OR THE AUTHORIZED 28 2. 29 REPRESENTATIVE ACTING ON BEHALF OF THE MEMBER AT LEAST 45 DAYS TO 30 PROVIDE THE SPECIFIC INFORMATION; AND PROVIDE WRITTEN NOTICE OF THE CARRIER'S DECISION 31 32 TO THE MEMBER AND THE AUTHORIZED REPRESENTATIVE WITHIN THE EARLIER OF: 15 DAYS AFTER RECEIPT OF THE SPECIFIC INFORMATION 33 34 REQUIRED IN ITEM 1 OF THIS SUBPARAGRAPH; OR

B. 36 WAS REQUIRED TO BE PROVIDED TO THE CARRIER.

15 DAYS AFTER THE DATE THE SPECIFIC INFORMATION

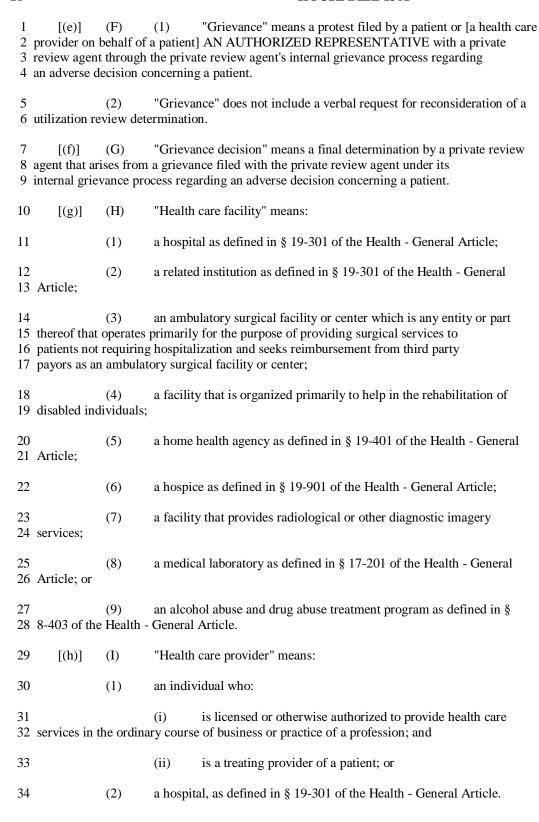
1 2	CARRIER:	(III)	THE CA	ARRIER MAY B	E ALLOWI	ED A 15-D	AY EXTE	ENSION IF T	ΉE
3 4	CIRCUMSTANCES	BEYONI	1. O THE C	DETERMINES ONTROL OF TI			NECESS.	ARY DUE T	О
	AUTHORIZED REPI PERIOD OF:	RESENT	2. ATIVE E	PROVIDES NO BEFORE THE EX					
8 9	TIME; AND		A.	THE CIRCUMS	STANCES I	REQUIRIN	IG THE EX	XTENSION	OF
10 11	A DECISION.		B.	THE DATE BY	WHICH T	HE CARR	IER EXPE	ECTS TO RE	NDER
14 15	[(k)] (J) [(f)(2)(iii)] (G)(2)(III certificate, enrollmen provides to a member coverage.	), (iv), an t materia	d (v) of t ls, or oth	er evidence of co	policy, HE verage that	ALTH BE the carrier	NEFIT pla	n,	
	[(l)] (K) internal grievance prounder Subtitle 10B of		private r		has a certifi	icate issued		its	
20 21	(2) review agent, the carr			ites its internal gr	rievance pro	ocess to a p	rivate		
22 23	agent acting on behal	(i) f of the c		y the grievance d	lecision mad	de by the p	rivate revie	ew	
	regardless of the dele subsection.	(ii) egation m		ble for a violatio e carrier under p			his subtitle	:	
27	15-10A-03.								
30 31	(a) (1) decision, a member of who filed the grievan 15-10A-02(B)(1) of the grievance decision.	r [a healt ce on bel his subtit	h care pro alf of the	ovider] THE AU e member under	THORIZED § [15-10A-0	REPRES 02(b)(2)(iii	ENTATIV )]	E,	
35	(2) subsection, the Common complaint within [5 v. Commissioner.	nissioner	shall not		nt is the subj	ject of the			

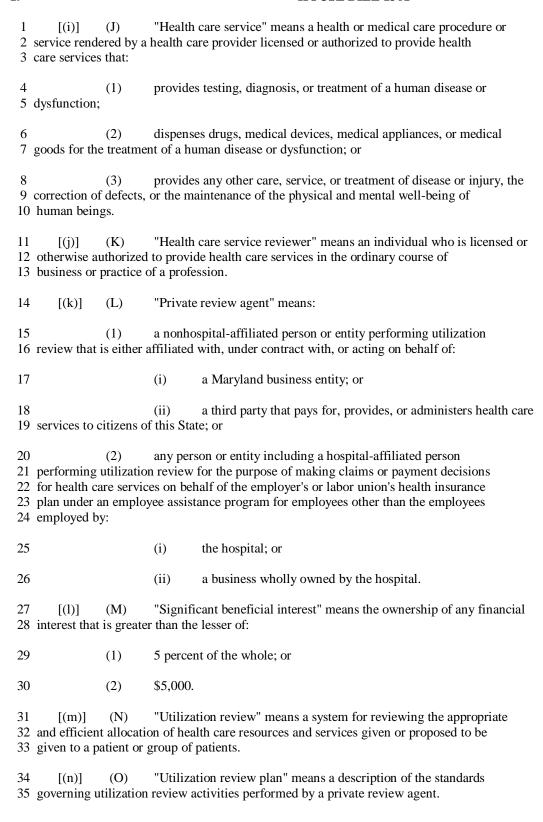


	(2) As part of the review of a complaint, the Commissioner or a designee of the Commissioner may consider all of the facts of the case and any other evidence that the Commissioner or designee of the Commissioner considers appropriate.
6 7	(3) As required under § [15-10A-02(i)] 15-10A-02(H) of this subtitle, 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.
14	(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.
16 17	(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.
20 21	(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.
25 26	(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.
28	15-10A-04.
29	(a) The Commissioner shall:
32	(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.

1 2				15-10A-02(E) SHALL BE APPLIED IN ANY HEARING TH SUBSECTION (A) OF THIS SECTION.
5 6	the Commissioner or health care provider]	the Comr AN AUT	er's final nissioner HORIZE	rgency cases, the Commissioner shall send written decision within [1 working day] 3 DAYS after 's designee has informed the member or [a D REPRESENTATIVE who filed the complaint on on through an oral communication.
8 9	(2) required under subsec			er shall include in the notice the information section.
	[(c)] (D) carrier's obligations t carrier's policies or c		or reimb	olation of this subtitle for a carrier to fail to fulfill the burse for health care services specified in the bers.
		rier's obli	gations to	n adverse decision or grievance decision, a carrier o provide or reimburse for health care services tracts with members, the Commissioner may:
16		(i)	issue an	administrative order that requires the carrier to:
17 18	any of the personnel	employed	1. l or assoc	cease inappropriate conduct or practices by the carrier or triated with the carrier;
19			2.	fulfill the carrier's contractual obligations;
20 21	denied improperly; o	r	3.	provide a health care service or payment that has been
22 23	provide a health care	service o	4. r paymer	take appropriate steps to restore the carrier's ability to at that is provided under a contract; or
24		(ii)	impose a	any penalty or fine or take any action as authorized:
25 26	plan organization, un	der this a	1. rticle; or	for an insurer, nonprofit health service plan, or dental
27 28	General Article or ur	nder this a	2. rticle.	for a health maintenance organization, under the Health -
31 32	organization, medica	issioner, l expert, t tandards	in consul he Depar	agraph (1) of this subsection, it is a violation of this tation with an independent review tment, or other appropriate entity, determines health maintenance organization to conduct
34		(i)	objective	e;
35		(ii)	clinicall	y valid;

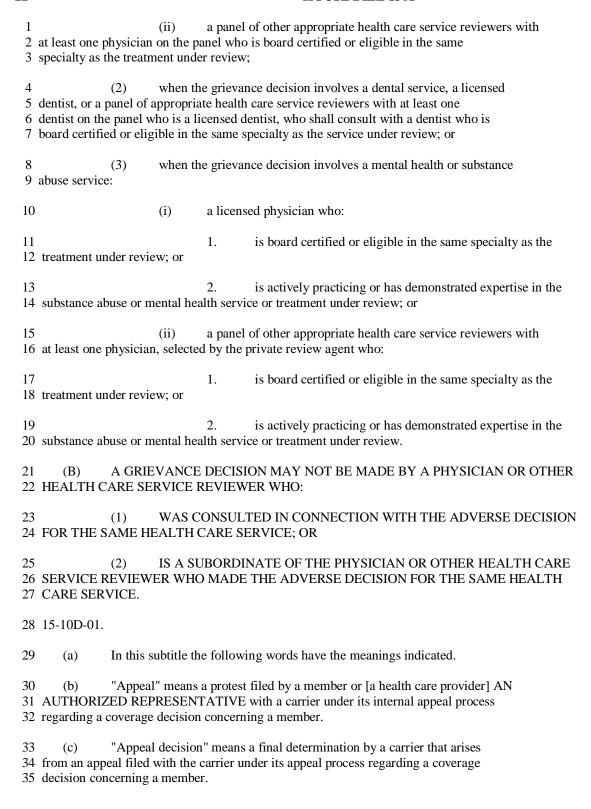
1		(iii)	compatible with established principles of health care; or
2 3	on a case by case bas	(iv) sis.	flexible enough to allow deviations from norms when justified
		diction to	mmissioner may refer complaints not within the the Health Advocacy Unit or any other appropriate gency or unit for disposition or resolution.
7	15-10B-01.		
8	(a) In this	subtitle th	e following words have the meanings indicated.
9 10	(b) (1) a private review age		se decision" means a utilization review determination made by proposed or delivered health care service:
11		(i)	is or was not medically necessary, appropriate, or efficient; and
12		(ii)	may result in noncoverage of the health care service.
13 14	(2) subscriber's status as		se decision" does not include a decision concerning a er.
			REPRESENTATIVE" MEANS A PERSON, INCLUDING A R, AUTHORIZED BY THE PATIENT TO ACT ON BEHALF OF THE
18 19	[(c)] (D) Commissioner to a p		cate" means a certificate of registration granted by the view agent.
20 21	2	(1) nce with	"Employee assistance program" means a health care service a contract with an employer or labor union:
22 23	both to:	(i)	consults with employees or members of an employee's family or
24 25	mental health, alcoh	ol, or sub	1. identify the employee's or the employee's family member's stance abuse problems; and
	health care provider treatment; and	s or other	2. refer the employee or the employee's family member to community resources for counseling, therapy, or
	payment decisions of health benefit plan.	(ii) on behalf o	performs utilization review for the purpose of making claims or of the employer's or labor union's health insurance or
	(2) plan operated by a h of that hospital.		yee assistance program" does not include a health care service lely for employees, or members of an employee's family,

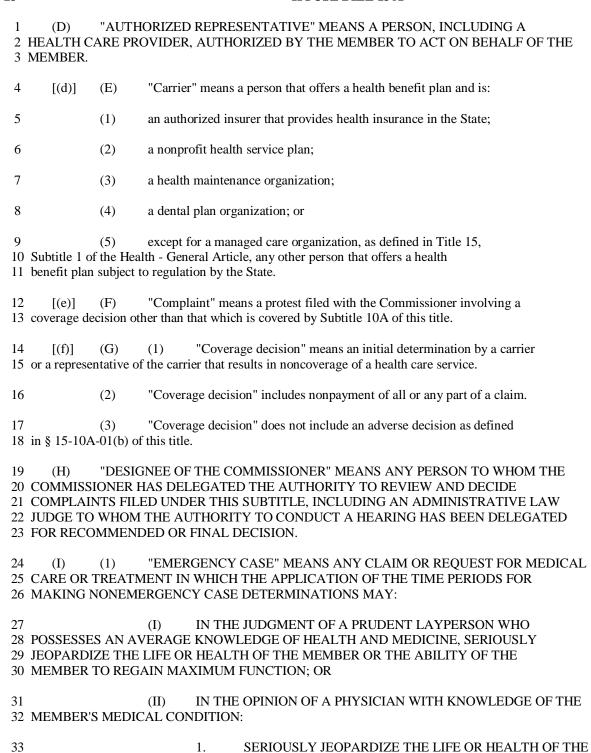




1	15-10B-06.		
2	(a)	[(1)]	A private review agent [shall:
			(i) make all initial determinations on whether to authorize or cy course of treatment for a patient within 2 working days after tion necessary to make the determination;
8			(ii) make all determinations on whether to authorize or certify an alth care facility or additional health care services within 1 eipt of the information necessary to make the determination;
10			(iii) promptly notify the health care provider of the determination.
13 14 15 16	determinational in DETERMIN	on, the proformation NATION ADVER	If within 3 calendar days after receipt of the initial request for health vate review agent does not have sufficient information to make a rivate review agent shall inform the health care provider that on must be provided.] SHALL PROVIDE NOTICE OF ALL S TO THE PATIENT AND THE AUTHORIZED REPRESENTATIVE, RSE OR NOT, WITHIN THE TIME PERIODS SPECIFIED IN § 15-10A-02(I)
20 21 22	authorize or determination provide the rendered the	certify a on warrar health ca determin	titial determination is made by a private review agent not to the health care service and the health care provider believes the nots an immediate reconsideration, a private review agent may be provider the opportunity to speak with the physician that nation, by telephone on an expedited basis, within a period of 4 hours of the health care provider seeking the reconsideration.
26 27	render an ac review agen	lverse dea it of the e r that adn	ergency inpatient admissions, a private review agent may not cision solely because the hospital did not notify the private emergency admission within 24 hours or other prescribed period nission if the patient's medical condition prevented the hospital
29		(1)	the patient's insurance status; and
30 31	notification	(2) requirem	if applicable, the private review agent's emergency admission nents.
32 33	- 1 / -	(C) of a patier	A private review agent may not render an adverse decision as to an at during the first 24 hours after admission when:
34 35	imminent da	(1) anger to s	the admission is based on a determination that the patient is in self or others;
	psychologis		the determination has been made by the patient's physician or unction with a member of the medical staff of the facility who has be admission; and

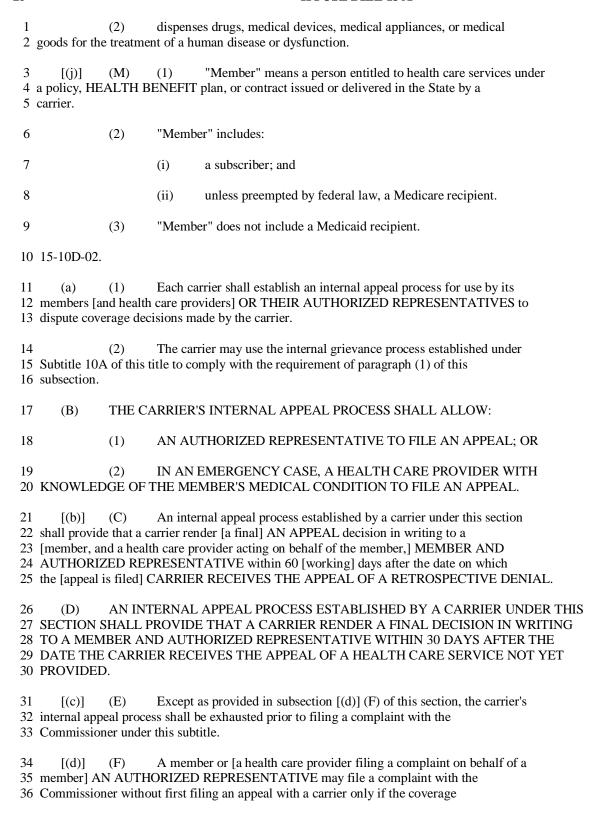
1	(3)	the hos	pital immediately notifies the private review agent of:
2		(i)	the admission of the patient; and
3		(ii)	the reasons for the admission.
6	review of proposed	l or delivere	A private review agent that requires a health care provider to er for the private review agent to conduct utilization ed services for the treatment of a mental illness, ance abuse disorder:
	Commissioner und treatment plan for		shall accept the uniform treatment plan form adopted by the 3-03(d) of this subtitle as a properly submitted
11		(ii)	may not impose any requirement to:
12			1. modify the uniform treatment plan form or its content; or
13			2. submit additional treatment plan forms.
14 15	(2) this subsection:	A unifo	rm treatment plan form submitted under the provisions of
16		(i)	shall be properly completed by the health care provider; and
17		(ii)	may be submitted by electronic transfer.
18	15-10B-08.		
21	agent, the private	review ager h care prov	ates its internal grievance process to a private review at shall establish an internal grievance process for its iders acting on behalf of a patient] AND THE TATIVES.
			[agent's internal grievance process] AGENT shall meet shed under §§ 15-10A-02 through 15-10A-05 of this
26 27			agent may not charge a fee to a patient or [health care D REPRESENTATIVE for filing a grievance.
28	15-10B-09.1.		
29	(A) A gri	evance dec	ision shall be made based on the professional judgment of:
30 31	(1) specialty as the tre	(i) eatment und	a physician who is board certified or eligible in the same er review; or

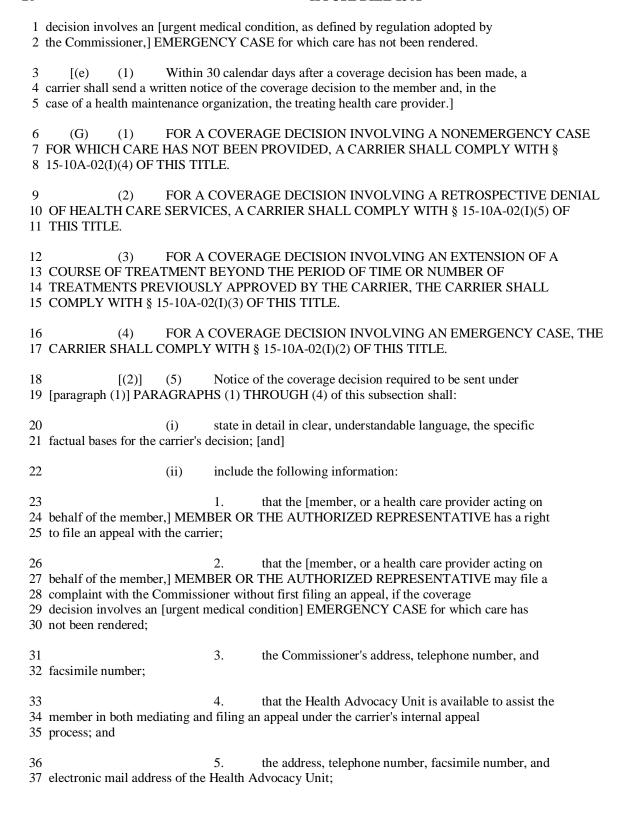




34 MEMBER OR THE ABILITY OF THE MEMBER TO REGAIN MAXIMUM FUNCTION; OR

	BE ADEQUATE			SUBJECT THE MEMBER TO SEVERE PAIN THAT CANNOT HOUT THE CARE OR TREATMENT THAT IS THE JEST.
4 5	(2) OF HEALTH C			CASE" DOES NOT INCLUDE A RETROSPECTIVE DENIAL
6	[(g)] (J)	(1)	"Health	benefit plan" means:
7 8	contract issued t	(i) under a mu		al or medical policy or contract, including a policy or ver trust or association;
9 10	health service p	(ii)	a hospit	al or medical policy or contract issued by a nonprofit
11		(iii)	a health	maintenance organization contract; or
12		(iv)	a dental	plan organization contract.
13 14	combination of			lan" does not include one or more, or any
15		(i)	long-ter	m care insurance;
16		(ii)	disabilit	y insurance;
17 18	insurance;	(iii)	accident	tal travel and accidental death and dismemberment
19		(iv)	credit he	ealth insurance;
20 21	defined in Title	(v) 15, Subtit		benefit plan issued by a managed care organization, as ealth - General Article;
22		(vi)	disease-	specific insurance; or
23		(vii)	fixed in	demnity insurance.
24	[(h)] (K	) "He	alth care prov	vider" means:
	provide health of profession and it	care servic	es in the ordi	o is licensed under the Health Occupations Article to nary course of business or practice of a the member; or
28	(2)	a ho	spital, as def	ined in § 19-301 of the Health - General Article.
29 30	[(i)] (L) service rendered			vice" means a health or medical care procedure or der that:
31 32	(1) dysfunction; or	prov	vides testing,	diagnosis, or treatment of a human disease or





1 2	(III) REFERENCE THE SPECIFIC HEALTH BENEFIT PLAN PROVISIONS ON WHICH THE COVERAGE DECISION IS BASED;
5	(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
10 11	(VI) IF THE CARRIER USES AN INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION TO MAKE THE COVERAGE DECISION:
12 13	1. PROVIDE THE INTERNAL RULE, GUIDELINE, PROTOCOLOR OTHER SIMILAR CRITERION; OR
16	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.
21 22	(2)] Notice of [the] AN appeal decision [required to be sent under paragraph (1) of this subsection] shall:
23 24	[(i)] (1) state in detail in clear, understandable language the specific factual bases for the carrier's decision; [and]
25	[(ii)] (2) include the following information:
28	[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
30 31	[2.] (II) the Commissioner's address, telephone number, and facsimile [number.] NUMBER;
32 33	(3) REFERENCE THE SPECIFIC PLAN PROVISIONS ON WHICH THE APPEAL DECISION IS BASED;
36	(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

1 2	OR OTHER	(5) SIMILA		CARRIER USES AN INTERNAL RULE, GUIDELINE, PROTOCOL, RION TO MAKE THE APPEAL DECISION:	
3	OTHER SIM	IILAR C	(I) RITERIO	PROVIDE THE INTERNAL RULE, GUIDELINE, PROTOCOL, OR ON; OR	
7		WILL E	BE PROV	INFORM THE MEMBER OR THE AUTHORIZED REPRESENTATIVE ERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR TIDED FREE OF CHARGE ON REQUEST FROM THE MEMBER ENTATIVE.	
11 12	consent form Commission	n authorizer or the	norized [ozing the r Commis	nmissioner may request the member that filed the complaint designee] REPRESENTATIVE of the member to sign a elease of the member's medical records to the sioner's designee that are needed in order for the decision on the complaint.	
	designee of t			During the review of a complaint by the Commissioner or a , a carrier shall have the burden of persuasion that its ecision, as applicable, is correct.	
			may con	of the review of a complaint, the Commissioner or a designee sider all of the facts of the case and any other evidence gnee of the Commissioner considers appropriate.	
20	[(i)]	(K)	(1)	The Commissioner shall:	
	filed with the jurisdiction;		(I) issioner u	make and issue in writing a final decision on all complaints nder this subtitle that are within the Commissioner's	
26	Title 10, Sub	[(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.			
	IN A HEAR SUBSECTION			OVISIONS OF SUBSECTION (J) OF THIS SECTION SHALL APPLY D IN ACCORDANCE WITH PARAGRAPH (1) OF THIS	
31 32	SECTIO effect Januar			FURTHER ENACTED, That this Act shall take	