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§15–10A–03.

(a) (1) Within 4 months after the date of receipt of an adverse decision or a grievance decision, a member, a member's representative, 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.

(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 45 days after a complaint regarding a pending health care service is filed; and

(ii) within 45 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:

(i) the Commissioner has not yet received information requested by the Commissioner; and

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

(d) The Commissioner shall 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) A carrier shall have the burden of persuasion that its adverse decision or grievance decision, as applicable, is correct:

(i) during the review of a complaint by the Commissioner or a designee of the Commissioner; and

(ii) in any hearing held in accordance with § 2–210 of this article.

(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, a member's representative, 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 shall allow the member, the member's representative, or the health care provider filing a complaint on behalf of the member at least 5 working days to provide the additional information described in subparagraph (ii) of this paragraph.

(iv) 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.

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