**[Md. Code, Ins. §§ 15-1001 through 15-1011.]**

## §§ 15-1001 through 15-1011: Claims and Utilization Review

## § 15-1001. Utilization review requirements

(a) This section applies to entities that propose to issue or deliver individual, group, or blanket health insurance policies or contracts in the State or to administer health benefit programs that provide for the coverage of health care services and the utilization review of those services, including:

(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.

(b)(1) Subject to paragraph (2) of this subsection, each entity subject to this section shall:

(i) 1. have a certificate issued under Subtitle 10B of this title; or

2. contract with a private review agent that has a certificate issued under Subtitle 10B of this title; and

(ii) when conducting utilization review for mental health and substance use benefits, ensure that the criteria and standards used are in compliance with the federal Mental Health Parity and Addiction Equity Act.

(2) For hospital services, each entity subject to this section may contract with or delegate utilization review to a hospital utilization review program approved under § 19-319(d) of the Health--General Article.

(c) Notwithstanding any other provision of this article, if the medical necessity of providing a covered benefit is disputed, an entity subject to this section that does not meet the requirements of subsection (b) of this section shall pay any person entitled to reimbursement under the policy or contract in accordance with the determination of medical necessity by:

(1) the treating provider; or

(2) when hospital services are provided, the hospital utilization review program approved under § 19-319(d) of the Health-General Article.

(d) An entity subject to this section may not:

(1) act as a private review agent without holding a certificate issued under Subtitle 10B of this title; or

(2) use a private review agent that does not hold a certificate issued under Subtitle 10B of this title.

(e) An entity that violates any provision of this section is subject to the penalties provided under § 15-10B-12 of this title.

## § 15-1002. Claim form requirements

To provide a standard system of payment for medical services, each claim form for use under an individual or group health insurance policy that is issued or delivered in the State shall conform to a form or regulations that the Commissioner adopts.

## § 15-1003. Uniform claims forms for reimbursement of hospital and health care practitioner's services

(a)(1) In this section the following words have the meanings indicated.

(2)(i) "Health care practitioner" means a person that is licensed or certified under the Health Occupations Article and reimbursed by a third party payor.

(ii) "Health care practitioner" does not include a physician or other person licensed or certified under this article when the physician or other person is rendering care to a member or subscriber of a health maintenance organization and is compensated by the health maintenance organization for that care on a salaried or capitated basis.

(3) "Hospital" has the meaning stated in § 19-301 of the Health-General Article.

(b) The Commissioner shall adopt by regulation as the uniform claims form for reimbursement of hospital services in the State the uniform claims form adopted by the National Uniform Billing Committee and approved by the Centers for Medicare and Medicaid Services for Hospital Payments under Title XVIII of the Social Security Act.

(c) The Commissioner shall adopt by regulation a uniform claims form for reimbursement of health care practitioners' services.

(d)(1) The Commissioner shall adopt by regulation:

(i) a definition of a clean claim, including:

1. the essential data elements that must be completed on the uniform claims form; and

2. uniform standards for attachments to the uniform claims form;

(ii) permissible categories of disputed claims for which additional information may be requested under §§ 15-1004(c) and 15-1005(c) of this subtitle; and

(iii) standards for determining when a claim is considered received for reimbursement.

(2) In adopting the regulations required under paragraph (1)(i) of this subsection, the Commissioner shall consider:

(i) standards for attachments required by the federal Centers for Medicare and Medicaid Services for the Medicare Program;

(ii) standards used by insurance carriers, nonprofit health service plans, and health maintenance organizations in the State; and

(iii) federal regulations adopted under the Health Insurance Portability and Accountability Act.

## § 15-1004. Acceptance of uniform claims forms and attachments

(a) For services rendered by a person entitled to reimbursement under § 15-701(a) of this title or by a hospital, as defined in § 19-301 of the Health-General Article, an insurer, nonprofit health service plan, or health maintenance organization:

(1) shall accept the uniform claims form and any attachments approved or adopted by the Commissioner under § 15-1003 of this subtitle:

(i) as a properly filed claim with all necessary documentation; and

(ii) as the sole instrument for reimbursement; and

(2) may not impose as a condition of reimbursement a requirement to:

(i) modify the uniform claims form or its content; or

(ii) submit additional claims forms.

(b)(1) A uniform claims form submitted under this section shall be completed properly and may be submitted by electronic transfer.

(2) If the health care practitioner rendering the service is a certified registered nurse anesthetist or certified nurse midwife, the uniform claims form shall include identification modifiers for the certified registered nurse anesthetist or certified nurse midwife that indicate whether the service is provided with or without medical direction by a physician.

(c) In accordance with §§ 15-1003(d)(1)(ii) and 15-1005(c) of this subtitle, if the legitimacy or appropriateness of a health care service is disputed, an insurer, nonprofit health service plan, or health maintenance organization may request additional medical information that describes and summarizes the diagnosis, treatment, and services rendered to the insured.

(d)(1) Insurers, nonprofit health service plans, and health maintenance organizations shall provide and update, as appropriate, all contracting providers and any other provider on request, with a manual or other document that sets forth the claims filing procedures, including:

(i) the address where the claims should be sent for processing;

(ii) the telephone number at which providers' questions and concerns regarding claims may be addressed;

(iii) the name, address, and telephone number of any entity to which the insurer, nonprofit health service plan, or health maintenance organization has delegated the claims payment function, if applicable; and

(iv) the address and telephone number of any separate claims processing center for specific types of applicable services.

(2) If an insurer, nonprofit health service plan, or health maintenance organization has delegated its claims processing function to a third party, the delegation agreement:

(i) shall require the claims processing entity to comply with the requirements of this subtitle; and

(ii) may not be construed to limit the responsibility of the insurer, nonprofit health service plan, or health maintenance organization to comply with the requirements of this subtitle.

(e)(1) If necessary to determine eligibility for benefits or to determine coverage, an insurer, nonprofit health service plan, or health maintenance organization may obtain additional information from its insured, member, or subscriber, the employer of the insured, member or subscriber, or any other nonprovider third party.

(2) If obtaining additional information results in a delay in paying a claim, the insurer, nonprofit health service plan, or health maintenance organization shall pay interest in accordance with the provisions of § 15-1005(g) of this subtitle.

(f) The Commissioner may impose a penalty not exceeding $5,000 on an insurer, nonprofit health service plan, or health maintenance organization that violates this section.

## § 15-1005. Prompt payment of claims for reimbursement

(a) In this section, "clean claim" means a claim for reimbursement, as defined in regulations adopted by the Commissioner under § 15-1003 of this subtitle.

(b) To the extent consistent with the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 et seq., this section applies to an insurer, nonprofit health service plan, or health maintenance organization that acts as a third party administrator.

(c) Except as provided in § 15-1315 of this title and subsection (i) of this section, within 30 days after receipt of a claim for reimbursement from a person entitled to reimbursement under § 15-701(a) of this title or from a hospital or related institution, as those terms are defined in § 19-301 of the Health--General Article, an insurer, nonprofit health service plan, or health maintenance organization shall:

(1) mail or otherwise transmit payment for the claim in accordance with this section; or

(2) send a notice of receipt and status of the claim that states:

(i) that the insurer, nonprofit health service plan, or health maintenance organization refuses to reimburse all or part of the claim and the reason for the refusal;

(ii) that, in accordance with § 15-1003(d)(1)(ii) of this subtitle, the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or

(iii) that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.

(d)(1)(i) In this subsection, "credit card" means a credit, debit, prepaid, or stored-value card used to make a payment through a private card network.

(ii) "Credit card" includes a method of payment to a provider where no physical card is presented.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization may pay a claim under subsection (c) of this section, or a portion of a claim under subsection (f) of this section, using a credit card or an electronic funds transfer payment method that imposes on the provider a fee or similar charge to process the payment if:

(i) the insurer, nonprofit health service plan, or health maintenance organization notifies the provider in advance of the payment that:

1. a fee or similar charge associated with the use of the credit card or electronic funds transfer payment method will apply; and

2. the provider will need to consult the provider's merchant processor or financial institution for the specific rates;

(ii) the insurer, nonprofit health service plan, or health maintenance organization offers the provider an alternative payment method that does not impose a fee or similar charge on the provider; and

(iii) the provider or the provider's designee elects to accept payment of the claim or a portion of the claim using the credit card or electronic funds transfer payment method.

(3) If a provider participates on a provider panel of an insurer, a nonprofit health service plan, or a health maintenance organization, the acceptance by the provider or the provider's designee of a payment method offered under paragraph (2)(ii) of this subsection or elected under paragraph (2)(iii) of this subsection shall apply to all claims paid for by the insurer, nonprofit health service plan, or health maintenance organization unless otherwise notified by the provider or the provider's designee.

(e)(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 after the date of denial of the claim to appeal the denial.

(3) If an insurer, nonprofit health service plan, or health maintenance organization erroneously denies a provider's claim for reimbursement submitted within the time period specified in paragraph (1) of this subsection because of a claims processing error, and the provider notifies the insurer, nonprofit health service plan, or health maintenance organization of the potential error within 1 year of the claim denial, the insurer, nonprofit health service plan, or health maintenance organization, on discovery of the error, shall reprocess the provider's claim without the necessity for the provider to resubmit the claim, and without regard to timely submission deadlines.

(f)(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 mail or otherwise transmit payment for 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) mail or otherwise transmit payment for 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 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 days after receipt of the requested additional information.

(g)(1) If an insurer, nonprofit health service plan, or health maintenance organization fails to pay a clean claim for reimbursement or otherwise violates any provision 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 receipt of the initial clean claim for reimbursement 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.

(2) The interest paid under this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest.

(h) An insurer, nonprofit health service plan, or health maintenance organization that violates a provision of this section is subject to:

(1) a fine not exceeding $500 for each violation that is arbitrary and capricious, based on all available information; and

(2) the penalties prescribed under § 4-113(d) of this article for violations committed with a frequency that indicates a general business practice.

(i)(1) An insurer, a nonprofit health service plan, or a health maintenance organization may suspend review of a claim for reimbursement for a preauthorized or approved health care service if the insurer, nonprofit health service plan, or health maintenance organization sends written notice within 30 days after receipt of the claim that informs the person filing the claim, that:

(i) review of the claim is suspended during the second or third month of a grace period under 45 C.F.R. § 156.270(d); and

(ii) on receipt of the payment of premium, the insurer, nonprofit health service plan, or health maintenance organization is required to comply with paragraph (2) of this subsection.

(2) Within 30 days after receipt of the payment of premium, an insurer, a nonprofit health service plan, or a health maintenance organization shall comply with subsection (c)(1) or (2) of this section.

## § 15-1006. Notice of reason for denial of claim

(a) On written request of the claimant, an insurer that denies a claim made on an individual health insurance policy shall give written notice to the claimant that states fully the reason for the denial.

Reason given for denial not estoppel or limit to insurer

(b) The reason given by an insurer for denial of a claim shall not act as an estoppel or limit the insurer from offering an additional reason for the denial.

(c) The notice given by an insurer under this section is subject to 45 C.F.R. § 164.522(b).

## § 15-1007. Summary explanation of benefits

(a) This section applies to insurers and nonprofit health service plans that propose to issue or deliver individual, group, or blanket health insurance policies or contracts or to administer health benefit programs that provide hospital, medical, or surgical benefits on an expense-incurred basis.

(b) Each entity subject to this section shall provide to an insured individual who has filed a claim described in subsection (c) of this section an annual summary explanation of benefits that covers the preceding 12-month period.

(c) The summary explanation of benefits required under subsection (b) of this section shall provide a summary of:

(1) all claims filed by health care providers for services rendered to the insured individual or covered dependent of the insured individual during an inpatient hospitalization or an outpatient surgical procedure;

(2) the amount paid by the entity for each claim filed; and

(3) the balance owed by the insured individual for each claim filed.

(d) The explanation of benefits required under this section is subject to 45 C.F.R. § 164.522(b).

## § 15-1008. Retroactive denial of reimbursement

(a)(1) In this section the following words have the meanings indicated.

(2) “Carrier” means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization;

(v) a managed care organization, as defined in § 15-101 of the Health--General Article; or

(vi) any other person that provides health benefit plans subject to regulation by the State.

(3) “Code” means:

(i) the applicable current procedural terminology (CPT) code, as adopted by the American Medical Association;

(ii) if for a dental service, the applicable code adopted by the American Dental Association; or

(iii) another applicable code under an appropriate uniform coding scheme used by a carrier in accordance with this section.

(4) “Coding guidelines” means those standards or procedures used or applied by a payor to determine the most accurate and appropriate code or codes for payment by the payor for a service or services.

(5) “Health care provider” means a person or entity licensed, certified or otherwise authorized under the Health Occupations Article or the Health--General Article to provide health care services.

(6) "Reimbursement" means payments made to a health care provider by a carrier on either a fee-for-service, capitated, or premium basis.

(b) This section does not apply to an adjustment to reimbursement made as part of an annual contracted reconciliation of a risk sharing arrangement under an administrative service provider contract.

(c)(1) If a carrier retroactively denies reimbursement to a health care provider, the carrier:

(i) may only retroactively deny reimbursement for services subject to coordination of benefits with another carrier, the Maryland Medical Assistance Program, or the Medicare Program during the 18-month period after the date that the carrier paid the health care provider; and

(ii) except as provided in item (i) of this paragraph, may only retroactively deny reimbursement during the 6-month period after the date that the carrier paid the health care provider.

(2)(i) A carrier that retroactively denies reimbursement to a health care provider under paragraph (1) of this subsection shall provide the health care provider with a written statement specifying the basis for the retroactive denial.

(ii) If the retroactive denial of reimbursement results from coordination of benefits, the written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denied claim.

(d) Except as provided in subsection (e) of this section, a carrier that does not comply with the provisions of subsection (c) of this section may not retroactively deny reimbursement or attempt in any manner to retroactively collect reimbursement already paid to a health care provider.

(e)(1) The provisions of subsection (c)(1) of this section do not apply if a carrier retroactively denies reimbursement to a health care provider because:

(i) the information submitted to the carrier was fraudulent;

(ii) the information submitted to the carrier was improperly coded and the carrier has provided to the health care provider sufficient information regarding the coding guidelines used by the carrier at least 30 days prior to the date the services subject to the retroactive denial were rendered;

(iii) the claim submitted to the carrier was a duplicate claim; or

(iv) for a claim submitted to a managed care organization, the claim was for services provided to a Maryland Medical Assistance Program recipient during a time period for which the Program has permanently retracted the capitation payment for the Program recipient from the managed care organization.

(2) Information submitted to the carrier may be considered to be improperly coded under paragraph (1) of this subsection if the information submitted to the carrier by the health care provider:

(i) uses codes that do not conform with the coding guidelines used by the carrier applicable as of the date the service or services were rendered; or

(ii) does not otherwise conform with the contractual obligations of the health care provider to the carrier applicable as of the date the service or services were rendered.

(f) If a carrier retroactively denies reimbursement for services as a result of coordination of benefits under provisions of subsection (c)(1)(i) of this section, the health care provider shall have 6 months from the date of

denial, unless a carrier permits a longer time period, to submit a claim for reimbursement for the service to the carrier, Maryland Medical Assistance Program, or Medicare Program responsible for payment.

## § 15-1009. Preauthorized or approved health care services

(a) In this section, "carrier" means:

(1) an insurer;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization; or

(5) any other person that provides health benefit plans subject to regulation by the State.

(b) If a health care service for a patient has been preauthorized or approved by a carrier or the carrier's private review agent, the carrier may not deny reimbursement to a health care provider for the preauthorized or approved service delivered to that patient unless:

(1) the information submitted to the carrier regarding the service to be delivered to the patient was fraudulent or intentionally misrepresentative;

(2) critical information requested by the carrier regarding the service to be delivered to the patient was omitted such that the carrier's determination would have been different had it known the critical information;

(3) a planned course of treatment for the patient that was approved by the carrier was not substantially followed by the health care provider; or

(4) on the date the preauthorized or approved service was delivered:

(i) the patient was not covered by the carrier;

(ii) the carrier maintained an automated eligibility verification system that was available to the contracting provider by telephone or via the Internet; and

(iii) according to the verification system, the patient was not covered by the carrier.

(c) Notwithstanding subsection (b) of this section, a carrier may suspend review of a claim for reimbursement of a preauthorized or approved health care service if:

(1) the patient is in the second or third month of a grace period under 45 C.F.R. § 156.270(d);

(2) the carrier maintains an automated eligibility verification system that was available to the health care provider by telephone or via the Internet at the time the health care service was provided;

(3) according to the verification system, the provider is informed that:

(i) the patient is in the second or third month of a grace period and review of a claim for reimbursement may be suspended; and

(ii) a carrier is not prohibited from denying a claim for reimbursement of a suspended claim; and

(4) the carrier complies with the notice and claim payment requirements under § 15-1005 of this subtitle.

(d) A carrier shall pay a claim for a preauthorized or approved covered health care service in accordance with §§ 15-1005 and 15-1008 of this subtitle.

## § 15-1010. Claims processing standards

(a)(1) In this section the following words have the meanings indicated.

(2) “Adverse benefit determination” means:

(i) a denial, reduction, or termination of a disability benefit;

(ii) a failure to provide or make payment, in whole or in part, for a disability benefit; or

(iii) any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility for coverage of a disability benefit.

(3)(i) “Disability benefit” means a benefit that is payable based on the disability of a covered individual.

(ii) “Disability benefit” does not include:

1. long-term care insurance;

2. a benefit that is payable based solely on a dismemberment of a covered individual;

3. benefits in a life insurance policy that operate to safeguard the contract from lapse or to provide a special surrender value, special benefit, or annuity in the event of total and permanent disability; or

4. benefits in a health insurance policy that operate to safeguard the contract from lapse due to disability.

(b)(1) The Commissioner shall adopt regulations that establish standards governing the processing of claims by an insurer that:

(i) issues or delivers individual policies in the State that include a disability benefit; or

(ii) issues or delivers group policies in the State that include a disability benefit.

(2) The regulations adopted under this subsection shall establish and maintain reasonable claims procedures governing the filing of disability benefit claims, including:

(i) notification of an adverse benefit determination; and

(ii) an appeal by an insured or the insured's authorized representative of an insurer's adverse benefit determination.

(3) The claims procedures established for both individual and group policies under this subsection shall be consistent with the provisions of the Department of Labor's regulation entitled “Employee Retirement Income Security Act of 1974, Rules and Regulations for Administration and Enforcement; Claims Procedure; Final Rule” (29 C.F.R. 2560).

## § 15-1011. Submission of expense reimbursement claim forms

(a)(1) This section applies to:

(i) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(2) This section does not apply to claims for reimbursement:

(i) for services received under Medicare supplemental policies or contracts; or

(ii) for pharmaceutical or vision services.

(b) An entity subject to this section shall permit an insured, a subscriber, or a member seeking reimbursement for expenses incurred by the insured, subscriber, or member, in connection with a covered service provided in the United States, to submit a claim for reimbursement:

(1) by first-class mail; and

(2) at the election of the entity:

(i) by facsimile transmission; or

(ii) through a Web site that allows for the secure transmission of information.

(c) An entity subject to this section annually shall provide:

(1) a notice that a claims form may be submitted:

(i) by first-class mail; and

(ii) at the election of the entity:

1. by facsimile transmission; or

2. through a Web site that allows for the secure transmission of information; and

(2) instructions on how to submit a claim by facsimile transmission or through a secure Web site.