

A Compendium of Maryland Insurance Law

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The 2011 Legislative Session

The Affordable Care Act in Maryland

Additions to the 2011 Compendium of Maryland Insurance include several bills that were passed to enable implementation of the federal Patient Protection and Affordable Care Act in the state. A new section of the Compendium on the Affordable Care Act summarizes the legislation included in Senate Bill (SB) 182 and House Bill (HB) 166 that establishes the initial structure and governance of the Maryland Health Benefit Exchange, which the Affordable Care Act requires to be in place by January 1, 2014. The final structure and operation of the Exchange will be determined after the legislature receives several requested studies and passes subsequent enabling legislation.

SB183/HB170 will require Maryland health insurers to follow several specific provisions of the Affordable Care Act and authorize the Maryland Insurance Commissioner to enforce these requirements.

Electronic Health Records

As the state continues to encourage physicians to adopt electronic health records (EHR), SB722/HB736 will require that the incentives that insurers are required to pay to primary care physicians to adopt EHR be paid as an up-front cash payment, unless the physician and the insurer agree on an alternate payment method. Group-model HMOs are not required to provide incentives to their employed physicians. The Maryland Health Care Commission (MHCC) is ordered to study whether these incentives should also be paid to non-primary care physicians and report back to the General Assembly by January 1, 2013. Because Axolotl, the company hired to develop the Maryland Health Information Exchange (HIE), is a for-profit company engaged in the sale of health insurance data to third parties as part of its consulting business, there was a concern that the contractual requirements for confidentiality of information collected by Axolotl through the HIE may not be sufficient, and that an additional statutory requirement for protection of patient information was warranted. Axolotl is now owned by Optuminsight (formerly known as Ingenix), a division of Optum, which, in turn, is a subsidiary of the UnitedHealth Group, which also operates UnitedHealthcare. SB723/HB784 will require the MHCC to adopt regulations for the privacy and security of protected health information transmitted through the Maryland HIE.

Mandated Benefits

SB702/HB452 will require health insurers to allow an adult enrollee to pay the difference in cost for any hearing aid that exceeds the amount of the benefit limit for hearing aid coverage. SB701/ HB888 will allow subscribers to receive early refills of covered prescription eye drops in accordance with the guidelines of Medicare Part D.

Medicaid Family Planning Services

SB743/HB777 will extend Medicaid coverage for family planning services to all women with family incomes at or below 200 percent of the federal poverty guidelines without regard to how recently a woman has delivered a child.

Physician Panel Applications

SB710/HB444 will require health insurance carriers to notify physicians within 10 days that their application to join a physician panel is complete. Acceptance by the insurer of an application through an online system will be considered proof of completeness. Previously, insurers were only required to return incomplete applications within 10 days of receipt and were allowed to remain silent for up to 30 days

after application receipt, until additional notices were required as to whether the application was rejected or subject to continued processing.

A more complete discussion of the outcome of MedChi's 2011 legislative agenda is available in the *MedChi Final Report* on the MedChi Web site: <http://www.medchi.org>. A summary of all legislation considered this year by the General Assembly is available in the *90 Day Report of the 2011 Legislative Session* on the Maryland General Assembly Web site: <http://www.mlis.state.md.us>. The complete text for all current Maryland statutes is also available on the Maryland General Assembly Web site at: http://mlis.state.md.us/asp/web_statutes.asp. The implementation timeline for EHR in Maryland, the *Health Information Technology State Plan for 2010 to 2013* is included in the latest December 2010 *Electronic Health Records Legislative Update* submitted by the (MHCC) to the General Assembly, which can be found at <http://mhcc.maryland.gov/legislative/index.html#r2010a>.

A Primer on Insurance Law

This sixteenth annual Compendium of Maryland Insurance Law extends the reviews published in previous issues of *Maryland Medicine* and *Montgomery MEDICINE*, the precursor to this publication. This review contains a primer on state insurance law and its interaction with federal law, followed by an annotated description of Maryland law that pertains to health insurance. Due to space limitations, the information presented generally represents only a summary of the statute, with the possible omission of certain specific conditions and exceptions. The information is taken from the Annotated Code of Maryland, the 2010 Cumulative Supplement, and the results of the 2011 legislative session. Title 15 of the Insurance Article covers the laws pertaining to health insurance. Subtitle 10A of Title 15 covers the appeal and grievance procedures for adverse decisions regarding medical necessity issues, Subtitle 10B contains the Private Review Agent statutes that govern utilization management decisions and Subtitle 10D covers the appeal and grievance procedures regarding coverage decisions for medical services. Subtitle 7 of Title 19 of the Health-General Article pertains to HMOs. More complete information on each statute, as well as bills introduced in the legislature, may be obtained from the Maryland General Assembly Web site listed above.

HMOs and Medicaid Managed Care Organizations (MCOs) are exempt from general insurance law, except when the law specifically includes these entities. However, most Maryland laws have now been amended to include HMOs within their provisions. Also, the Maryland small group benefit package determines coverage for Maryland-based groups of 50 or fewer employees. Certain mandated benefits may not be included in this coverage unless the Maryland Health Care Commission specifically incorporates them. Complaints about Maryland insurance companies should be directed to the Maryland Insurance Administration, 525 St. Paul Place, Baltimore, MD 21202-2272, phone 410.468.2000 or 800.492.6116.

Remember that the health plans of self-insured companies are under the protection of the Employee Retirement Income Security Act (ERISA). ERISA was enacted in 1974 to provide uniform national standards that protect the health and pension benefits of employees. The preemption clause of ERISA supersedes any state laws that relate to an employee benefit plan, allowing companies operating across state borders to offer uniform benefits. ERISA originally provided few requirements for health care plans, other than mandating disclosure of internal claim procedures and setting fiduciary standards for individuals controlling plan assets.

Over the years, several laws, such as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, have attempted to provide extended protection to employees with ERISA-controlled insurance coverage. The Department of Labor has published regulations that standardize summary plan descriptions and dictate the required response of plan administrators to claim submission and appeal determinations. (See the Editor's Notes for "Utilization Review.") Separate federal legislation currently provides a limited number of mandated benefits for breast reconstruction, maternal length of stay, mental illness and emotional disorders and alcohol and drug abuse. In addition, the federal Patient Protection and Affordable Care Act signed into

law in March 2010 will mandate coverage for certain preventive health care services beginning on September 23, 2010, except for grandfathered health plans in existence at the time that the law was enacted. (See the Editor's Notes for the appropriate sections.)

Although the original intent of ERISA was to allow states to regulate insurers and insurance policies, many employers elect to self-insure their employees in the belief that their benefit plans would be totally exempt from state regulation because the employer is not actually operating as an insurance company. These employers then hire benefit management companies or established insurance companies, including PPOs and HMOs, to provide a physician network and/or to administer their benefits, and contend that these administrators are also subject to the ERISA preemption. Unfortunately, it is often difficult to know from the insurance card if a patient is insured under a regulated insurance plan or through a self-insured, ERISA-based, administrative contract.

Until recently, ERISA was strictly interpreted to limit all available remedies for wrongfully denied care to actions in federal court that seek only to recover denied benefits. There is no provision for any punitive damages that might be awarded in state courts. Absent congressional action, however, this shield may be lifting based on recent appellate court decisions that have distinguished insurance company operations from insurance benefit issues. Although ERISA plans continue to be exempt from any state-mandated insurance benefits, the Supreme Court, in two separate decisions, has held that the state laws that provide for external review of HMO treatment or medical necessity decisions are not subject to ERISA preemption. Moreover, new Supreme Court guidelines may void any assertions of ERISA preemption by the insurers hired to administer the ERISA plans.

Information on ERISA and federal health law may be obtained from the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor (<http://www.dol.gov/ebsa>). Complaints about ERISA plans may be directed to the EBSA district office at 1335 East West Highway, Suite 200, Silver Spring, MD 20910, telephone 301.713.2000, fax 301.713.2008. Maryland is also within the jurisdiction of the Philadelphia Regional Office at The Curtis Center, Suite 870 West, 170 S. Independence Mall West, Philadelphia, PA 19106-3317, telephone 215.861.5300, fax 215.861.5348.

A Compendium of Current Maryland Insurance Law

Affordable Care Act

Effective July 1, 2011, §15-137.1 will require that the provisions of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010, and any regulations governing this act, will apply to all individual and small and large group health insurance coverage in Maryland. The named provisions include: coverage of children up to 26 years old, preexisting condition exclusions, policy rescissions, bona fide wellness programs, lifetime limits, annual limits for essential benefits, waiting periods, designation of primary care providers, access to obstetrical and gynecological services, emergency services, summary of benefits and coverage explanations, minimum loss ratio requirements and premium rebates, and disclosure of information. Appropriate changes have been made to the individual statutes that relate to these specific issues. The Maryland Insurance Commissioner will enforce these provisions. (see "Appeal and Grievance.")

Effective June 1, 2011, §31-101 to 31-111 of the Insurance Article, titled Maryland Health Benefit Exchange, will establish the governance, structure and funding of the Maryland Health Benefit Exchange that will certify and make available qualified health plans to individuals and businesses and serve as a gateway to an expanded Medicaid program under the federal Affordable Care Act, which requires the implementation these exchanges by January 1, 2014. The Exchange is initially established as a public corporation and independent unit of state government, governed by a nine-member board of trustees. By December 23, 2011, the Exchange must make recommendations on contracting with insurers both locally and regionally; the rules under which health benefit plans should be offered within and outside of the Exchange; the design of the Exchange's consumer assistance programs; whether it should remain an

independent public institution or become a nongovernmental, nonprofit entity; and how the Exchange will become self-sustaining by 2015. The Exchange is prohibited from exercising any duties under the Affordable Care Act until after these studies have been completed and additional legislation is enacted by the Maryland General Assembly.

After Hours Bonus Payments – Primary Care Physicians

§15-134 and §19-706 will require carriers—including HMOs, but not group model HMOs—to pay a bonus to primary care physicians who provide services after 6 p.m. and before 8 a.m. on weekdays and on weekends and national holidays. The bonus amount is not specified in the statute but the carrier must describe the terms of the bonus payment in a separate clause of the carrier’s contract with the physician.

Alzheimer’s Disease/Elderly Individuals

§15-801 requires that carriers—excluding HMOs—offer the option of providing benefits for Alzheimer’s disease or the care of elderly individuals with any other disease designated by the insurance commissioner. Coverage, if elected, must include nursing home, intermediate, or custodial care.

Anatomic Pathology Billing

§1-306 of the Health Occupations Article specifically prohibits a physician from billing a patient or insurance carrier for anatomic pathology services unless the services are performed by the physician or under the direct supervision of the physician. Anatomic pathology services are defined as subcellular and molecular pathology; histopathology or surgical pathology; cytopathology; and hematology—including blood banking services and the examination of bone marrow aspirates, biopsies and peripheral blood smears performed by a pathologist.

However, health care practitioners who order but do not supervise or perform anatomic pathology services on a pap smear may bill the patient or payor, provided that they comply with the ethics policies of the American Medical Association that relate to referring physician billing for laboratory services and that the bill specifies the name of the laboratory, the amount paid to the laboratory for the test and the amount of procurement or processing charge, if any, for each specimen taken.

Appeal and Grievance of Adverse Decisions Regarding Medical Necessity

§12-4A-04 and §13-4A-02 of the Commercial Law Article give the Health Education and Advocacy Unit (HEAU) of the Consumer Protection Division of the Office of the Attorney General authority to assist consumers in their appeals to health insurers.

§19-705.2 of the Health-General Article gives the Maryland Insurance Administration (MIA) the responsibility to adopt regulations for the investigation of complaints by members of HMOs. Quality of care complaints should be referred to the Maryland Department of Health and Mental Hygiene (DHMH). §2-104, §2-112.2 and §2-113.3 of the Insurance Article give the MIA authority to utilize an independent review organization or medical expert to assist in the evaluation of complaints against insurance carriers and HMOs and to finance the appeals program through an assessment on these carriers.

§15-10A-01 through §15-10A-09 of the Insurance Article address the grievance procedures for an adverse decision regarding the *medical necessity* (as opposed to coverage) of a proposed health care service that is rendered by an insurer or HMO. With the exception of Medicaid recipients, carriers must establish an internal grievance process for their members. The complaint may be filed by the patient, the patient’s representative (*effective for plan years beginning July 1, 2011 or thereafter*) or by the physician on behalf of the patient. Carriers have five working days to request additional information when necessary.

Grievances regarding adverse decisions concerning emergency care must be finalized within 24 hours. For denials of non-emergent care, grievance decisions must be rendered within 30 working days, and for grievances of retrospective denials, within 45 working days. A complaint may be filed up to 180 days following a retrospective adverse decision. Carriers must send written notice to the member and provider within one day of making a determination regarding emergency services and within five days of a determination about non-emergency services, for both the initial adverse decision regarding medical

necessity and any subsequent grievance decision. All denials of care must reference specific guidelines or criteria on which the denial is based, avoiding certain general terms as stipulated, and provide information regarding the filing of a complaint with the insurance commissioner or the HEAU.

The carrier's internal grievance process must ordinarily be exhausted before a complaint is filed with the insurance commissioner (*waived for plan years beginning July 1, 2011 or thereafter*) unless there is compelling reason to bypass the carrier. A member or provider has 30 working days (*four months for plan years beginning July 1, 2011 or thereafter*) after receiving a final grievance decision from the carrier to file a complaint with the insurance commissioner. The carrier has the burden of persuasion that its decision is correct. Response times for the insurance commissioner are similar to those required of the carriers. The commissioner may consult with outside experts to make a determination of medical necessity. The commissioner may require coverage of or payment for a procedure and issue fines as appropriate. Carriers are required to send reports to the MIA on their internal grievance process and the MIA and the HEAU are required to report these findings to the General Assembly on a regular basis. (See "Utilization Review.")

Appeal and Grievance of Adverse Decisions Regarding Coverage Issues

§15-10D-01 through §15-10D-04 of the Insurance Article address appeal procedures when an insurer or HMO determines that a health care service is not covered or fails to pay all or part of a claim.

With the exception of Medicaid recipients, carriers may use the internal grievance process established under Subtitle 10A as described above. The carrier must send a written notice of an initial *coverage* decision (as opposed to a medical necessity decision) that results in non-coverage of a health care service to the member and provider within 30 calendar days after the decision has been made. A final decision must be rendered within 60 working days after an appeal of a non-coverage decision is filed. The decision must be in a form similar to that described for Subtitle 10A, referencing specific criteria. A complaint may be filed with the insurance commissioner within 60 working days (*four months for plans years beginning July 1, 2011 or thereafter*) after receipt of a carrier's appeal decision. The carrier has the burden to prove that its decision is correct. (See "Utilization Review.")

Editor's Note: The italicized changes for the Appeal and Grievance statutes in Maryland for plan years beginning July 1, 2011 or thereafter were made to conform to the appeal and grievance provisions of the federal Affordable Care Act.

Assignment of Benefits for Non-Participating PPO Physicians

All of the following sections of Title 14 of the Insurance Article will become effective for any policies issued or renewed on or after July 1, 2011: §14-201 is amended to define a "hospital-based physician" as a physician employed by a hospital or a physician group practice that is under contract to a hospital. An "on-call" physician is a physician who is required to respond within an agreed upon time period to provide care for an unassigned patient at the request of a hospital or hospital-based emergency room and who is not a hospital-based physician.

§14-205 requires that the allowed payment by a PPO for a non-participating physician may not be lower than the amount paid to a similarly licensed participating physician in the same geographic region. The coinsurance percentage amount for PPO members seen by non-participating physicians can be no more than 20 percentage points above the coinsurance amount charged to members who remain in-network. Any provision contained within a PPO insurance contract for a patient to pay a balance bill will not apply for non-participating hospital-based or on-call physicians who accept assignment.

§14-205.2 specifies that a non-participating hospital-based or on-call physician with a valid assignment of benefits, as described below, may not balance bill a patient for covered services except (1) for applicable copayments, deductibles or coinsurance specified by the insurance contract; (2) for Medicare patients, any amounts below the Medicare limiting charge after coordination of benefits with all secondary insurers has been completed or (3) for any non-covered services.

Non-participating *hospital-based* physicians with a valid assignment of benefits must be paid no less than the greater of (1) 140% of the average rate the insurer paid for the same covered service to similarly licensed hospital-based participating physicians in the same geographic area during the 12-month period that ends on January 1 of the previous calendar year or (2) the final allowed amount that the insurer paid for the 12-month period that ended on January 1, 2010 to a hospital-based physician billing under the same tax identification number used in 2009, as inflated by the change in the Medicare Economic Index from 2010 to the current year.

Non-participating *on-call* physicians with a valid assignment of benefits must be paid no less than the greater of (1) 140% of the average rate the insurer paid for the same covered service to similarly licensed participating physicians in the same geographic area during the 12-month period that ends on January 1 of the previous calendar year or (2) the average rate that the insurer paid to non-participating physicians in the same geographic area during the 12-month period that ended on January 1, 2010, as inflated by the change in the Medicare Economic Index from 2010 to the current year.

The insurer may request adjunct claim documentation from the physician. Claim payments must be made within 30 days and the insurer must disclose the reimbursement rate upon the request of the non-participating physician. The insurer may seek reimbursement from a patient for any amounts paid to the non-participating physician under these circumstances that are later deemed to be the responsibility of the patient. Physicians may enforce these payment provisions through a complaint to the Maryland Insurance Administration (MIA) or through a civil action against the insurer. The MIA or court may award reasonable attorney's fees to the physician if the insurer's conduct in maintaining or defending the proceeding was in bad faith or the insurer acted willfully in the absence of a bona fide dispute. The MIA may investigate and enforce these provisions and fine the insurer up to \$5,000 for each violation.

§14-205.3 states that an insurer may not prohibit the assignment of benefits by a patient to a physician and may not refuse to directly reimburse a non-participating physician under a valid assignment of benefits unless the assignment of benefits notice is received after the benefits have been paid to the patient, the insurer paid the patient through an inadvertent administrative error, the patient withdraws the assignment of benefits before the non-participating physician has been paid or the patient has paid the full amount due to the physician at the time of service.

A non-participating physician seeking assignment of benefits must provide a statement to the patient that he or she is a "nonpreferred" physician, that the patient may be charged for non-covered services and that the patient may be balanced billed for covered services. The statement must include an estimate of the cost of services to be provided, the terms of payment that will apply and whether any interest will be charged, including the amount of interest. The physician must also submit a disclosure form, to be developed by the MIA, to the insurance company to document the assignment of benefits. In the absence of an assignment of benefits, the explanation of benefits statement sent to the patient by the insurer will instruct the patient to send the payment to the physician unless payment has already been made.

§15-304 makes the provisions of §14-205.2 and §14-205.3 applicable to group health insurance policies

Editor's Note: To summarize, beginning in July 2011, and over the next 12 months as policies renew, insurers must accept a valid assignment of benefits from non-participating physicians for PPO and indemnity subscribers as long as the patient receives a specified disclosure and the insurer receives the assignment of benefits form created by the MIA. Non-participating physicians who are not hospital-based or acting as an on-call physician for an unassigned hospital or emergency room patient are free to balance bill for any charges over and above the insurance reimbursement. Although hospital-based and on-call physicians are not required to accept assignment, those who do must accept the prescribed reimbursement amount that is at least 140 percent above the amount paid to a similar participating physician, indexed for inflation, and may not balance bill the patient except for non-covered services or amounts stipulated by the insurance company to be the patient's responsibility. Note, however, that these provisions do not apply to HMO members or to PPO or indemnity patients who are part of an ERISA plan.

Although not formalized in statute, the General Assembly noted its intent that non-participating on-call and hospital-based physicians should be paid no less than the rate paid to these non-participating physicians as of December 31, 2009.

Both the Maryland Health Care Commission and the Maryland Insurance Administration have been instructed to study the impact of this legislation with final reports due by 2014. All aspects of the assignment of benefits legislation are due to expire on September 30, 2016, unless extended by the General Assembly.

Assignment of Provider Contract for PIP, Workers' Compensation, Casualty or Property Insurance

§15-125 and §19-706 prohibit carriers—including HMOs—from assigning a physician's contract to an insurer that offers personal injury protection coverage (PIP) without the written consent of the physician. Refusal to agree to the assignment may not be a basis for termination of the physician's contract.

§15-125 also prohibits carriers—including HMOs—from requiring participation in a workers' compensation panel. The contract must disclose the physician's right to refuse participation in the workers' compensation panel. Such refusal may not be a basis to terminate or limit a physician's contract. §19-115 prohibits an insurer from conditioning physician participation on an HMO or non-HMO health insurance provider panel on the physician's additional participation on the panel of a casualty or property insurer.

An entity creating a physician panel for a casualty or property insurer must provide a written payment schedule of the insurer for up to the 50 most common services billed by the specialty of the physician at the time of contract execution, and a written or electronic payment schedule at least 30 days before a change in fees or upon request by the physician.

Balance Billing of HMO and PPO Subscribers

§19-710 states that with the exception of copayments, coinsurance, or charges for services that are not covered under the HMO subscriber's contract, an HMO member shall not be liable to any health care provider for any covered service provided to the member. In addition, the health care provider may not attempt to collect any money from the subscriber that is owed to the provider by an HMO. A hospital emergency facility, however, may collect payment for services from an HMO member if the medical condition is determined not to be an emergency as defined by the "prudent layperson" standard. (See "Emergency Services.")

When Medicare is the primary insurer and an HMO is the secondary insurer, physicians may collect from the patient the difference between the Medicare-allowed amount and the total amount paid to the provider by Medicare and the HMO after coordination of benefits has been completed, even though the HMO-allowed amount may be less than the Medicare-allowed amount.

Effective for any policies issued or renewed on or after July 1, 2011, §14-205.2 specifies that a non-participating hospital-based or on-call physician with a valid assignment of benefits may not balance bill a PPO patient for covered services except (1) for applicable copayments, deductibles or coinsurance specified by the insurance contract; (2) for Medicare patients, any amounts below the Medicare limiting charge after coordination of benefits with all secondary insurers has been completed; or (3) for any non-covered services. (See "Assignment of Benefits for Non-Participating PPO Physicians.")

Editor's Note: *The operative term in the HMO statute is "covered service." If a participating physician fails to obtain the necessary authorization for a covered service as required by the HMO policy guidelines, the patient may not be billed for the service that would otherwise have been covered with the HMO's approval.*

If the HMO decides to extend coverage to a service provided by an out-of-network physician by special authorization, either before or after the service is performed or through a grievance procedure, the out-of-network physician must accept the HMO allowance for the procedure as a covered service and may

only bill the patient for the copay stipulated by the patient's coverage, unless the patient has signed a waiver as described in the following paragraphs. (See Non-Participating Specialist Referral.)

A service provided by a non-participating provider under a point-of-service (POS) contract may also be considered to be a covered service and, depending on the nature of the member's contract, may or may not be subject to the HMO balance billing limitation. If the member's contract stipulates that the POS plan is contained within the insurer's PPO product, the non-participating physician is free to balance bill the patient beyond the HMO allowance. If, however, the POS option is wrapped under the HMO coverage, the "hold harmless" statute contained in §19-710 prevents both a participating and non-participating physician from collecting any money from the patient for covered services, except for the copayment or coinsurance. Because you will not have access to the member's contract, you must contact the HMO to be sure. (See "Assignment of Benefits" for limitations on balance billing PPO members by non-participating hospital-based and on-call physicians and reimbursement amounts for these physicians, "Non-Participating HMO Physician Reimbursement" and "Point-of-Service Plan.")

According to an opinion issued by the Maryland Attorney General in November 2000, a non-participating physician may enter into a private contract with an HMO member to provide services at the physician's full fee if the HMO or its agent did not refer the patient. The patient's intent not to utilize the HMO coverage and the patient's knowledge of the financial consequences must be clearly documented in writing. The waiver must state that "the member will be solely responsible for the provider's charges, the HMO will not pay the provider, the provider will not accept payment from the HMO and the member's obligation to pay HMO premiums will not be affected." If the HMO sends a payment to the physician, the payment should not be accepted. If the HMO sends a payment to the patient, the HMO may recover that payment from the patient. A waiver form may be downloaded from the MedChi Web site at www.medchi.org.

If a network physician provides services outside the bounds of the HMO contract—without a referral from a primary care physician or by utilizing an out-of-network laboratory by patient request—the patient should sign a similar waiver form, voluntarily and without coercion, acknowledging responsibility for payment and an understanding that the service would be covered by the HMO under normal circumstances. You should be aware that recommending an out-of-network provider of service might be a violation of your HMO contract when there is provision for in-network availability.

Blood Transfusions

§15-803 and §19-706 require that carriers—including HMOs—cover blood transfusions as part of a covered medical therapy.

Breast Cancer Screening

§15-814 requires that carriers—excluding HMOs—cover a baseline mammogram for women between the ages of 35 and 39; a mammogram every two years—or more frequently if recommended by a physician—for women between the ages of 40 and 49; and a yearly mammogram for women over the age of 50, without a deductible.

Effective for all health insurance policies issued or renewed on or after October 1, 2009, §15-814 and §19-706 require that carriers—including HMOs—cover breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society, in lieu of the current statutory requirements. (See "Preventive Health Care Services.")

***Editors Note:** As of March 2008, the American Cancer Society recommends a clinical breast examination as part of a periodic health exam every three years for women in their twenties and thirties and annually for women age 40 and older, yearly mammograms starting at age 40 and continuing for as long as a woman is in good health, and annual mammograms and MRIs for women at a greater than 20 percent lifetime risk of breast cancer.*

Breast Prosthesis/Reconstructive Surgery

§15-815 and §19-706 require that carriers—including HMOs—provide coverage for reconstructive breast surgery resulting from a mastectomy, including reconstruction of the non-diseased breast to establish symmetry with the diseased breast. Benefits must also include coverage for any physical complications of mastectomy, including lymphedema.

§15-829 and §19-706 require that carriers—including HMOs—provide coverage for a breast prosthesis following mastectomy if reconstructive surgery is not performed.

§20-116 requires that low-income women in the Breast Cancer Program who have undergone a mastectomy be eligible for breast reconstruction and prostheses as part of their treatment.

***Editors Note:** The federal Women’s Health and Cancer Rights Act, signed into law in October 1998, requires all plans, including ERISA plans, that cover mastectomy to also cover breast reconstruction for both the cancerous breast and the non-cancerous breast, to provide a symmetrical appearance; breast prostheses; and treatment of all physical complications, such as lymphedema. The federal law does not provide for any minimum hospital stay following mastectomy.*

Capitation

§15-113 requires that HMOs pay all capitation accrued from the beginning of the contract year within 45 days from the date that a patient chooses or obtains care from a physician.

Child Wellness

§15-817 requires that carriers—excluding HMOs—cover childhood and adolescent immunizations and age-appropriate screening for newborn metabolic disease, TB, anemia, lead toxicity, hearing, and vision. Effective for all insurance policies issued or renewed on or after October 1, 2010, additional coverage will be required for the evaluation and management of childhood obesity and for developmental screening as recommended by the American Academy of Pediatrics.

Children’s Habilitative Services

§15-835 requires that insurers—including HMOs—provide occupational, physical and speech therapy for children under the age of 19 with congenital birth defects.

Claim Denial Appeal Deadlines

§15-1005 requires that an insurer—including an HMO—allow a physician at least 90 working days after the date of denial of a claim to appeal the claim.

If an insurer—including an HMO—erroneously denies a provider's claim that is submitted within the statutory time period of 180 days because of a claims processing error, and the provider notifies the insurer of the error within one year of the claim denial, the insurer must reprocess the claim automatically, without the need to resubmit the claim, and without regard to timely submission deadlines.

Claim Submission Deadlines

§15-1005 and §19-712 require that carriers—including HMOs—allow a minimum of 180 days from the date of service for the submission of a claim.

Clean Claims

§15-1003 and §19-706 require the insurance commissioner to develop regulations that define a clean claim and incorporate the use of a uniform claim form with required data elements and standard attachments. The regulations must also include permissible types of disputed claims for which additional information may be required and the standards for determining when a claim is received for reimbursement.

§15-1004 and §19-706 require that carriers—including HMOs—must accept the uniform claim form and any approved attachments as the sole instrument for reimbursement of services. A carrier may not require

the physician to modify the form or its content or submit additional claim forms. Insurers must provide physicians with updated manuals that describe their claim filing procedures.

The carrier may only request additional medical information that describes the diagnosis and treatment rendered to the patient for certain permissible types of disputed claims established by regulation and the carrier must request such information within 30 days after receipt of the claim. Carriers may also request information from the member or employer to make a determination on eligibility or coverage; however, delays in payment that result from these requests are subject to the payment of interest. (See “Interest on Overdue Claims.”)

Editor’s Note: *The “clean claims” regulations, which took effect on September 7, 2001, require the use of the CMS-1500 for claim submission, and limit the coding methodology for physicians to CPT, ICD-9 and, where applicable, HCPCS codes, NDC codes, DSM-IV codes, American Society of Anesthesiology codes, and ICD-9 auto codes for emergency services.*

Payers may only require the following additional attachments: a referral or consultant treatment plan; an Explanation of Benefits statement from the primary payer, if a different primary payer exists; a description of the service, which may include the medical record, only if there is no corresponding CPT code; an operative report, if the claim is for multiple surgeries or if modifiers 22, 58, 62, 66, 78, 80, 81 or 82 are included; anesthesia records, if modifiers P4 or P5 are used; documents required under a global contract; and office notes, if modifier 21 or 22 is used. Additional information may also be requested if the payer detects a pattern of improper billing, has a reasonable belief of fraud, or determines that a service is outside the scope of a referral or authorization.

Claims are presumed to be received by the carrier according to the carrier’s written or electronic record or within three days from the date that the claim was mailed, based on a stamped postal certificate of mailing. Carriers must provide verification of the date of receipt upon request of the physician. The complete version of the regulations may be downloaded from the “Legal and Regulatory Issues” section of the MedChi Web site at www.medchi.org.

Cleft Lip and Palate

§15-818 and §19-706 require that carriers—including HMOs—include benefits for inpatient or outpatient management of cleft lip and palate.

Clinical Trials

§15-827 and §19-706 require that carriers—including HMOs—cover testing for the prevention, early detection, or treatment of cancer and treatment for a life-threatening condition—when provided under an approved clinical trial—if there is no clearly superior non-investigational treatment alternative. FDA-approved drugs must be covered. Coverage for investigational drugs is not required. (See “Off-Label Drug Use.”)

Clinically Integrated Organization

§15-801 through §15-803 and §19-706 establish the Clinically Integrated Organization (CIO), a joint venture between a hospital and physician group that has received an advisory opinion from the Federal Trade Commission providing a waiver from antitrust law. The CIO must either (1) evaluate and improve the practice pattern of health care providers and establish a high degree of cooperation and collaboration among providers to promote the efficient, medically appropriate delivery of covered medical services or (2) be accountable for total spending and quality and be certified by the Maryland Insurance Commissioner as meeting the criteria of the federal Department of Health and Human Services for an Accountable Care Organization. A contract between insurance carriers, including HMOs, and the CIO may contain provisions to pay for coordination of covered services to members and for bonus or other incentive payments to promote the efficient delivery of covered services to patients. Such contracts must be filed with the insurance commissioner who will develop regulations delineating the type of permissible

payments and incentives in consultation with the Maryland Health Care Commission (MHCC). The CIO must, within three years of the contract, submit an evaluation of its program to the MHCC.

Coding Guidelines

§15-115 requires that carriers—including HMOs—provide a written description of their coding guidelines that are applicable to the physician’s specialty at the time of contract execution, 30 days prior to a change, and upon request. (See “Retroactive Denials of Claims” for the definition of improper coding.)

Colorectal Cancer Screening

§15-837 and §19-706 require that carriers—including HMOs—cover colorectal cancer screening in accordance with guidelines issued by the American Cancer Society. (See “Preventive Health Care Services.”)

Contraceptives

§15-826 and §19-706 require that carriers—including HMOs—provide coverage for any approved prescription contraceptive drug or device, including insertion and removal, together with any necessary examination associated with the use of the contraceptive. Religious organizations may request an exemption.

Diabetes Supplies

§15-822 and §19-706 require that carriers—including HMOs—provide coverage for medically necessary diabetes equipment and supplies in addition to outpatient self-management training and educational services, including nutrition therapy.

Dietary Treatment – Modified Food Products/Infant Formula

§15-807 and §19-705.5 require that carriers—including HMOs—cover low-protein modified food products and any other food intended for the dietary treatment of an inherited metabolic disease for which nutritional requirements are established by medical evaluation and which are formulated to be administered enterally under the direction of a physician.

§15-843 and §19-706 require health insurance carriers—including HMOs—to provide coverage for amino acid-based elemental formula, regardless of delivery method, for the diagnosis and treatment of allergies to multiple food proteins; severe food protein-induced enterocolitis syndrome; eosinophilic disorders, as evidenced by the results of a biopsy; and the impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract. The carrier may review the physician’s order for medical necessity.

Domestic Violence

§19-706 prevents an HMO from refusing to issue or renew a health benefits plan based on information about abuse or the individual’s status as a victim of domestic violence. Further, an HMO cannot use this information to increase rates, apply a surcharge, or refuse to pay a claim.

Downstream Risk Contracts

§19-712 and §19-713.2 clarify that carriers—including HMOs and MCOs—are responsible for all payments to providers for services provided under an administrative risk contract, regardless of the solvency of the contractor or subcontractor, and that these payments are not limited by the amounts in any segregated fund. This stipulation does not apply if the physician is affiliated with the HMO through common ownership and the insurer records a reserve for the liabilities of the contracting provider. Contracting providers are subject to stricter auditing measures and may be fined or have their registrations revoked for noncompliance. §19-730 imposes similar penalties on HMOs for noncompliance. §19-713.3 requires that downstream risk contractors register with the insurance commissioner.

Drug Formulary Exception

§15-830 requires that carriers—including HMOs—establish a procedure by which a patient may receive a non-formulary drug if, in the opinion of the physician, there is no equivalent medication in the formulary or if the formulary drug has been ineffective or is likely to cause an adverse reaction.

Electronic Health Records

§19-143 requires that the Maryland Health Care Commission (MHCC) and the Maryland Health Services Cost Review Commission designate a Health Information Exchange (HIE), a statewide infrastructure that provides for the electronic exchange of health information, on or before October 1, 2009. On or before January 1, 2010, the MHCC must make recommendations to the General Assembly for legislation that specifies how any incentives that are necessary for state-regulated national payors to promote the adoption and meaningful use of electronic health records (EHR) will take into account existing carrier activities.

On or before January 1, 2011, following consultation with stakeholders, the MHCC must post on its Web site and submit to the governor and the General Assembly a report on the development of a public-private approach to improve the state's health information infrastructure. The MHCC must also recommend legislation and regulations necessary to provide for the effective operation of the HIE, protect the privacy and security of information stored in EHRs or exchanged through the HIE and align funding opportunities with federal, state and private programs for health information technology—including the patient-centered medical home and existing Medicare and Medicaid initiatives.

On or before September 1, 2011, the MHCC—in consultation with the Department of Health and Mental Hygiene (DHMH), payors and health care providers—must adopt regulations that require state-regulated payors—including HMOs, and the Maryland Medical Assistance Program, but not MCOs or ERISA plans—to provide incentives to health care providers to promote the adoption and meaningful use of EHRs. These incentives shall have “monetary value,” and be consistent with existing payor incentives, including those provided under Medicare, Medicaid and federal grants or loans. The incentives may include increased reimbursement for specific services, lump sum payments, gain-sharing arrangements, rewards for quality and efficiency and in-kind payments.

Effective July 1, 2011, §19-142 will require that carriers—including HMOs—pay any required incentives to adopt EHR in cash, unless the insurer and the physician agree on an incentive of equivalent value. The carrier may request information from the physician to validate the incentive claim and may reduce the incentive amount if a duplicate payment or overpayment has been made. The Maryland Health Care Commission, in consultation with stakeholders, is required to study whether the incentive payments should be expanded beyond primary care physicians and issue its report by January 1, 2013. The regulations that specify the incentive payment may not require a group model HMO to provide an incentive to physicians employed by the multispecialty group of physicians under contract with the group model HMO.

On or before October 1, 2012, the MHCC must designate one or more management service organizations (MSOs) that will offer hosted EHR solutions and other management services to health care providers throughout the state and use federal grants and loans to subsidize the use of the MSOs by health care providers.

On and after the later of January 1, 2015, or the date established for the imposition of penalties by the federal American Recovery and Reinvestment Act of 2009, each health care provider using an EHR that seeks payment from a state-regulated payor must use EHRs that are certified by a national certification organization designated by the MHCC and that are capable of connecting to and exchanging data with the HIE designated by the MHCC. The incentives required to utilize EHRs may include reductions in payments to health care providers that do not use electronic health records that meet the specified requirements.

Effective October 1, 2011, §4-302.2 will require that the Maryland Health Care Commission adopt regulations for the privacy and security of protected health information obtained or released by the HIE.

The regulations must protect the secondary use of the information—except for hospitals, credentialed members of the hospital staff and hospital-affiliated clinical providers with a business associate agreement—and control the conditions under which this information may be sold for financial remuneration. §4-302.3 will require a payor that acts as or owns an HIE to act in a manner consistent with federal and state privacy laws, and to respond to requests for clinical information transmitted to the HIE.

Editor's Note: In August 2009, the Chesapeake Regional Information System for our Patients (CRISP), a non-profit consortium of Johns Hopkins Health, MedStar Health, the University of Maryland Medical System, Erickson Retirement Communities, and the Erickson Foundation, was chosen by the MHCC to implement the Maryland HIE. CRISP is currently piloting the delivery of medication information to hospital emergency rooms and plans to roll out the sharing of laboratory results and hospital discharge summaries in the near term. The HIE will be overseen by a 33-member Policy Board that includes health care stakeholders, consumers and non-health care interests. There is, however, only one practicing physician. The board membership and meeting information is available at the MHCC Web site at http://mhcc.maryland.gov/electronichealth/hie_policy_board/index.html.

In April 2010, CRISP contracted with Axolotl Corp, which operates other HIEs around the country, to provide the statewide systems that will network medical information from certified EHR software between hospitals, physicians, laboratories, radiology centers, pharmacies and other health care providers in Maryland through the Internet. Financial support for the state HIE presently consists of a \$10 million allocation over three years, funded through an increase in the Maryland all-payor rate system, and a \$9.3 million grant from the United States Department of Health and Human Services' Office of the National Coordinator for Health Information Technology.

CRISP was also chosen as the health information technology (HIT) Regional Extension Center for the state of Maryland by the Office of the National Coordinator as part of the HITECH Act under the American Recovery and Reinvestment Act, and will receive an additional \$5.5 million over four years to fulfill this function. Maryland is also requesting an additional \$1.4 million in funding from the Centers for Medicare and Medicaid Services (CMS) for one year to support development of the Medicaid portion of the state's HIT plan.

Workgroups, consisting of various stakeholders, have been convened by the MHCC to address the various issues surrounding governance, privacy and security, access, hardware and software solutions, costs and the criteria for the MSOs that seek state designation. In addition, the MHCC has met with the large insurance payors in the state and, in November, requested that they submit a compliance plan for monetary incentives to promote the adaptation and meaningful use of EHR beginning in 2011. In the meantime, the MHCC has developed a physician EHR product portfolio that is located on the MHCC Web site at <http://mhcc.maryland.gov/electronichealth/ehr/cchitehrvendors.html>.

Legislation was passed in 2011 to address two concerns raised by MedChi with regard to the EHR statutes: First, Axolotl, the company hired by CRISP to develop the Maryland HIE is a for-profit company that is now owned by Optum, a subsidiary of UnitedHealth Group, which also operates UnitedHealthcare. Axolotl is part of the Optuminsight division of Optum, formerly known as Ingenix, which sells health insurance data to third parties as part of its analytics and consulting business. Although the contract between CRISP and Axolotl requires data confidentiality, it was felt that an additional statutory requirement for protection of patient information was warranted.

Second, the regulations that were established by the Maryland Health Care Commission for the one-time incentive payment to Maryland primary care physicians—\$8.00 per patient, not to exceed \$15,000 per practice from each insurance company—did not require that a cash incentive payment be made in advance unless both the physician and the insurer agreed. Physicians will now be allowed to request an advance payment from the insurer in order to pay for the EHR system. It should be noted that Maryland is the only state that requires private insurers doing business in the state provide these incentive payments to physicians to assist in the purchase of EHR systems.

Emergency Services

§19-701 establishes a “prudent layperson” definition for an emergency situation that should ensure coverage for the onset of symptoms of sufficient severity that an average person feels would place his or her health in serious jeopardy.

§15-126 and §19-706 require that carriers—including HMOs—not promote or require the use of an emergency transport system in competition with 911. A preauthorization may not be required to access the 911 system.

§19-705.1, §19-705.6, and §19-705.7 require that an HMO have a system for providing a member with 24-hour access to a physician when there is an immediate need for medical services and provide 24-hour access by telephone to a person who is able to respond to calls from members and providers about after-hours care.

HMOs must also provide a 24-hour toll-free telephone access system that allows hospital emergency departments to determine the primary care physician assigned to the member and the names of three contracted specialist providers for the HMO who have privileges at a particular hospital in Maryland. There is a presumed authorization to utilize the specialist on-call to the emergency room if the telephone access system for hospital emergency rooms is not operational or if the member’s primary care physician or the specialist needed by the patient cannot be ascertained within a reasonable time as determined by the treating emergency room physician, not to exceed 30 minutes after the initial documented call to the telephone access system.

§19-712.5 requires an HMO to reimburse a hospital emergency facility and provider for medically necessary services if the HMO authorized the member to use the emergency room, if the HMO fails to provide 24-hour access to a physician as noted above, or for any medical screening, assessment, and stabilization services rendered to meet the requirements of the federal Emergency Medical Treatment and Active Labor Act (EMTALA). A hospital, emergency facility, provider, or an HMO that has reimbursed a provider may collect payment from a member for health care services provided for a medical condition that is determined not to be an emergency.

An HMO must reimburse a surgeon, dentist, or podiatrist who performs emergency surgery for any medically necessary follow-up care performed in consultation with the patient’s primary care physician, with no additional cost-sharing by the patient.

***Editor’s Note:** The legislature has adopted a “prudent layperson” definition of a medical emergency and prohibits any requirement for preauthorization of truly emergent situations as defined by the statute. However, if the medical problem is deemed not to be a true emergency by the HMO, the HMO, the provider of care, and/or the hospital may hold subscribers financially responsible. While members may protest, they are supposed to be well informed by their HMO of procedures for urgent and emergent care. (See “Non-Participating Provider Reimbursement.”)*

Experimental Care

§15-123 and §19-706 require that carriers, including HMOs—including HMOs—define experimental medical care in provider contracts and in marketing and enrollment materials offered to members. The carrier must subscribe to a systematic, scientific process for evaluating emerging medical and surgical treatments on an annual basis, including a review of medical literature and input from physicians and other experts who are not employees of the carrier. Carriers must provide a description of the evaluation process to enrollees and any provider on request, and file an annual report with the insurance commissioner, available to the public, summarizing the clinical issues and services that were evaluated and the results of the evaluations, including the expert opinions

Extended Coverage After Policy Termination for Total Disability/Claim in Progress/Accident/ Eyeglasses/Contact Lenses/Dental Care

§15-833 and §19-706 require that carriers—including HMOs—extend coverage, if the insured is totally disabled at the time of policy termination, for the condition causing the disability until the insured is no longer totally disabled—up to a period of one year. If there is a claim in progress at the time of

termination, the carrier must continue to pay for covered services until the patient is released from the care of a physician for the condition that is the basis of the claim, up to a period of one year. If the insured is confined in a hospital at the time of policy termination, the carrier must continue to pay for covered services until the patient is released from the hospital, up to a period of one year. If an accident occurs prior to termination of a policy, the carrier must cover any loss that occurs up to 90 days following the accident.

Covered glasses or contact lenses ordered prior to termination of coverage must still be provided if the items are received within 30 days of the order. Similar provisions apply for certain types of dental care. Premiums may not be charged during the extension period. These stipulations do not apply if coverage was terminated due to nonpayment of premium or fraud, or if succeeding coverage is provided at a lower or equal cost than the prior policy.

Eye Drops

Effective with policies issued or renewed on or after October 1, 2011, §15-845 and §19-706 will require that carriers—including HMOs—that provide coverage for prescription eye drops must provide coverage for prescription eye drop refills in accordance with guidance for early refills of topical ophthalmic products provided to Medicare Part D plan sponsors under the following conditions: the prescriber indicates that additional quantities are needed, the refill request does not exceed the number of refills prescribed and the eye drops are covered under the health insurance policy.

False Claims

§2-601 through §2-611 of the Health General Article prohibit a person from knowingly making a false claim for payment or approval from a Maryland-sponsored health plan or program. The state may file a civil action against a person who makes a false health claim with a potential civil penalty of up to \$10,000 per violation plus an amount equal to triple the amount of damages sustained by the state. A private citizen may also file a *qui tam* civil action on behalf of the state against a person who has made a false health claim and be awarded a certain percentage of the proceeds of the action. For the civil action to proceed, however, any *qui tam* filing must be taken over by the state. The statute prohibits retaliatory actions against the individual disclosing a false claim to protect the whistleblower. The statute of limitations is the later of six years from the date of the violation or three years after the date when material facts were known or should have been known, but no later than 10 years after the date on which the violation is committed.

Family Planning Services - Medicaid

Effective January 1, 2012, §15-103 will require the Maryland Medical Assistance Program to provide family planning services, subject to the limitations of the state budget, to all women whose family income is at or below 200 percent of the federal poverty level.

Editor's Note: Currently, Medicaid provides family planning services only to women with family income at or below 250 percent of the federal poverty level and only for five years after the second month following the month in which a woman delivers her child.

Gag Clauses

§15-116 and §19-706 state that carriers—including HMOs— may not prohibit a health care provider from discussing information that is necessary or appropriate for the delivery of health care services, including treatment alternatives, an enrollee's right to appeal coverage determinations, and opinions regarding public policy issues. This stipulation does not prevent a carrier from prohibiting tortious interference with the contract as recognized under Maryland law.

Editor's Note: Translation: Say what you want to your patients regarding their care or managed care in general. Just don't criticize a specific company in front of witnesses.

Genetic Testing

§19-706 and §27-909 prohibit an HMO from using a genetic test, genetic information, or a request for genetic services to deny, limit, cancel, or affect the premium of a health insurance policy. The HMO may not require a genetic test to determine whether to issue or renew coverage or release any genetic information without consent.

Hair Protheses for Cancer Patients

§15-835 requires that carriers—including HMOs—cover a hair prosthesis prescribed by an oncologist, up to a cost of \$350, for people who have hair loss resulting from chemotherapy or radiation.

Hearing Aids

§15-838 requires that carriers—including HMOs—provide coverage of at least \$1,400 per hearing aid every 36 months for minor children.

Effective for all policies issued or renewed on or after October 1, 2011, §15-838 requires that carriers—including HMOs—that provide coverage for hearing aids for adults with a dollar limit on the cost of the hearing aid, allow the subscriber to purchase a more expensive hearing aid and play the difference between the cost of the hearing aid and the dollar limit of the benefit.

HMO Medical Directors

§19-708 and §15-10C-01 through §15-10C-04 require the medical director of an HMO to be licensed in Maryland and certified by the insurance commissioner.

HMO/PPO Panel Application, Recredentialing and Termination

§15-103.4 provides that a Medicaid Managed Care Organization may deem a physician to be credentialed for up to six months from the receipt of a completed application if the physician is credentialed by another entity in the state that is required to credential health care providers and remains in good standing with that entity.

§15-112 and §19-706 require that carriers—including HMOs—provide an initial response to a physician application within 30 days and a final decision within 120 days. Carriers that receive an incomplete application must return the application to the physician within 10 days after receipt and notify the physician as to what additional information is required. These requirements do not apply to carriers that use hospitals or academic medical centers that participate on the carrier's provider panel as credentialing intermediaries for physicians that have privileges at the hospital or academic center. (See "Uniform Credentialing Form.")

Effective October 1, 2011, carriers that do not accept applications through an online credentialing system must notify physicians that the application is complete within 10 days after receipt of an application. For carriers that utilize an online credentialing system, notice to the physician from the online system that the carrier has received the application is considered to be notice that the application is complete.

A carrier must reimburse a group practice on the carrier's panel for covered services provided by a physician who is not a participating provider if the physician is employed by or a member of the group practice, has a valid Maryland license, is currently credentialed by an accredited Maryland hospital, has malpractice insurance, has applied for participation with the carrier and has been notified within the mandated 30 days of the carrier's intent to continue processing the application in order to obtain the necessary credentialing information.

Insurance reimbursement is mandated for services provided from the date of the carrier's notice to continue processing the application until the date of any subsequent rejection notice by the carrier. Beginning on the date of a written notice of rejection for credentialing, the carrier must provide reimbursement for covered services as it would for a non-participating physician. An HMO may specifically not deny payment to a physician solely because the physician was not participating at the time that services were provided under this scheme. Patients may not be charged for the cost of any covered

services provided during the pending application period, except for deductibles and copayments. The group practice must disclose in writing to patients at the time services are rendered that the treating physician is not participating but has applied to participate, that the carrier has not completed its assessment of the qualifications of the physician to participate and that any covered services will be paid by the carrier at the participating rate.

Recredentialing cannot be required based on a change in the federal tax identification number of a physician or the physician's employer, or a change in the physician's employer if the new employer is a participating provider on the carrier's panel or employs physicians that participate in the carrier's panel. Not less than 45 days before the change, information specified in the statute must be provided to the carrier. The carrier must acknowledge this notice within 30 business days and issue a new participating provider number when necessary. A carrier may not terminate the contract of the physician or the physician's employer based solely on this change.

At least 90-days notice must be provided to a physician for termination unrelated to fraud, patient abuse, incompetency, or loss of license. Physicians must provide the carrier with 90-days notice of their intent to terminate participation in a provider panel and must continue to care for the carrier's members during that 90-day period. Members must be notified of the termination of their PCP and PCPs must be notified of the termination of specialists. Members must be notified of their right to continue care with a terminated PCP for up to 90 days if they so desire.

Providers may not be terminated for filing appeals and complaints, advocating the interests of their patients, or based on gender, age, race, religion, national origin, or a protected disability. Each HMO and insurance carrier must establish an internal review system to resolve any provider grievances, including termination from the provider panel. Carriers must provide members with a printed list of physicians on its provider panel at the time of enrollment. Carriers must also make this information available on the Internet.

***Editor's Note:** The statutes relating to managed care panel applications and terminations do not prevent an HMO from denying an application or terminating a physician based on a business decision about the complement of its provider panel. (See "Physician Profiling.")*

HMO/PPO Panel Participation with Multiple Lines of Business

§15-112 and §19-706 require that carriers—including HMOs—may not stipulate that physicians participate in an HMO panel as a consideration of participating in a non-HMO panel. The contract must disclose the carriers comprising each panel and, if a contract includes more than one schedule of fees, the contract may not require the acceptance of each schedule of fees as a condition of participation, nor may the carrier require the physician to treat the enrollees of carriers that reimburse according to the rejected fee schedule. However, a contract may require a physician to accept the fee schedule for a carrier that is not affiliated through common ownership with the entity arranging the provider panel. A carrier may still require a physician to participate with its HealthChoice (Medicaid) provider panel as a condition of participation with one or more of the carrier's other benefit plans.

***Editor's Note:** These statutes, as amended, effectively preclude United Healthcare from requiring participation in MAMSI panels in order to participate in United Healthcare panels and vice versa.*

Hold Harmless Clauses

§15-117 and §19-710 prohibit carriers—including HMOs—from requiring a health care provider to indemnify the carrier or hold the carrier harmless from a coverage decision or negligent act of the carrier.

Hospice Services

§15-809 and §19-703 require that carriers—including HMOs—offer benefits for hospice services by a hospice care program as an option to all of their members.

Hospital Length of Stay/Home Visits – Cesarean Section/Vaginal Delivery/Newborns and Mastectomy/Orchiectomy

§15-811 and §19-703 require that carriers—including HMOs—provide up to four days of hospitalization for newborns when the mother is required to remain hospitalized for medical reasons.

§15-812 and §15-10B-09 require that carriers—including HMOs—provide coverage for a minimum of 48 hours of hospitalization following an uncomplicated vaginal delivery and 96 hours of hospitalization following an uncomplicated cesarean section. The carrier must authorize one home visit after delivery and, if a shorter length of stay is elected, one additional home visit within 24 hours after discharge.

§15-832 requires that carriers—including HMOs—provide one home visit within 24 hours after discharge and an additional visit on the prescription of the attending physician for all patients with less than a 48-hour hospital stay following orchiectomy.

§15-832.1 requires that carriers—including HMOs—provide coverage for inpatient hospitalization for a minimum of 48 hours following a mastectomy. If the patient, in consultation with her physician elects a shorter stay, or undergoes mastectomy on an outpatient basis, coverage must be provided for one home visit scheduled to occur within 24 hours after discharge and an additional visit on the prescription of the attending physician. For a woman who is hospitalized for at least 48 hours, coverage for a home visit must be provided if prescribed by the attending physician. Coverage for the 24-hour visit may not be denied if the services do not occur within the time specified. Carriers may not deny, limit, or impair the participation of physicians under contract with the carrier for advocating the interest of mastectomy patients, including lengthier inpatient stays or additional home visits

***Editor’s Note:** The federal Newborns’ and Mothers’ Health Protection Act of 1996, signed into law in September 1996, requires all plans that provide maternity benefits, including ERISA plans, to pay for at least a 48-hour stay following vaginal delivery and at least a 96-hour stay for the mother and baby following cesarean section. There is no federal mandate for a specified length of stay following mastectomy or orchiectomy for patients covered under an ERISA plan.*

Incentive-Based Physician Compensation

§15-113 prevents carriers—including HMOs—from basing a physician’s compensation or bonus on the cost or number of medical services provided to patients, with the exception of preventive services. The carrier must provide information about the methodology used to increase or decrease the level of reimbursement or for the provision of a bonus or other form of incentive-based compensation at contract execution, 30 days prior to a change, and upon request. (See “Clinically Integrated Organization” and “Patient Centered Medical Home Program.”)

Interest on Overdue Claims

§15-1005, §15-102.3, and §19-706 mandate that carriers—including HMOs and MCOs—have 30 days after receipt of a claim to either reimburse the physician, send a notice stating the reason for denial of the claim or request additional information as permitted under the clean claims regulation. If a notice of dispute is sent, the carrier must still pay any undisputed claims within 30 days from receipt of the claim. Otherwise, interest on the unpaid portion should be paid without request on a sliding scale of 1.5 percent to 2.5 percent, depending on the duration of the payment delay. Delay of reimbursement because of the need to determine eligibility for benefits, determine coverage, or to seek additional information from the insured or other third party is subject to interest payment. Interest is due from the date of receipt of an initial clean claim, regardless of whether the claim must be resubmitted due to a processing error on the part of the insurer. Interest is not payable on a claim subject to ERISA. Violations are subject to a \$500 fine per incident with higher penalties possible if violations occur with a frequency to indicate a general business practice. (See “Clean Claims.”)

***Editor’s Note:** Interest is not required on overdue claims for federal employees or claims paid by self-insured companies under ERISA protection when the insurer is acting as an administrative agent.*

Unfortunately, it is often difficult to ascertain the nature of the patient's coverage in this regard without calling the carrier.

In Vitro Fertilization

§15-810 and §19-706 require that carriers—including HMOs—cover in vitro fertilization under contracts issued or delivered in Maryland. Benefits for IVF must conform to benefits provided for other pregnancy-related procedures by insurers and to benefits provided for other infertility services by an HMO. The patient's oocytes must be fertilized by her husband's sperm and the couple's infertility must be either of two years' duration or longer, or be associated with endometriosis, damage to one or both fallopian tubes, DES exposure, endometriosis, or male factor. Coverage may be limited to three attempts per live birth, not to exceed a lifetime benefit of \$100,000. Religious organizations are exempt if IVF conflicts with the organization's beliefs or practices.

Maintenance Drugs

§15-824 and §19-706 require that carriers—including HMOs—cover up to a 90-day supply of maintenance drugs, defined as drugs anticipated to be required to treat a chronic condition for six months or longer. This stipulation does not apply to residents of nursing homes, to the first prescription, or to any change in prescription for a specific drug.

Mental Illness, Emotional Disorders, and Alcohol or Drug Abuse

§15-127 and §19-706 require carriers—including HMOs—that own or contract with a managed behavioral health care organization to distribute to their members a description of coverage and exclusions; the procedure for obtaining services, including out-of-network care; and the methodology used to reimburse behavioral health care providers. The carrier is also required to list its participating behavioral health providers in its provider directory. A carrier that owns or contracts with a behavioral health organization must submit a yearly report by March 1 to the MIA that reflects the actual amount spent by the carrier on the provision of behavioral health services and the amount spent on utilization management and quality assurance. The report must be available to the public upon request and payment of a specified preparation fee.

§15-802 and §19-703.1 prohibit discrimination against subscribers with these disorders. Benefits are required for treatment that in the professional judgment of practitioners is medically necessary. Benefits must be provided under the same terms and conditions as physical illness, with certain exceptions. Outpatient services are subject to certain minimum coverage requirements; visits for medication management must be counted as a visit for a physical illness. Outpatient psychological and neuropsychological testing for diagnostic purposes are also subject to certain minimum coverage requirements.

§15-840 requires that carriers—including HMOs—cover residential crisis services, as defined in the statute, for a child or adult experiencing or at risk of a psychiatric crisis.

***Editor's Note:** The federal Mental Health Parity and Addiction Equity Act of 2008 that took effect on January 1, 2010 requires that all employer-based insurance plans (including ERISA plans) that provide coverage for mental illness, emotional disorders and alcohol and drug abuse—and that cover more than 50 employees—must provide these benefits at the same level as benefits provided for physical illness. In addition, the administration and review of mental health and addiction coverage requests must be similar to that provided for physical illness. There is, however, no requirement for coverage of these services and an employer plan may be exempted from the comparable benefit level requirement if compliance increases the total cost of coverage by specified amounts. The federal law allows state laws that provide greater protections to take precedence. Beginning in 2014, small group and individual market plans purchased through state health exchanges will also have to comply with these requirements.*

Morbid Obesity

§15-837 and §19-706 require that carriers—including HMOs and MCOs—cover gastric bypass or other surgical methods for the treatment of morbid obesity, as defined by the statute.

Most Favored Nation Clause

§15-112 and §19-706 require that carriers—including HMOs—may not prohibit physicians, ambulatory surgical facilities or hospitals from providing services to the enrollees of another carrier at a lower rate of reimbursement, may not require that the carrier's reimbursement be the same that providers receive from another carrier if the reimbursement from the other carrier is lower, and may not require a provider to certify that the reimbursement rate being paid by the carrier is not higher than the reimbursement rate received from another carrier.

Non-Participating HMO Specialist Referral

§15-830 requires that HMOs implement a procedure under which a member may request a referral to a non-participating physician if the member's condition requires specialized care and the carrier does not have an available participating specialist with the training and experience to treat the condition without unreasonable delay or travel. HMOs must also provide for the referral to a non-participating non-physician specialist, defined as a licensed practitioner for a specified condition or disease, under similar circumstances. The patient's copayment or deductible is required to be the same as for in-network care. (See "Balance Billing of HMO and PPO Subscribers" and "Non-Participating HMO Physician Reimbursement.")

Non-Participating HMO Physician Reimbursement

§19-710.1 requires that HMO payment to non-participating physicians for an evaluation and management service be no less than the greater of 125 percent of the average rate the HMO paid as of January 1 of the previous calendar year to contracted physicians in the same geographic area for the same covered service or 140 percent of the rate paid by Medicare to a similarly licensed physician in the same geographic area on August 1, 2008—as inflated by the change in the Medicare Economic Index from 2008 to the current year. For a service that is not an evaluation and management service, non-participating physicians must be reimbursed no less than 125 percent of the average rate the HMO paid as of January 1 of the previous calendar year to contracted physicians in the same geographic area for the same covered service.

HMOs must reimburse non-participating trauma physicians for trauma care at a trauma center at the greater of 140 percent of Medicare or the rate the HMO paid a similar provider on January 1, 2001 for a similar service in a similar geographic area. The HMO may require the submission of medical records to reimburse the physician. An HMO may not require an authorization or referral for this care to be considered a covered service.

The HMO must, upon request by the non-participating provider, disclose the amount of payment. The physician may enforce these provisions by filing a complaint with the insurance commissioner or by filing a civil action in a court of competent jurisdiction. The HMO may obtain reimbursement from the enrollee for payments to non-participating physicians that the HMO determines to be the enrollee's responsibility. The Maryland Health Care Commission is required to review compliance with these payments annually and report its findings to the Maryland Insurance Administration, which, in turn, is empowered to investigate and enforce a violation of these payment requirements.

§15-112 prohibits carriers from considering a physician who provides services through a contracted participating group practice or health care facility to be a participating provider that is required to accept the contracted fee schedule when the physician is providing services to enrollees through a separate individual or group practice, using a different federal tax identification number, that is not contracted with the carrier.

***Editor's Note:** §19-710.1 contains the only legislative requirement for HMO payment to out-of-network physicians. There is no provision for review or approval of HMO payment rates by the Maryland Insurance Administration or any other outside entity. (See "Assignment of Benefits for Non-Participating*

PPO Physicians” for required payments by a PPO to out-of-network hospital-based or on-call physicians who elect to accept an assignment of benefits from the patient, “Balance Billing of HMO and PPO Subscribers” for limitations on balance billing HMO and PPO patients, “HMO/PPO Panel Application, Recredentialing and Termination” for payment requirements for non-participating physicians in group practices who are currently in the managed care credentialing process and “Non-Participating Specialist Referral.”)

The changes that took effect in January 2010 regarding HMO payment to non-participating, non-trauma, physicians as a result of legislation passed in 2009 are scheduled to sunset on December 31, 2014.

Nurse Midwives and Nurse Practitioners

§15-816 and §19-706 require that carriers—including HMOs—must allow a woman to receive medically necessary *routine* obstetric and gynecologic care from an in-network certified nurse midwife, or other in-network provider authorized to provide these services, without first visiting a primary care provider. Midwives and other non-physician providers must consult with an obstetrician/gynecologist with whom they have a collaborative agreement.

Obstetric and Gynecologic Care – Direct Access

§15-816 and §19-706 require that carriers—including HMOs—allow a woman to receive all medically necessary gynecologic care from an in-network obstetrician/gynecologist without first visiting a primary care provider. Following each visit for gynecologic care, the obstetrician/gynecologist should communicate with the woman’s primary care physician about any diagnosis or treatment rendered. The obstetrician/gynecologist should confer with the primary care physician before performing any diagnostic procedure that is not routine gynecologic care rendered during an annual visit. (See “Preventive Health Care Services” and “Standing Referrals to Obstetricians and Specialist Physicians.”)

Off-Label Drug Use

§15-804 and §19-706 prevent carriers—including HMOs—that provide drug coverage from denying drug coverage on the grounds that the FDA has not approved the drug for a particular indication, if the drug is recognized in specified standard reference compendia or in the medical literature for treatment of the indication.

Orthopedic Braces and Prosthetic Devices

§15-820 requires that nonprofit carriers—excluding HMOs—cover orthopedic braces

§15-844 and §19-706 require that carriers—including HMOs—cover prosthetic devices, defined as an artificial device to replace in whole or in part a leg, an arm, or an eye, and any components or repairs for these devices. Insurers may not require a copayment or coinsurance that is higher than that for covered primary care benefits nor impose an annual or lifetime maximum separate from any aggregate maximum for all covered benefits.

Osteoporosis Screening

§15-823 and §19-706 require that carriers—including HMOs—cover the cost of bone mass measurement performed for the prevention, diagnosis, and treatment of osteoporosis. Qualified individuals include (1) an estrogen-deficient woman at clinical risk for osteoporosis, (2) an individual with vertebral abnormalities, (3) an individual receiving long-term glucocorticoid therapy, (4) an individual with primary hyperparathyroidism, or (5) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Patient Centered Medical Home Program

§15-801 through §15-802 of the Insurance Article and §19-1A-01 through §19-1A-05 and §19-706 of the Health General Article create the Patient Centered Medical Home (PCMH) Program and codify the

PCMH as a primary care practice of family medicine physicians, internists, pediatricians or nurse practitioners that provides a first, coordinated, ongoing and comprehensive source of care to patients. Insurance carriers—including HMOs, but not group model HMOs—may elect to participate in the PCMH demonstration project. Companies with at least \$90 million in health benefit premiums—Aetna, CareFirst, CIGNA, Coventry and United Healthcare—and, subject to the state budget, Maryland Medicaid and Medicaid Managed Care Organizations (MCO) will be required to participate. The Maryland Community Health Resources Commission will consult with the Maryland Health Care Commission (MHCC) to assist federally qualified health centers in joining the PCMH program. The MHCC will establish regulations for the general PCMH program. In addition to the state-regulated PCMH, the MHCC may authorize an insurer to implement a separate single-carrier PCMH program that conforms to the principles of a PCMH, as adopted by a national coalition of physicians, carriers, purchasers and consumers. With patient authorization, medical information may be shared between the insurer, the PCMH practice and other consulting physicians. Carriers may pay a PCMH practice for coordination of services and provide bonuses, fee-based incentives, bundled incentives or other incentive-based compensation as authorized by the MHCC. The MHCC will create a patient enrollment form; adopt regulations to qualify a medical practice as a PCMH, using standards delineated by the legislation; establish the permissible general payment and incentive payment methodologies for medical practices and create a uniform set of quality and performance measures that practices must report to the MHCC and to carriers. Additionally, the MHCC will conduct culturally and linguistically appropriate educational activities for physicians and patients to increase awareness of the PCMH. An outside consultant must be retained by the MHCC to evaluate the effectiveness of the PCMH in reducing health care costs and improving outcomes and report back to the legislature by December 1, 2014. This legislation will sunset on December 31, 2015 unless extended by the General Assembly.

Physical Therapy

§19-705.4 requires that any limitation imposed by an HMO on the covered services of a licensed physical therapist be imposed per incident or per injury within a contract period.

Physician Contract Review

The legislature removed the previous requirement that the insurance commissioner review and approve the terms and provisions of contracts executed with hospitals, physicians, chiropractors, chiropractors, pharmacists, dentists, psychologists, or optometrists.

Physician Fee Schedule/Drug Formulary Updates

§15-113 requires that carriers—including HMOs—provide physicians with a written schedule of fees that includes up to the 50 most common services billed by a physician in that specialty. This schedule must be provided in writing at the time of contract execution, and in writing or electronically 30 days prior to a change or upon request of the physician. A carrier must also make its formulary available electronically. Physicians may submit a request for written versions of the fee schedule or formulary.

§19-115 requires that an entity creating a physician panel for a casualty or property insurer must provide a written payment schedule of the insurer for up to the 50 most common services billed by the specialty of the physician under the same conditions noted above

Physician Profiling

§19-710 requires that an HMO utilizing a practice profile to evaluate a physician's status on a provider panel disclose at the commencement and renewal of the contract, and not more often than annually upon the request of the provider, a description of the criteria used to compile the practice profile and the manner in which the profile is used to evaluate the physician. The information provided may not be used to create a cause of action. An HMO may not terminate a physician's contract or employment with the HMO on the basis of a practice profile without first informing the physician of the findings of the practice profile and the physician-specific data underlying those findings.

Physician Rating Systems

§15-1701 defines a physician rating system as a program that measures, rates or tiers the performance of physicians under contract with an insurer—including an HMO—and discloses this information to enrollees or the public. Health insurers may not use a physician rating system unless a ratings examiner that is under contract with and paid by the carrier approves it. The rating system must be approved by the ratings examiner as of January 1, 2010 and maintain its approval despite any revisions.

§19-143 requires the Maryland Health Care Commission to approve entities that will serve as independent rating examiners to review physician rating systems and require that they meet certain criteria as outlined below. However, an entity that has a physician performance rating certification program approved after August 1, 2008 by a national consortium of employer, consumer and labor organizations working to ensure access to publicly-reported health care performance information is deemed to be a ratings examiner and to meet the requirements for establishing a rating system.

The rating system must only use quality of performance and cost efficiency as measurement categories, must separately calculate and report these measures and must disclose to physicians and patients the proportion of each component score in a combined rating. Quality of performance measures must be based on nationally recognized, evidence-based or consensus-based recommendations or guidelines or, when available, guidelines endorsed by entities whose work in physician performance quality is generally accepted. The quality rating system must include appropriate risk adjustments for the physician's patient population and disclose to physicians the basis for the carrier's ratings, the measurements and their relative weight for each criterion used, and the data used to determine these ratings—including a determination of whether a sufficient number of patients and episodes of care exist to create a reliable rating. Cost efficiency ratings must compare physicians within the same specialty in an appropriate geographic market and use appropriate episode-of-care software for evaluation. There must be a process for physicians to appeal the rating received and for any necessary corrections to the data used to rate the physician.

§15-704 requires that an insurer notify the insurance commissioner of the results of any final review of its physician rating system conducted by the ratings examiner. The commissioner may order the carrier to correct any deficiency or to discontinue use of the rating system. The carrier must report annually to the insurance commissioner on the number of appeals and the outcome of the appeals.

§15-1703 requires that insurers prominently post information on their Web site that discloses where an enrollee can find the physician performance ratings of the carrier, the basis for measurement of physician performance and the basis for the lack of a performance measure due to insufficient data or a pending appeal. The information must include the criteria used in the rating system, any limitations of the data used and the mechanism for physicians to appeal their rating. There must be a disclosure that physician performance ratings are only a guide to choosing a physician and should not be the sole basis for selecting a physician because the ratings have a risk of error.

At least 45 days before providing enrollees with any new or revised quality or cost-efficiency information or revised inclusions or exclusions from the rating system, carriers must provide a notice to physicians of any proposed changes in their ratings. This notice must include an explanation of the data and methodology used to determine the rating, information on how physicians may access the data, and instructions on how to file a timely appeal to contest the rating. Carriers may not disclose any ratings until a decision is made following the investigation of an appeal.

Physician Reimbursement Disclosure by Insurers

§19-706 requires that insurers disclose in their member enrollment materials, in layman's terms, the reimbursement methodology that the carrier uses for physicians, together with a uniform definition of each reimbursement methodology as developed by the Maryland Health Care Commission. The carrier must also disclose the distribution of the premium dollar in the form of a pie chart or bar graph to include provider payments for medical care expenses and administrative costs.

Point-of-Service Plan

§19-710.2 states that when the health coverage offered to employees is only through an HMO, a point-of-service (POS) option must be offered, which the employee may accept or reject. A POS plan is defined as a health benefit plan that permits an HMO member to receive any health care service that is covered by the member's contract with the HMO outside of the provider panel of the HMO.

Preventive Health Care Services

Effective for all insurance policies issued or renewed on or after October 1, 2010, but no later than October 1, 2011, §15-134 and §19-706 will require all carriers—including HMOs—that cover an annual preventive examination—including an annual child-wellness examination, a routine gynecologic visit, an annual vision visit that includes a vision test and screening for chlamydia, HPV, colorectal cancer, prostate cancer or breast cancer—to provide such coverage once per plan year. The statute, however, does not include any requirement for the coverage of these preventive services.

Except for grandfathered health plans in effect on March 23, 2010, the Preventive Services Mandate included in the federal Patient Protection and Affordable Care Act signed into law in March 2010 will require that all health plans—including ERISA plans—provide coverage without any cost sharing for (1) services that are rated “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF); (2) immunizations recommended by the Center for Disease Control and Prevention's Advisory Committee on Immunization Practices; (3) preventive care and screenings for infants, children and adolescents supported by the federal Health Resources and Services Administration (HRSA) and (4) preventive care and screenings for women supported by the HRSA.

Editor's Note: Because the current and quite controversial USPSTF guidelines released in November 2009 state that routine mammogram screening for women should not begin until age 50 and recommend mammogram screening only every two years for women between the ages of 50 and 64, Congress added a provision that the bill should not be construed to prohibit a plan from providing coverage for services in addition to those recommended by the USPSTF or to deny coverage for services that are not recommended by the task force.

Prostate Cancer Screening

§15-825 and §19-706 require that carriers—including HMOs—provide coverage for digital rectal examination and prostate-specific antigen (PSA) testing for men between the ages of 40 and 75 under the following conditions: when used for patient management in monitoring the response to prostate cancer treatment, when used for staging to determine the need for a bone scan in patients with prostate cancer, or when used for male patients who are at high risk for prostate cancer. (See “Preventive Health Care Services.”)

Retrospective Denial of Authorization

§15-303 and §19-706 require that any group insurance policy—including HMO policies—contain a provision requiring the employer, union, or association to continue to pay the insurance premium until the insurer receives a notice of termination.

§15-10B-07 states that a private review agent may not retrospectively render an adverse decision on a preauthorized course of treatment unless the information provided to the private review agent was incomplete, fraudulent or intentionally misleading, or the approved course of treatment was not substantially followed by the provider. Once a preauthorization has been issued, the criteria or standards may not be modified.

§15-1009 prohibits carriers—including HMOs—from denying reimbursement for a previously authorized procedure for similar reasons. In order for the carrier to claim that the member was not covered on the day of the procedure, the carrier must maintain an automated eligibility verification service, available to the provider by telephone or the Internet, confirming that the carrier did not cover the patient.

***Editor's Note:** Insurers may deny payment for a preauthorized procedure if the member was not covered on the day of service unless they fail to provide an automated verification service or the service did not confirm cancellation of coverage. It is the provider's responsibility to verify coverage and document the findings on that day.*

Retroactive Denial of Claim Reimbursement

§15-1008 and §19-706 prohibit carriers—including HMOs and MCOs—from retroactively denying a claim or collecting, by any method, monies paid to the physician after six months from the date of payment. For claims denied within the six-month period, a written statement must provide the basis for the denial. If the payment was the responsibility of another insurer, the carrier has up to 18 months to deny reimbursement and must provide the name and address of the insurer acknowledging responsibility for payment of the denied claim. The provider will then have up to six months to resubmit the claim to the responsible carrier.

These provisions do not apply to duplicate claims or if the original claim information submitted to the carrier was fraudulent or improperly coded. "Improper coding" is defined as the use of a code that does not conform to the coding guidelines used by the carrier or the contractual obligations of the physician to the carrier on the date of service. The carrier must provide the coding guidelines at least 30 days prior to the date of service. These provisions also do 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. For MCOs, the provisions do not apply to services provided to a Medicaid enrollee during a time for which the Medical Assistance Program permanently retracted the capitation payment for the enrollee from the MCO. (See "Clean Claims" and "Coding Guidelines.")

Sexually Transmitted Disease Screening - Chlamydia and HPV

§15-829 and §19-706 require that carriers—including HMOs—provide coverage for an annual routine chlamydia screening test for (1) sexually active women under the age of 20 years; (2) women who are 20 years or older who have a prior history of an STD or cervical ectopy, are exposed to new or multiple sex partners, or use barrier contraception inconsistently; and (3) men who have multiple risk factors. Carriers—including HMOs—must provide coverage for human papilloma virus (HPV) screening according to the cervical cytology screening guidelines of the American College of Obstetrics and Gynecology. (See "Preventive Health Care Services.")

Smoking Cessation

§15-841 and §19-706 require that carriers, including HMOs, that provide coverage for prescription drugs must cover prescription drugs approved by the FDA to aid in smoking cessation and two 90-day courses of nicotine replacement therapy during each policy year.

Standing Referrals to Obstetricians and Specialist Physicians

§15-830 requires that carriers—including HMOs—allow primary care physicians to issue a standing referral to a participating specialist for conditions that are life threatening, degenerative, chronic or disabling. There cannot be a requirement that the patient see a physician in addition to the PCP prior to issuance of the standing referral. A pregnant woman must receive a standing referral to an obstetrician who then becomes responsible for the primary management of the woman, including the issuance of referrals, through the postpartum period.

Subrogation Provisions in HMO Member Contracts

§19-713.1 prohibits an HMO from recovering any payments made to a member under a personal injury protection policy. HMOs, however, may otherwise recover payments for the medical expenses of a member if the member receives payments for those same medical expenses under a cause of action. Effective with all policies issued or renewed on or after October 1, 2010, the term "personal injury protection policy" is changed to "personal injury protection coverage of a motor vehicle liability

insurance policy.” Further, a contract between an HMO and its subscribers may not contain a provision that requires personal injury protection benefits under a motor vehicle liability insurance policy to be paid before benefits under the contract.

Uniform Credentialing Form

§15-112.1 requires that carriers—including HMOs, MCOs, and their credentialing intermediaries — use a uniform credentialing form for their provider panels, as developed by the Maryland Insurance Administration (MIA). The MIA may designate a form developed by a nonprofit alliance of health plans and trade associations for an online credentialing system— i.e., the Council for Affordable Quality Healthcare (CAQH)—as the uniform credentialing form. This application must be available at no charge and its use may not be conditioned on submitting the application to a carrier through the online credentialing system.

Hospitals or academic medical centers that participate on the carrier’s provider panel and act as credentialing intermediaries for physicians that have privileges at the hospital or academic center are exempt from this requirement. (See “HMO/PPO Panel Application, Recredentialing and Termination.”)

Uniform Referral Forms

§15-119 and §19-713.4 require that carriers—including HMOs—utilize the uniform consultation referral form adopted by the Maryland Insurance Administration (MIA) without modification or the requirement to submit additional referral forms. The uniform consultation referral form may be transmitted electronically.

Utilization Review

§15-10B-01 through §15-10B-19 legislate the conduct of private review agents—including HMOs—that perform utilization review in Maryland. Prior to performing any utilization review services, private review agents must submit an application delineating their policies and procedures to become certified by the Maryland Insurance Administration. All criteria and standards must be objective, clinically valid, compatible with established principles of health care, and sufficiently flexible to allow deviation from norms when justified on a case-by-case basis. New or changed criteria must be sent to the insurance commissioner at least 10 days prior to implementation. One copy of the standards and criteria must be provided on the written request of any person or health care facility upon payment of a reasonable fee. (The insurance commissioner has issued a bulletin prohibiting a private review agent from considering any internally developed criteria to be proprietary and refusing to disclose on that basis.) A representative of the private review agent must be available to patients and providers 24 hours per day and seven days per week.

All determinations on whether to authorize a non-emergency course of treatment must be made within two working days and all determinations on whether to authorize an extended stay in a health care facility or additional health care services must be made within one working day of receipt of the necessary information. The review agent must make requests for additional information within three calendar days. If the attending physician requires immediate reconsideration, a determination must be available by telephone on an expedited basis, not to exceed 24 hours from the request for reconsideration.

An involuntary or voluntary inpatient admission for a patient judged to be in imminent danger to self or to others by the patient’s physician or psychologist, in conjunction with a member of the medical staff of the hospital, may not be denied during the initial 24 hours that the patient is in an inpatient facility. Uniform treatment plan forms for utilization review of services for mental illness, emotional disorders or substance abuse must be used and may only require the member’s policy number and first name to protect the member’s confidentiality, unless used solely for internal purposes. Private review agents must also accept the treatment plan form mandated by another state if the service was performed in that state.

All adverse decisions must be rendered by a physician or a panel of health care providers with at least one physician member who is board-certified or board-eligible in the same specialty as the treatment under review. All adverse decisions for the treatment of alcoholism, drug abuse, or mental illness must be made

by a physician or a panel with at least one physician member who is either board-certified or eligible in the same specialty as the treatment under review, actively practicing, or has a demonstrated expertise in the area under review. The physician may not be compensated by the review agent in a manner that provides a financial incentive, either directly or indirectly, to deny or reduce coverage. All carriers and private review agents must have an internal grievance process as stipulated in §15-10A-02 through §15-10A-05. (See “Appeal and Grievance of Adverse Decisions Regarding Medical Necessity,” “Appeal and Grievance of Adverse Decisions Regarding Coverage Issues,” and “Retroactive Denial of Authorization.”)

Editor’s Note: *On November 20, 2000, the Department of Labor issued final regulations altering the manner and time frames in which ERISA plans must respond to both the initial request for preauthorization and the appeal of any subsequent denial of preauthorization or claim payment, effective for all submissions on or after January 1, 2002. Under the regulations, plans must respond to an initial request and any subsequent appeal of a denial of service for urgent care, as determined by the treating physician, within 72 hours. For “pre-service claims,” defined as situations in which a plan requires the advance approval of a service, a decision on an initial request must be made within 15 days and a decision on the appeal of any denied service must be made within 30 days. For “post-service claims,” defined as claims that are not pre-service claims, a decision on an initial submission must be made within 30 days and a decision on the appeal of any denied claim must be made within 60 days. Plans are allowed a one-time extension of 15 days on initial decisions for pre-service and post-service claims. Plan enrollees will have 180 days to file an appeal, up from the previous 90-day limit. Appeals must be decided by someone other than the person who issued the initial denial and outside physicians must be consulted. The entire regulation was published in the Federal Register Vol. 65. , No. 225, on November 21, 2000 and may be accessed through the Web site of the Employee Benefits Security Administration, designated previously.*

Withholds

§15-113 requires that a carrier not reimburse a provider in an amount less than the sum or rate negotiated in the carrier’s contract with the provider. This stipulation does not prohibit a carrier from providing bonuses or other incentive-based compensation to a provider if the bonus or other incentive-based compensation does not violate the quality standards required of HMOs or deter the delivery of medically appropriate care to an enrollee. (See “Incentive-Based Physician Compensation.”)

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