

Private Review Agent Application for Certification

PRA NAME:
DATE OF SUBMISSION:

The items listed below may paraphrase the law or regulation. **The checklist is not required to be filed with the application.** It should be used as a guide in determining which laws and regulations apply to the application. Unless otherwise specified, all section references are to the Insurance Article of the Annotated Code of Maryland

A. Application Submission Requirements

	Citation	Description	"X" Means Applicable	Document/ Page
A1.	§15-10B-04 COMAR 31.10.21.02C(11)	Application fee-\$1,500.00		
A2.	§15-10B-05(a)(11) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	Signed Criteria Certification page		
A3.		Ownership Disclosure including list of names, titles, and addresses of the officers and directors, where applicable		

B. Scope of utilization review being requested in this State (Application items 5 through 16)

	Citation	Description	"X" Means Applicable	Document/ Page
B1.	§15-10B-05(a)(8)	<p>List of:</p> <ul style="list-style-type: none"> • Insurers, nonprofit health service plans, health maintenance organizations, and dental plan organizations • Third party payers • Third party administrators for which PRA performs utilization review. <p>Include names, addresses, contract commencement date, and term of the contract</p>		

B2.	§15-10B-05(a)(1)(ii)	If applicable, description of the circumstances under which utilization review has been delegated to a hospital utilization review program.		
B3.		List of entities, including external review organizations, to which PRA has delegated utilization review decisions. <ul style="list-style-type: none"> • Include names and addresses 		
B4.	§15-10B-05(a)(3) COMAR 31.10.21.02C(1)(a)(i)(ii)	List of insurers, nonprofit health service plans, health maintenance organizations, and dental plan organizations for which PRA has been delegated the internal grievance process <ul style="list-style-type: none"> • Include names, addresses, contract commencement date, and term of the contract 		

C. Utilization Review Criteria – §15-10B-05(a)(1) (Application Item 17)

	Citation	Description	"X" Means Applicable	Document/ Page
C1.	§15-10B-05(a)(1) COMAR 31.10.21.02C(b)	Specific Criteria and Standards <ol style="list-style-type: none"> 1. If nationally recognized: <ul style="list-style-type: none"> a. List of interpretive guidelines that include title, author, publisher, and publication date b. Frequency in which criteria updated and evaluated for appropriateness 2. If Internally developed: <ul style="list-style-type: none"> a. Copies of criteria with interpretive guidelines and table of contents b. Dates criteria developed 		
	§15-10B-05(a)(10) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	c. List of providers/health care professionals who were consulted to develop/update the criteria, and their credentials, including each person's board certification or practice specialty, licensure category and title within the person's organization.		
		d. List of written resources used to develop, evaluate, and update the criteria.		

C2.	§15-10B-05(b) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025) House Bill 848, Chpt 669, Acts of 2025 (effective 6/1/2025)	Link to the member's and provider's pages of PRA's or carrier's website where criteria is posted.		
C3.	COMAR 31.10.33	If performing utilization review for patients covered under health insurance/nonprofit/HMO contracts subject to § 15-839 of the Insurance Article, criteria for the review of surgical treatment of morbid obesity.		
C4.	COMAR 31.10.39	If performing utilization review for patients covered under <u>insured</u> health benefit plans covering Maryland residents that include benefits for habilitative services, criteria and process for the utilization review of treatment for autism and autism spectrum disorders.		
C5.	§15-802(d)(5)	If performing utilization review for patients covered under health insurance/nonprofit/HMO contracts subject to § 15-802 of the Insurance Article, must use the most recent edition of the American Society of Addiction Medicine treatment criteria for addictive, substance-related, and co-occurring conditions ("ASAM criteria") for all medical necessity and utilization management determinations for substance use disorder benefits.		
C6.	§15-142(c) §15-142(e)	If performing pharmacy utilization review for patients covered under insurance/nonprofit/HMO contracts subject to § 15-142 of the Insurance Article, step therapy or fail first protocols may not be imposed if certain criteria are satisfied.		

D. Time frames – Determinations to authorize or certify – §15-10B-06 (Application item 18)

	Citation	Description	"X" Means Applicable	Document/ Page
D1.	§15-10B-06(a)(1)(i) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	A nonemergency course of treatment or health care service, including pharmaceutical services not submitted electronically – within 2 working days after receipt of information necessary to make the determination.		
D2.	§15-10B-06(a)(1)(ii) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	An extended stay or additional health care services (concurrent review) – within 1 working day after receipt of information necessary to make the determination.		
D3.	§15-10B-06(a)(1)(iii) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	A request for additional visits or days of care submitted as part of an existing course of treatment or treatment plan within 1 working day after receipt of the information necessary to make the determination.		
D4.	§15-10B-06(a)(1)(iv) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	Health care provider must be promptly notified of the determination.		
D5.	§15-10B-06(b)(1) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	If prior authorization required for an emergency inpatient or residential crisis admission for treatment of mental health or substance use disorder: a. Determination must be made within 2 hours after receipt of the information necessary to make the determination.		
	§15-10B-06(b)(2) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	b. If additional information is needed, promptly request the specific information needed, including any lab or diagnostic test or other medical information, and		
	§15-10B-06(b)(3) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	c. Promptly notify the health care provider of the determination		

D6.	§15-10B-06(a)(2) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	<p>After receipt of the request for authorization of health care services, and confirming through a complete review of information already submitted by the health care provider, if the PRA does not have sufficient information to make the determination, the PRA must, within 3 calendar days after receipt of the initial request, inform the provider that additional information must be provided by specifying:</p> <ul style="list-style-type: none"> • The information, including any lab or diagnostic test or other medical information, that must be submitted to complete the request; and • The criteria and standards to support the need for additional information. 		
D7.	§15-10B-06(c)(1) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	<p>Step therapy exception request determinations must be made in real time if no additional information is needed to process the request and the request meets the criteria for approval. Otherwise, determinations must be made within 1 working day after receipt of all necessary information.</p>		
	§15-10B-06(c)(2) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	<p>If additional information is needed to make a determination after confirming through a complete review of the information already submitted by the health care provider, the private review agent shall request the information promptly, but not later than 3 calendar days after receipt of the initial request, by specifying:</p> <ul style="list-style-type: none"> • The information, including any lab or diagnostic test or other medical information, that must be submitted to complete the request; and • The criteria and standards to support the need for the additional information. 		
D8.	§15-10B-06(d)(1)(i) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	Except as provided in E1 and E2, initial determinations on whether to authorize or certify an emergency course of treatment or healthcare services must be made within 24 hours after the initial request after receipt of the information necessary to make the determination.		

D9.	§15-10B-06(d)(1)(ii) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	<p>If, after confirming through a complete review of the information already submitted by the health care provider, additional information is needed, the private review agent shall:</p> <ul style="list-style-type: none"> • Promptly request the specific information needed, including any lab or diagnostic test or other medical information; and • Promptly, but not later than 2 hours after receipt of the information, notify the health care provider of the determination. 		
D10.	§15-10B-06(d)(2) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	A private review agent shall initiate a review of an emergency case at the request of the patient, patient's representative or provider, if emergency complies with §15-10A-02(b)(3).		
D11.	§15-10B-06(e) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	If a private review agent fails to make a determination within the time limits required, the request shall be deemed approved.		
D12.	§15-10B-05(e)(1)(ii) House Bill 848, Chpt 669, Acts of 2025 (effective 10/1/2025)	Except where a shorter time period is otherwise required, a private review agent must respond to a voice mail or email within 2 business days after receipt of the voicemail or email.		

E. Prohibited Adverse Decisions (Application item 18)

	Citation	Description	"X" Means Applicable	Document/ Page
E1.	§15-10B-06(g) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	<p>For emergency inpatient admissions, a private review agent may not render an adverse decision solely because the hospital did not notify the private review agent of the emergency admission within 24 hours or other prescribed period of time after that admission if the patient's medical condition prevented the hospital from determining:</p> <ol style="list-style-type: none"> (1) The patient's insurance status; and (2) If applicable, the private review agent's emergency admission notification requirements 		

E2.	<p>§15-10B-06(h)(1) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)</p>	<p>A private review agent may not render an adverse decision as to an admission of a patient during the first 24 hours after admission when:</p> <ul style="list-style-type: none"> i. The admission is based on a determination that the patient is in imminent danger to self or others; ii. The determination has been made by the patient's physician or psychologist in conjunction with a member of the medical staff of the facility who has privileges to make the admission; and iii. The hospital immediately notifies the private review agent of: <ol style="list-style-type: none"> 1. The admission of the patient; and 2. The reasons for the admission 		
E3.	<p>§15-10B-06(h)(2) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)</p>	<p>A private review agent may not render an adverse decision as to an admission of a patient to a hospital for up to 72 hours, as determined to be medically necessary by the patient's treating physician, when:</p> <ul style="list-style-type: none"> i. The admission is an involuntary admission under §§ 10-615 and 10-617(a) of the Health - General Article; and ii. The hospital immediately notifies the private review agent of: <ol style="list-style-type: none"> 1. The admission of the patient; and 2. The reasons for the admission 		

E4.	§15-10B-07(d)	<p>A private review agent may not retrospectively render an adverse decision regarding preauthorized or approved services delivered to a patient unless:</p> <ol style="list-style-type: none"> <li data-bbox="589 270 1090 439">(1) The information submitted to the private review agent regarding the services to be delivered to the patient was fraudulent or intentionally misrepresentative; <li data-bbox="589 439 1090 692">(2) Critical information requested by the private review agent regarding services to be delivered to the patient was omitted such that the private review agent's determination would have been different had the agent known the critical information; or <li data-bbox="589 692 1090 868">(3) The planned course of treatment for the patient that was approved by the private review agent was not substantially followed by the provider 		
E5.	§15-10B-07(e)	<p>If a course of treatment has been preauthorized or approved for a patient, a private review agent may not revise or modify the specific criteria or standards used for the utilization review to make an adverse decision regarding the services delivered to that patient.</p>		
E6.	§15-854	<p>If performing prior authorization for prescription drugs for patients covered under insurance/nonprofit/HMO contracts:</p>		
	§15-854(b)(1)(ii)	<p>a. For a chronic condition, may not request a reauthorization for a repeat prescription for 1 year or for the standard course of treatment, whichever is less</p>		
	§15-854(b)(2)	<p>b. For a prior authorization that is filed electronically, the PRA must maintain a database that will prepopulate prior authorization requests with an insured's available insurance and demographic information.</p>		

	§15-854(c)(1) and (2)	c. The PRA shall honor a prior authorization granted to an insured from a previous entity for at least the lesser of 90 days or the length of the course of treatment. A PRA may perform its own review to grant a prior authorization for the prescription drug.		
	§15-854(d)	d. The PRA must honor a prior authorization issued by the PRA for a prescription drug and may not require a health care provider to submit a request for another prior authorization for that drug in certain situations.		
	§15-854(f)	e. The PRA may not require more than one prior authorization of two or more tablets of different dosage strengths of the same prescription drug as prescribed at the same time as part of an insured's treatment plan and manufactured by the same manufacturer. A PRA is allowed to require more than one prior authorization for two or more tablets of different dosage strengths of an opioid that is not an opioid partial agonist.		

F. Forms Used to Conduct Utilization Review (Application item 19)

	Citation	Description	"X" Means Applicable	Document/ Page
F1.	COMAR 31.10.21.02C (1)(c)	Copies of forms that are completed during the utilization review process. If PRA performs on-line reviews, printed copies of computer screen shots should be submitted.		

F2.	<p>§15-10B-06(i)(1)(i) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025) COMAR 31.10.21.02-1</p>	<p>If the PRA requires a health care provider to submit a treatment plan in order to conduct utilization review of proposed or delivered services for the treatment of a mental illness, emotional disorder, or a substance abuse disorder, the PRA shall accept:</p> <ul style="list-style-type: none"> • The uniform treatment plan (UTP) form adopted under §15-10B-03(d); or • If a service was provided in another state, a treatment plan form mandated by the state in which the service was provided. 		
	<p>§15-10B-06(i)(1)(ii) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025) COMAR 31.10.21.02-1C and E</p>	<p>a. The PRA may not modify the UTP form, or require the provider to modify the UTP form or submit additional treatment plan forms.</p>		
	<p>§15-10B-06(i)(2)(ii) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025) COMAR 31.10.21.02-1G</p>	<p>b. The PRA must allow the UTP form to be submitted electronically.</p>		
	<p>COMAR 31.10.21.02-1I</p>	<p>c. If telephonic reviews are performed, the PRA may not require the provider to provide any information not requested on the UTP form.</p>		

G. Adverse Decision Process (Application items 20, 21, and 22)

	Citation	Description	"X" Means Applicable	Document/Page
G1.		<p>Names and qualifications (job description or CV) of persons making adverse decisions for the following services (where applicable):</p>		
	<p>§15-10B-07(a)(1) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)</p>	<p>Medical/surgical services must be made by a licensed physician, or a panel with at least one physician on the panel, who is:</p> <ol style="list-style-type: none"> a. Board certified or eligible in the same specialty as the treatment under review; and b. Knowledgeable about the requested health care service or treatment through actual clinical experience. 		

	§15-10B-07(a)(2)	<p>Mental health and substance abuse services must be made by a licensed physician, or a panel with at least one physician on the panel who is:</p> <ol style="list-style-type: none"> Board certified or eligible in the same specialty as the treatment under review; and Actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review. 		
	§15-10B-07(a)(3)	Dental services must be made by a licensed dentist or have one licensed dentist on the panel who is knowledgeable about the requested healthcare service or treatment through actual clinical experience.		
G2.	§15-10B-07(b)	Adverse decision-makers shall not be compensated by the PRA in a manner that violates §19-705.1 of the Health-General Article or that deters the delivery of medically appropriate care.		
G3.	§15-10B-06(f)(1), Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	<p>Reconsideration:</p> <ol style="list-style-type: none"> If an initial determination is made by a private review agent not to authorize or certify a health care service and the health care provider believes the determination warrants an immediate reconsideration, a private review agent shall provide the health care provider the opportunity to speak with the physician that rendered the determination, by telephone on an expedited basis, within a period of time not to exceed 24 hours of the health care provider seeking the reconsideration. The discussion, determination, and verbal notice of the determination must take place within 24 hours of the ordering provider's request for the reconsideration. 		

	§15-10B-06(f)(2) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	<p>b. If the physician is unable to immediately speak with the health care provider seeking the reconsideration, the physician shall provide the health care provider with:</p> <ul style="list-style-type: none"> • A direct telephone number that is not the general customer call number; or • A monitored e-mail address that is dedicated to communication related to utilization review. 		
G4.		Notice of adverse decision ¹ :		
	§15-10A-02(f)(1)(i) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	a. Inform member, member's representative, or the health care provider of the adverse decision either orally, or with the affirmative consent of the member, member's representative or the health care provider, by text, facsimile, e-mail, online portal or other expedited means.		
	§15-10A-02(f)(1)(ii) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	b. Nonemergency case-written notice of the adverse decision sent within 5 working days after the decision was made to the member, the member's representative, and a health care provider acting on behalf of the member.		
	§15-10A-02(j)(1)	c. Emergency case-written notice of the adverse decision sent within 1 day after the decision has been orally communicated to the member, the member's representative, or a health care provider acting on behalf of the member.		

¹ Title 15, Subtitle 10A of the Insurance Article is applicable when the PRA has been delegated the internal grievance process by a carrier and only to adverse decisions for patients covered under insured health benefit plans that are delivered or issued in Maryland.

G5.	<p>§15-10A-02(f)(1)(ii)(1), (2) and (3) House Bill 848, Chpt 669, Acts of 2025 (effective 10/1/2025)</p>	<p>Content of written notice of adverse decision¹:</p> <ul style="list-style-type: none"> • Must include sample adverse decision letter <p>a. At top of letter in prominent bold print:</p> <ul style="list-style-type: none"> • The notice is a denial of a requested health care service • The member may file an appeal • The phone number and email address as required under §15-10B-05(e) • Additional information on how to file and receive assistance for filing a complaint (see disclosure in COMAR 31.10.18.04). <p>b. The specific factual bases for the decision and the reasoning used to determine that the health care service is not medically necessary and did not meet the criteria and standards used in conducting the utilization review, in detail in clear, understandable language</p> <p>c. Provides the specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines, on which the decision was based. May not solely use:</p> <ul style="list-style-type: none"> • Generalized terms such as “experimental procedure not covered,” “cosmetic procedure not covered,” “service included under another procedure,” or “not medically necessary.” OR • Language directing the member to review the additional coverage criteria in the member’s policy or plan documents. 		
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<p>§15-10A-02(f)(1)(ii)(4) HB848, Chpt 669, Acts of 2025 (effective 10/1/2025)</p>	<p>d. A unique identifier, business address, and business telephone number of:</p> <ul style="list-style-type: none"> • The medical director or associate medical director who made the decision if the PRA has been delegated the adverse decision process by a Maryland HMO; or • The designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process and the physician who is required to make all adverse decisions if the PRA has been delegated the adverse decision process by a carrier that is not an HMO. 		
<p>§15-10A-02(f)(1)(ii)(5) HB848, Chpt 669, Acts of 2025 (effective 10/1/2025) §15-10A-02(d)(1)(i)</p>	<p>e. Written details of the internal grievance process, including a statement that a complaint may be filed with the Commissioner without first filing a grievance with a carrier and receiving a final decision on the grievance if:</p> <ol style="list-style-type: none"> 1. The carrier waives the requirement that the carrier's internal grievance process be exhausted before filing a complaint with the Commissioner; or 2. The carrier has failed to comply with any internal grievance process requirements. 		
<p>§15-10A-02(f)(1)(ii)(6) HB848, Chpt 669, Acts of 2025 (effective 10/1/2025)</p>	<p>f. A statement that:</p> <ul style="list-style-type: none"> • The member, the member's representative, or a health care provider on behalf of the member has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's grievance decision • Includes the Commissioner's address, telephone number, and facsimile number 		
<p>COMAR 31.10.18.04</p>	<ul style="list-style-type: none"> • The disclosure required in at least 12-point typeface, with the first sentence in bold capital typeface. The disclosure should be revised as follows to conform to the amended definition of "compelling reason" in COMAR 31.10.18.11: 		

"THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES. You may contact the Health Advocacy Unit of Maryland's Consumer Protection Division at (phone number, address, fax, e-mail).

The Health Advocacy Unit can help you, your representative, and your health care provider prepare a grievance to file under the carrier's internal grievance procedure. That unit can also attempt to mediate a resolution to your dispute. The Health Advocacy Unit is not available to represent or accompany you during any proceeding of the internal grievance process.

Additionally, you, your representative, or your health care provider may file a complaint with the Maryland Insurance Administration, without having to first file a grievance with the plan, if:

- (1) The plan has denied authorization for a health care service not yet provided to you; and
- (2) You, your representative, or your provider can show a compelling reason to file a complaint, including that a delay in receiving the health care service could result in loss of life, serious impairment to a bodily function, or serious dysfunction of a bodily organ or part, or the member remaining seriously mentally ill or using intoxicating substances with symptoms that cause the member to be in danger to self or others, or the member continuing to experience severe withdrawal symptoms.

INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO BE FOUND IN (cite policy, plan, certificate, enrollment materials, or other evidence of coverage)."

G6.	§15-10A-02(f)(2) House Bill 848, Acts of 2025 (effective 10/1/2025)	The business telephone number included in the notice required by §15-10A-02(f)(1)(ii)4 must be a dedicated number for adverse decisions and may not be the general customer call number for the carrier.		
G7.	§15-10A-10	Notice must be sent in a culturally and linguistically appropriate manner as described in the federal Affordable Care Act.		

H. Internal Grievance Process² (Application item 23)

	Citation	Description	"X" Means Applicable	Document/ Page
H1.		Names and qualifications (job description or CV) of persons making adverse decisions for the following services (where applicable):		
	§15-10B-09.1(1) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	Medical/surgical services must be made by a licensed physician, or a panel with at least one physician on the panel, who is: a. Board certified or eligible in the same specialty as the treatment under review; and b. Knowledgeable about the requested health care service or treatment through actual clinical experience.		
	§15-10B-09.1(2) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	Dental services must be made by a licensed dentist or have one licensed dentist on the panel who is: a. Board certified or eligible in the same specialty as the treatment under review; and b. Knowledgeable about the requested health care service or treatment through actual clinical experience.		

² Title 15, Subtitle 10A of the Insurance Article is applicable when the PRA has been delegated the internal grievance process by a carrier and only to grievance decisions for patients covered under insured health benefit plans that are delivered or issued in Maryland.

	§15-10B-09.1(3) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	Mental health and substance abuse services must be made by a licensed physician, or a panel with at least one physician on the panel who is: a. Board certified or eligible in the same specialty as the treatment under review; and b. Actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review		
H2.	§15-10A-01(b)(1), (2) and (3) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	Definition of adverse decision		
H3.	§15-10A-01(k) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	Definition of health care services		
H4.	§15-10A-02(b)(2)(iii)	Must allow a member's representative or a health care provider to file a grievance on behalf of a member		
H5.	§15-10A-02(b)(2)(v)	For retrospective denials, must allow at least 180 days after receipt of adverse decision to file a grievance		
H6.		Information Regarding Emergency Case Grievances		
	COMAR 31.10.18.07B(1)	a. Who will make the determination whether an emergency case exists		
	COMAR 31.10.18.07B(2)	b. How the determination will be made about the existence of an emergency case		
	COMAR 31.10.18.07B(3) §15-10A-02(g) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	c. How the member, member's representative or health care provider will be notified if the carrier does not have sufficient information to complete its internal grievance process		

	COMAR 31.10.18.07B(3)	d. How the PRA will notify the member, member's representative or health care provider that the PRA will provide assistance in gathering necessary information without further delay in cases where the PRA maintains that insufficient information has been submitted (for emergencies—5 days as allowed by §15-10A-02(g) is not sufficient for emergency cases)		
	COMAR 31.10.18.07B(4)	e. How the notice will be communicated to the member, member's representative, and health care provider		
H7.		Timing of grievance decision:		
	§15-10A-02(b)(2)(i)	a. Emergency case-24 hours of the date a grievance is filed		
	§§15-10A-02(b)(2)(ii), 15-10A-02(h)	b. Nonemergency case prospective denial-30 working days after the filing date. The PRA may have an extension not to exceed 30 working days with the member's, member's representative's or health care provider's written approval		
	§§15-10A-02(b)(2)(iv), 15-10A-02(h)	c. Nonemergency case retrospective denial-45 working days after the filing date. The PRA may have an extension not to exceed 30 working days with the member's, member's representative's or health care provider's written approval		
	§15-10A-02(g) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	d. Insufficient Information: <ul style="list-style-type: none"> After confirming through a complete review of any information already submitted by the health care provider, the PRA is required to notify the member, member's representative or a health care provider filing a grievance on behalf of a member within 5 working days of the filing date if more information is required and assist the member, member's representative, or health care provider in gathering the information without further delay 		

		<ul style="list-style-type: none"> The request must be for specific information that must be submitted to complete the internal grievance process and include the specific reference, language or requirements from the criteria and standards used by the carrier to support the need for the additional information. 		
H8.		Notice of grievance decision:		
	§15-10A-02(j)	<p>a. Emergency case- written notice of grievance decision must be sent within one day after the decision has been orally communicated to member, member's representative or health provider</p>		
	§15-10A-02(i)(1)	<p>b. Nonemergency case- document grievance decision in writing after oral communication has been communicated to member, member's representative or health care provider acting on behalf of the member. Send written notice within 5 working days after the grievance decision is made to member, member's representative and a health care provider acting on behalf of the member</p>		
H9.	§15-10A-02(i)(1)(ii) House Bill 848, Acts of 2025 (effective 10/1/2025)	<p>Content of written notice of grievance decision:</p> <ul style="list-style-type: none"> Must include sample grievance decision letter 		
		<p>a. At top of letter in prominent bold print:</p> <ul style="list-style-type: none"> The notice is a denial of a requested health care service The member may file a complaint with the commissioner The phone number and email address as required under §15-10B-05(e) Additional information on how to file and receive assistance for an appeal. 		
		<p>b. The specific factual bases for the decision and the reasoning used to determine that the health care service is not medically necessary and did not meet the criteria and standards used in conducting utilization review, in detail in clear, understandable language</p>		

	c. Provides to the specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines, on which the decision was based		
	d. A unique identifier, business address, and business telephone number of: <ul style="list-style-type: none"> • The medical director or associate medical director who made the decision if the PRA has been delegated the grievance process by a Maryland HMO; or • The designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process if the PRA has been delegated the grievance process by a carrier that is not an HMO 		
§15-10A-02(i)(1)(ii)5 House Bill 848, Acts of 2025 (effective 10/1/2025)	e. A statement that the member, the member's representative, or a health care provider on behalf of the member has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's grievance decision		
	f. The Commissioner's address, telephone number, and facsimile number		
	g. A statement that the Health Advocacy Unit is available to assist the member or the member's representative in filing a complaint with the Commissioner		
	h. The address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.		
§15-10A-02(i)(2) House Bill 848, Acts of 2025 (effective 10/1/2025)	i. The business telephone number required by §15-10A-02(i)(1)(ii)4 included in the notice must be a dedicated number for grievance decisions and may not be the general customer call number		
§15-10A-10	j. Notice must be sent in a culturally and linguistically appropriate manner as described in the federal Affordable Care Act		

	§15-10A-02(i)(3) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	<p>k. The notice may not use:</p> <ul style="list-style-type: none"> Generalized terms such as “experimental procedure not covered,” “cosmetic procedure not covered,” “service included under another procedure,” or “not medically necessary;” or Language directing the member to review the additional coverage criteria in the member’s policy or plan documents. 		
H10.		Definitions:		
	COMAR 31.10.18.11	a. Compelling Reason		
	§15-10A-02(b)(3) Senate Bill 791, Chpt 848, Acts of 2024 (effective 1/1/2025)	b. Emergency Case		
	COMAR 31.10.18.02B(5)	c. Filing Date		

I. Other Required Information (Application items 24 through 31)

	Citation	Description	"X" Means Applicable	Document/ Page
I1.	§15-10B-05(a)(2)	The types and qualifications of personnel either employed by or under contract to perform utilization review.		
	§15-10B-11(5)	<ul style="list-style-type: none"> There must be a sufficient number of registered nurses, medical records technicians, or similarly qualified persons supported and supervised by appropriate physicians to carry out the PRA’s utilization review activities. 		
I2.	§15-10B-05(a)(9)	<p>The policies and procedures to ensure that the private review agent has a formal program for:</p> <ul style="list-style-type: none"> The orientation of the personnel either employed or under contract to perform the utilization review. The training of the personnel either employed or under contract to perform the utilization review 		

		<ul style="list-style-type: none"> Submit a sample presentation schedule or agenda for the orientation program and the training program 		
I3.	§15-10B-05(a)(6)	The policies and procedures to ensure that all applicable State and federal laws to protect the confidentiality of individual medical records are followed.		
I4.	§15-10B-05(a)(4) HB848, Chpt 669, Acts of 2025, effective 10/1/2025	The procedures and policies to ensure that a representative of the private review agent is reasonably accessible to patients and health care providers 7 days a week, 24 hours a day in this State, including having a direct telephone number and monitored email address.		
I5.	§15-10B-05(a)(5)	If applicable, the procedures and policies to ensure that a representative of the private review agent is accessible to health care providers to make all determinations on whether to authorize or certify an emergency inpatient admission, or an admission for residential crisis services as defined in § 15-840 of this title, for the treatment of a mental, emotional, or substance abuse disorder within 2 hours after receipt of the information necessary to make the determination.		
I6.	§15-10B-05(a)(7)	A copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan.		

J. AI, Algorithms or Software Tools §15-10B-05.1 (Application item 32)

	Citation	Description	"X" Means Applicable	Document/ Page
J1.	§15-10B-05.1(c) HB820, Chpt 747, Acts of 2025 (effective 10/1/2025	Signed attestation that use of AI, algorithms or other software tools comply.		
J2.	§15-10B-05.1(c)(8)	<p>Written policies and procedures are submitted</p> <ul style="list-style-type: none"> Includes description of what oversight will be provided Includes policy/procedure for each software tool listed in the application 		