

Chapter 850: HEALTH PLAN ACCOUNTABILITY**Table of Contents**

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Section 1. Purpose

This rule establishes standards applicable to health maintenance organizations (HMOs), as defined by Chapter 56 of the Insurance Code, utilization review entities, as defined by Chapter 34 of the Insurance Code; pharmacy benefits managers as defined by Chapter 56-C of the Insurance Code, that conduct utilization review; and carriers as defined by Chapter 56-A of the Insurance Code. In the interest of consolidating standards applicable to carriers and adopting current National Association of Insurance Commissioners (NAIC) health plan accountability models, it repeals and replaces old Bureau of Insurance Rule Chapter 520, Medical Utilization Review Entities, and incorporates provisions of the NAIC Utilization Review Model Act, Health Carrier Grievance Procedure Model Act and Health Care Professional Credentialing Verification Model Act. The 2002 Amendments to Revised Rule Chapter 850 reflect amendments to the Health Plan Improvement Act, Title 24-A, Chapter 56-A M.R.S.A. (§§ 4301 *et seq.*), enacted by Public Law 1999, Chapter 742, An Act to Establish a Patient's Bill of Rights. The 2003 Amendments reflect amendments to 24-A M.R.S.A. §4303, enacted by Public Law 2003, Chapters 108 and 469. The 2007 Amendments to the access requirements in section 7 are Major Substantive Amendments proposed by the Superintendent pursuant to a consensus-based rule development process governed by 5 M.R.S.A. §8051-B. The 2012 Amendments, which include Major Substantive Amendments to the access requirements in section 7, are adopted to reflect amendments to the Maine Health Plan Improvement Act enacted by Public Law 2011, Chapters 90 and 364, and to bring the appeal and grievance procedures in sections 8 through 10 into compliance with the requirements of the federal Affordable Care Act. The 2020 Amendments are Routine Technical Amendments adopted to reflect amendments to the Maine Health Plan Improvement Act enacted by Public Law 2019, Chapters 171, 238, and 273. The 2025 Amendments are Major Substantive Amendments adopted to reflect amendments to the Maine Health Plan Improvement Act enacted by Public Law 2021, Chapter 603 and by Public Law 2023, Chapter 680, and to comply with new federal requirements established by the Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2025.

Section 2. Authority

This rule is promulgated by the Superintendent pursuant to Title 24-A M.R.S.A. §§ 2772, 2774, 4218, 4218-A, 4222-A, 4303, 4309, and 4309-A. The 2020 Amendments are promulgated by the Superintendent pursuant to unallocated provisions in Public Law 2019, Chapters 171, 238, and 273 authorizing Routine Technical Amendments.

Section 3. Applicability and Scope

- A. This rule shall apply to all health carriers, utilization review organizations, pharmacy benefits managers that conduct utilization review, and managed care plans as applicable. Section 7 is applicable to any carrier offering a managed care plan. Section 8 is applicable to any carrier that provides or performs utilization review services, any designee of the carrier or utilization review entity (URE) that performs utilization review functions on the carrier's behalf, and any URE performing utilization review on behalf of an employer. The requirements of section 8 are also applicable to all "adverse health care treatment decisions" rendered by or on behalf of "carriers" offering "health plans," as defined by 24-A M.R.S.A. §4301-A subsections 1, 3 and 7. Sections 9 and 10 are applicable to all carriers. The relationship of the appeals processes set forth in subsections

8(G) and 8(G-1) to the grievance review procedures of section 9 is as follows. All adverse health care treatment decisions denying benefits to a covered person are subject to the appeals procedures set forth in subsections 8(G) and 8(G-1). All requests for review of “adverse benefit determinations,” other than “adverse health care treatment decisions,” are subject to the grievance review procedures set forth in section 9. In the event of conflict between the provisions of this rule and those of any other rule promulgated by the Superintendent, the provisions of this rule shall be controlling. Any request for confidential handling of filings required by this rule must follow the confidentiality protocol established by the Superintendent and available from the Bureau of Insurance.

- B. All group and individual health plans under which covered services are subject to utilization review, pre-existing condition determinations, or determinations regarding experimental or investigational services, are subject to the disclosure requirements of subsection 8(I).
- C. All group and individual health plan contracts must incorporate the appeal and grievance procedure description required by subsection 10(B).

Section 4. Affordable Care Act

Pursuant to 24-A M.R.S.A. §§ 4218-A and 4309-A, carriers are required to comply with all applicable requirements of the federal Affordable Care Act, in addition to applicable requirements of this rule.

Section 5. Definitions

For purposes of this rule:

- A. “Adverse benefit determination” means any of the following, including but not limited to adverse health care treatment decisions: a denial of, reduction of, termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including an action based on a determination of a participant’s or beneficiary’s ineligibility to participate in a plan.

DRAFTING NOTE: The term “adverse benefit determination” includes both adverse health care treatment (medical) decisions and other (non-medical) adverse benefit determinations. Adverse health care treatment decisions are subject to section 8 of this rule. Adverse non-medical benefit determinations are subject to section 9 of this rule. All adverse benefit determinations are subject to section 10 of this rule.

- A-1. “Adverse health care treatment decision” means a health care treatment decision made by or on behalf of a carrier offering a health plan, denying in whole or in part payment for or provision of otherwise covered services requested by or on behalf of an enrollee. “Health care treatment decision” means a decision regarding diagnosis, care, or treatment when medical services are provided by a health plan, or a benefits decision involving determinations regarding medically necessary health care, preexisting condition determinations and determinations regarding experimental or investigational services. “Adverse health care treatment decision” includes a rescission determination and an initial coverage eligibility determination, consistent with the requirements of the federal

Affordable Care Act, and a prior authorization determination in accordance with 24-A M.R.S.A. § 4304.

- B. “Ambulatory review” means utilization review of health care services performed or provided in an outpatient setting.
- C. “Ancillary Services” means appropriately licensed ancillary non-physician services which may include but are not limited to home health care, durable medical equipment, physical therapy, chiropractic, podiatry, certified nurse midwifery, pharmacy, home care, alcohol and chemical dependency services, and mental health services provided by psychologists, social workers, counseling professionals and psychiatric nurses in inpatient, outpatient treatment and residential treatment settings, as appropriate in each case. The listing of a particular service or category of provider in this definition does not function to mandate that coverage for that service or category of provider is required.
- D. “Appeals procedure” means a formal process whereby a covered person or a representative of a covered person, including an actively treating physician, facility or health care provider, can contest an adverse health care treatment decision rendered by the health carrier or its designee utilization review entity (URE), which results in the denial, reduction without further opportunity for additional services or termination of coverage of a requested health care service.
- E. “Carrier” or “health carrier” means:
 - 1) An insurance company licensed in accordance with Title 24-A to provide health insurance;
 - 2) A health maintenance organization licensed pursuant to Title 24-A Chapter 56;
 - 3) A preferred provider arrangement administrator registered pursuant to Title 24-A Chapter 32;
 - 4) A fraternal benefit society, as defined by 24-A M.R.S.A. §4101;
 - 5) A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24;
 - 6) A multiple-employer welfare arrangement licensed pursuant to 24-A M.R.S.A. Chapter 81;
 - 7) A self-insured employer subject to state regulation as described in 24-A M.R.S.A. §2848-A; or
 - 8) Notwithstanding any other provision of Title 24-A, an entity offering coverage in this State that is subject to the requirements of the federal Affordable Care Act.

An employer exempted from the applicability of 24-A M.R.S.A. Chapter 56-A under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a carrier.

- F. “Case management” means a coordinated set of activities conducted for individual patient management of covered persons with specific health care needs.
- G. “Certification” means a determination by a health carrier or its designee utilization review entity (URE) that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.
- H. “Clinical peer” means a physician or other licensed health care practitioner who holds a non-restricted license in a state of the United States, is board certified in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and whose compensation does not depend, directly or indirectly, upon the quantity, type, or cost of the medical condition, procedure, or treatment that the practitioner approves or denies on behalf of a carrier.
- I. “Clinical review criteria” means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the necessity and appropriateness of health care services.
- J. *[REPEALED]*
- K. “Concurrent review” means utilization review conducted during a patient’s hospital stay or course of treatment.
- L. “Covered benefits” or “benefits” means those health care services a covered person is entitled to have paid, in whole or in part, under the terms of a health benefit plan.
- M. “Covered person” means an enrollee as defined in 24-A M.R.S.A. § 4301-A(5). As used in this rule, the terms “covered person” and “enrollee” are considered interchangeable.
- M-1. “Designated Provider” means any health care provider that has been identified so that a covered person may receive incentives for obtaining services from the designated provider that differ from the incentives generally available for obtaining services from a network provider. A designated provider does not have to be a network provider within the plan’s service area. A designated provider may be identified as a member of a class (for example, through a rating system), or may be identified by name. A designated provider may be designated either in advance or at the time an enrollee requests services.
- N. “Discharge planning” means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.
- O. “Emergency medical condition” means the sudden and, at the time, unexpected onset of a physical or mental health condition, including severe pain, manifesting itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe:
- 1) that the absence of immediate medical attention could reasonably be expected to result in:

- a) placing the physical or mental health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
 - b) serious impairment of a bodily function; or
 - c) serious dysfunction of any organ or body part; or,
- 2) with respect to a pregnant woman who is having contractions, that there is:
 - a) inadequate time to effect a safe transfer of the woman to another hospital before delivery, or,
 - b) a threat to the health or safety of the woman or unborn child if the woman were to be transferred to another hospital.
- P. “Emergency service” means a health care item or service, furnished or required to evaluate and treat an emergency medical condition, that is provided in an emergency facility or setting.
- Q. “Essential Community Provider” includes, but is not limited to, the following, consistent with the requirements of federal law:
 - 1) Federally-qualified health centers as defined in section 1861(aa) of the Social Security Act;
 - 2) nonprofit maternal and child health providers that receive funding for their services under Title V of the Social Security Act;
 - 3) Indian health programs under the Indian Health Care Improvement Act; and
 - 4) health care service provider recipients or sub recipients of grants under Title X, Title XIX, Title XXIII or sections 329, 330, 340, 340A, of the Public Health Service Act.
- Q-1. “Exigent circumstances” exist when a covered person is suffering from a health condition that may seriously jeopardize the covered person’s life, health or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a nonformulary drug.
- R. “Facility” means an institution providing health care services or a health care setting, including but not limited to appropriately licensed or certified hospitals and other inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.
- S. “Grievance” means a written complaint submitted by or on behalf of a covered person regarding:

DRAFTING NOTE: Written complaints include complaints sent via e-mail.

- 1) The availability, delivery or quality of health care services, including a complaint regarding an adverse health care treatment decision made pursuant to utilization review;
- 2) Claims payment, handling or reimbursement for health care services;
- 3) Matters pertaining to the contractual relationship between a covered person and a health carrier; or
- 4) Adverse benefit determinations.

S-1. “Grievance procedure” means a formal process whereby a covered person or a representative of a covered person can contest an adverse benefit determination.

DRAFTING NOTE: Because “adverse benefit determinations” include adverse medical decisions as well as adverse non-medical determinations, the term “grievance procedure” includes the procedures for review of both medical and non-medical determinations.

- T. “Health plan” or “health benefit plan” means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan, other than a plan that provides only accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care or other limited benefit coverage not subject to the requirements of the federal Affordable Care Act. A plan that is subject to the requirements of the federal Affordable Care Act and offered in this State by a carrier, including, but not limited to, a qualified health plan offered on an American Health Benefit Exchange or a SHOP Exchange established pursuant to the federal Affordable Care Act, is a health plan for purposes of this rule.
- U. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law. This definition applies to individual health professionals, not corporate “persons.”
- V. “Health care provider” or “provider” means a practitioner or facility licensed, accredited or certified to perform specified health care services consistent with state law.
- W. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease including mental illness and alcohol and chemical dependency.
- X. “Health carrier.” See definition of “carrier” at subsection 5(E).
- Y. “Managed care plan” means a health benefit plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan through:
- 1) arrangements with selected providers to furnish health care services; and
 - 2) financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan. A return to work program

developed for the management of workers' compensation claims may not be considered a managed care plan.

- Z. "Network" means the group of participating providers providing services to a managed care plan.
- AA. *[REPEALED]*
- BB. "Participating provider" means a licensed or certified provider of health care services, including mental health services, or health care supplies that has entered into an agreement with a carrier to provide those services or supplies to an individual enrolled in a managed care plan.
- CC. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a limited liability company, a trust, an unincorporated organization, any similar entity, any affiliate of these entities or any combination of the foregoing.
- DD. "Physician" means a duly licensed doctor of medicine or osteopathy practicing within the scope of a license.
- EE. "Primary care" means initial and basic care, and includes general internal medicine, general pediatrics, general obstetrics and gynecology, and care customarily provided by general and family practitioners or OB/GYNs.
- FF. "Primary care provider" means a physician, or a nurse practitioner or physician assistant under the supervision of a physician, under contract with a managed care plan to supervise, coordinate, and provide initial and basic care to plan enrollees, maintain continuity of patient enrollee care, and initiate patient enrollee referrals for specialist care.
- GG. "Primary verification" means verification of a health professional's credentials based upon evidence obtained from the issuing source of the credentials.
- HH. "Prospective review" means utilization review conducted prior to an admission or a course of treatment.
- II. "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.
- JJ. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by an appropriately licensed or certified provider, other than the provider making the initial recommendation for a proposed health service, to assess the clinical necessity and appropriateness of the initially proposed health service.
- KK. "Secondary verification" means verification of a health professional's credentials based upon evidence obtained by means other than direct contact with the issuing source of the credential (e.g., copies of certificates provided by the applying health professional).

- LL. “Service Area” means the area lying within the geographic perimeters of an approved managed care plan health care network.
- MM. “Special Needs” means individuals who have intellectual disabilities, mental illness, behavioral and/or emotional disturbances and developmental delays and disabilities, requiring coordinated health care services. Individuals with special needs may include but are not limited to individuals diagnosed with schizophrenia, bipolar disorder, pervasive developmental disorder or autism, paranoia, panic disorder, obsessive-compulsive disorder, major depressive disorder, attention deficit disorder, and/or conduct disorder or physical impairments of chronic duration such that an individual so diagnosed cannot function effectively in home, school or community settings without coordinated health care services.
- NN. “Specialty Physician Services” means general physician services beyond primary care.
- OO. “Stabilized” means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result or occur before an individual can be transferred.
- PP. “Superintendent” means the Superintendent of Insurance.
- QQ. “Urgent Services” or “Urgent Care” means medical care or treatment provided in response to exigent circumstances.
- RR. “Utilization review” means any program or practice by which a person, on behalf of a carrier, third-party administrator, or employer, which is a payor for or which arranges for payment of medical services, seeks to review the utilization, clinical necessity, appropriateness, efficacy or efficiency of pharmaceutical or health care services, procedures, providers or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Decisions regarding medical necessity made by a covered person’s primary care provider do not constitute utilization review.
- SS. “Utilization review entity (URE)” means an entity that conducts utilization review, other than a health carrier performing review for its own health plans, and includes a pharmacy benefits manager that conducts utilization review on behalf of a carrier, whether or not the pharmacy benefits manager is also separately licensed as a utilization review entity.

Section 6. Quality Assurance Standards

A carrier seeking licensure in the State of Maine as a health maintenance organization pursuant to the requirements of Title 24-A Chapter 56, and which has received accreditation by a nationally recognized accrediting organization may, as an alternative to the application requirements of Bureau of Insurance Rule Chapter 191, subsection (6)(F), file the accrediting organization’s applicable quality assurance standards for consideration by the Superintendent and the Commissioner of the Department of Human Services.

Section 7. Access to Services

In addition to the requirements of Title 24-A, Chapter 56 or otherwise required by rule a carrier offering a managed care plan is subject to the requirements of this section.

A. Access Plan

In addition to the requirements of 24-A M.R.S.A. §4203(3) or requirements otherwise provided by rule, a carrier's application for approval of a managed care plan, application for an HMO certificate of authority, or application for a Preferred Provider Arrangement registration shall include an Access Plan. Carriers shall, consistent with the requirements of section 11 of this rule, file annual Access Plan information updates reflecting any changes to previously filed information, except that consistent with the requirements of Title 24-A M.R.S.A. §4204(8), the net loss of 5 or more primary care physicians in any county in any 30-day period must be reported within 10 days. Access Plans must include a description of the provider network, including:

- 1) A current list of all providers and facilities;
- 2) The projected ratio of primary care providers to enrollees by county;
- 3) A demonstration that the network is sufficient in numbers and types of providers to assure that all services to covered persons will be reasonably accessible without unreasonable delay.
- 4) A description of the carrier's plan for providing services for rural and underserved populations and for developing relationships with essential community providers.
- 5) A description of the carrier's plan for addressing the needs of patients needing coordinated care, frequent services, or other needs that might impede access to care.
- 6) Information on whether each network provider offers telehealth services and any other information required under federal law.

B. Access to Health Care Providers

- 1) **Primary Care.** To the extent reasonably possible, carriers that offer managed care plans utilizing primary care providers shall maintain a minimum ratio of one full-time equivalent primary care provider to 2000 enrollees. Carriers shall ensure the availability of practitioners who provide primary care services, including general and internal medicine, family practice, and pediatrics.
- 2) **Network Adequacy.** For plan years beginning on or after January 1, 2026, all managed care plans must meet the network adequacy standards established pursuant to this paragraph, unless the Superintendent grants an exception pursuant to subparagraph (b).

- a) Publication by Superintendent. The Superintendent shall specify the standards required for network adequacy and the exception process in a bulletin, which shall be published on the Bureau's website. The standards, including the criteria that must be satisfied to obtain an exception, may not be inconsistent with the federal requirements for qualified health plans as set forth in regulations and guidance issued by the United States Department of Health and Human Services. The Superintendent shall review the bulletin at least annually and revise it as necessary.
 - b) Exception Process. A carrier may request an exception to the network adequacy standards prescribed under this paragraph by submitting a justification on a form prescribed by the Superintendent. The Superintendent may grant the exception only if it meets the requirements published in the bulletin issued under subparagraph (a).
 - c) Transition. For plan years beginning before January 1, 2026, if the network does not comply with the requirements of this paragraph, it must continue to comply with the standards that were in effect on December 31, 2024.
- 4) 3) Carriers that offer managed care plans must provide enrollee access to medically necessary emergency services at all times, and access to urgent services.
- 5) 4) In any case where the carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the Superintendent.

C. Timely Access to Health Care Services

- 1) Health care services shall be made accessible by carriers offering managed care plans to their enrollees on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care. Using valid methodology, each carrier shall collect and perform an annual analysis of data to measure performance against standards for access to:
 - a) regular and routine care appointments;
 - b) urgent care appointments;
 - c) after-hours care; and
 - d) member services by telephone.
- 2) Using valid methodology, each carrier shall collect and annually analyze data to measure behavioral health care performance against standards for access to:
 - a) care for non-life-threatening emergencies within 6 hours;
 - b) urgent care within 48 hours; and
 - c) an appointment for a routine office visit within 10 business days.

D. Incentives to Use Providers That Have Been Designated on the Basis of Cost or Quality

- 1) Carriers may offer enrollees incentives to use designated providers who have been selected on the basis of cost or quality. Any financial incentive to encourage enrollees to use specific providers designated on the basis of cost or quality must be an additional benefit to benefits otherwise provided under the plan.
- 2) The carrier may not offer a financial incentive to obtain emergency services from a specific designated emergency services provider.
- 3) Financial incentives may include, but are not limited to, waiver of copayments or coinsurance, waiver of deductibles, or travel expenses.
- 4) Nothing in this subsection may be construed as superseding any applicable requirements relating to network adequacy, tiering programs, profiling programs, credentialing, or other laws regulating the administration of managed care plans.
- 5) Carriers may not require enrollees to use designated providers as a condition of receiving benefits under the plan.

E. Access to Emergency Services

Emergency services must be provided in accordance with 24-A M.R.S.A. §4320-C.

F. Coordination of Care

- 1) If the carrier offering a managed care plan requires primary care providers to make referrals to specialty physicians and ancillary services, the enrollee's primary care provider or the carrier shall initiate the referrals. Enrollees on whose behalf referrals have been made shall receive timely written notification of the referral including all relevant information.
- 2) Carriers that require primary care providers to make referrals are responsible for the coordination, continuity of care and appropriate discharge planning for enrollees given a referral to specialty physicians, and for enrollees using ancillary services.
- 3) Carriers are responsible for the coordination and continuity of care for enrollees in accordance with the requirements of 24-A M.R.S.A. §4303(6) 'Standing referrals to specialists' and §4303(7) 'Continuity of Care.' HMOs are responsible for the coordination and continuity of care for new enrollees who notify the HMO that, as of the effective date of enrollment in the HMO, they are undergoing care or treatment for covered services by providers not a part of the HMO's provider network. An HMO is not required to provide coverage for out-of-network services if it transfers an enrollee to a network provider without unreasonably disrupting the enrollee's ongoing care or treatment.
- 4) An enrollee dissatisfied with an assigned or selected primary care provider shall be allowed to change primary care providers in accordance with defined carrier

procedures and policies but at least after their initial sixty days of coverage and once a year thereafter.

- 5) Carriers shall maintain a written plan providing for continuity of care in the event of contract termination between the carrier and any of its contracted providers, or in the event of site closings involving a primary care provider with more than one location of service. The written plan shall describe how enrollees with special needs or who are at special risk will be identified and how continuity of care will be provided. The written plan shall comply with the requirements of 24-A M.R.S.A. §4303(7)(A).

G. Provider Credentialing for Carriers Offering Managed Care Plans (as Applicable)

- 1) A carrier or the entity to whom credentialing is delegated shall credential all health professionals with whom the carrier contracts in accordance with written policies and procedures.
- 2) A carrier shall make credentialing decisions within 60 days after receipt of a complete credentialing application from a provider. If the carrier is unable to make a provider credentialing decision within 60 days, it must apply for an extension on a form prescribed by the Superintendent and provide a detailed explanation of the reason or reasons it is unable to make the credentialing decision within 60 days, or, if the problem is not specific to a particular application, the carrier must provide a written remediation plan to bring its credentialing review practices into conformity with the 60-day limit.
- 3) The effective date of credentialing is the date the carrier receives a complete application. A credentialing application is complete if the application includes all of the information required by the uniform credentialing application used by carriers and providers in this State, such attachments to that application as required by the carrier at the time of application, and all corrections required by the carrier. The carrier must publish a full list of what constitutes a complete application on the carrier's publicly accessible website. Within 30 days after first receiving the application, the carrier shall complete its initial review of the entire application and shall either notify the provider that the application is complete or furnish the provider with a comprehensive list of all corrections needed to make the application complete. A carrier may not require that a provider have a home address within the State before accepting an application.
- 4) The carrier shall establish a credentialing committee consisting of licensed physicians and other health professionals to review credentialing information and supporting documents.
- 5) The carrier's application and credentialing policies and procedures shall be made available for review by the health professional upon written request.
- 6) Except as otherwise provided by law and by subparagraph 7(G)(12)(a), all information obtained by the carrier in the credentialing process shall be held confidential.

- 7) The carrier shall retain all records and documents relating to a health professional's credentialing process for at least three years.
- 8) A carrier, to the extent pertinent, shall obtain primary verification of at least the following information regarding the applicant:
 - a) Current license, certificate of authority or registration to practice in the health field which the applicant has applied to practice in Maine;
 - b) Current Drug Enforcement Agency (DEA) registration certificate; and
 - c) Specialty board certification status.
- 9) A carrier shall obtain the following, subject to either primary or secondary verification. Secondary verification may be obtained from the National Practitioner Data Bank or other national data banks authorized by the Superintendent.
 - a) The health professional's license history for the preceding ten years in this and all other states including a chronological history of the health professional's health care license, dates, times and places, of all applications for license privileges, any action taken on the application, any challenges to licensure or registration, or the voluntary or involuntary relinquishment of a license;
 - b) The health professional's malpractice history including any involvement in a professional liability action and any final judgment or settlement involving the individual health professional; and
 - c) The health professional's practice history for the preceding five years including a chronological history of the health professional's health care practice, including staff membership, practice privileges, professional associations, dates and places of practice, any action taken on practice privileges, and the voluntary or involuntary relinquishment, suspension, limitation, reduction or loss of staff membership or practice privileges; and
 - d) Current level of professional liability coverage.
- 10) At least every 3 years the carrier shall obtain primary verification of:
 - a) Current license or certificate of authority to practice medicine, osteopathy or other health profession in Maine; and
 - b) Current DEA registration certificate.
- 11) The carrier shall require all contracting health professionals to notify the carrier of any changes in the status of any of the items above at any time.

12) Health Professional Review Process

- a) To the extent permitted by law, each health professional subject to the credentialing process shall have the right to review all information, including the source of that information, gathered by the carrier in satisfaction of the requirements of this section in the course of its credentialing and recredentialing processes as regards that health professional.
- b) Each health professional shall be notified of any information obtained during the carrier's credentialing process that does not meet the carrier's credentialing standards or that varies substantially from the information provided to the carrier by the health professional, except that the carrier shall not be required to reveal the source of information if the information is not obtained to meet the requirements of this section, or if disclosure is prohibited by law.
- c) A health professional shall have the right to submit for correction any erroneous information. Each carrier shall have a formal process whereby a health professional who feels the credentialing body has received incorrect or misleading information may request a reconsideration and submit supplemental information to the credentialing body. Supplemental information shall be subject to confirmation by the carrier.
- d) The carrier shall have a formal appeal procedure for dealing with:
 - i) health professionals' concerns relating to the denial of credentialing for failure to meet the objective credentialing standards of the plan; and
 - ii) provider concerns relating to the contractual relationship between the health professional and the carrier.
- e) Nothing in this section shall be construed to require a carrier to select a provider as a participating provider solely because the provider meets the carrier's credentialing verification standards, or to prevent a carrier from utilizing separate or additional criteria in selecting the health care professionals with whom it contracts. A carrier may utilize separate or additional criteria in selecting the health professionals with whom it contracts.

Section 8. Adverse Health Care Treatment Decisions

In addition to the requirements of Title 24-A, Chapter 34, any health carrier that provides or performs utilization review services, and any designee of the health carrier or URE that performs utilization review functions on the carrier's behalf, is subject to the requirements of this section. The requirements of this section are applicable to all "adverse health care treatment decisions" rendered by or on behalf of "carriers."

A. Corporate Oversight of Utilization Review Program

A health carrier shall be responsible for monitoring all utilization review activities carried out by or on its behalf, and for compliance with the requirements of this. The health carrier shall also ensure that, consistent with the requirements of Title 24-A M.R.S.A. §4304(1), appropriate personnel have operational responsibility for the conduct of the health carrier's utilization review program.

B. Contracting

Whenever a health carrier contracts to have a URE perform the utilization review functions required by this rule, the Superintendent shall hold the health carrier responsible for monitoring the activities of the utilization review entity with which it contracts and for ensuring that the requirements of this rule are met.

C. Written Utilization Review Program

A health carrier that provides or performs utilization review shall implement a written utilization review program that, consistent with the requirements of Title 24-A M.R.S.A. §2771(3) and this rule, shall comprehensively describe all utilization review activities and procedures, both delegated and non-delegated, applicable to any of its health plans. The utilization review program must be consistent with the requirements of this section.

D. Operational Requirements

- 1) A utilization review program shall use documented clinical review criteria that are based on published sound clinical evidence and which are evaluated periodically to assure ongoing efficacy. A health carrier or the carrier's designated URE may develop its own clinical review criteria or may purchase or license clinical review criteria from qualified vendors. Upon request, a health carrier or the carrier's designated URE shall make available its clinical review criteria to the Superintendent and the Commissioner of the Department of Human Services.
- 2) Qualified health care professionals shall administer the utilization review program and oversee review decisions. A clinical peer shall evaluate the clinical appropriateness of adverse health care treatment decisions.
- 3) A health carrier or the carrier's designated URE shall issue utilization review decisions in a timely manner pursuant to the requirements of subsections F, G, G-1, and H.
 - a) A health carrier or the carrier's designated URE shall obtain all information required to make a utilization review decision, including pertinent clinical information.
 - b) A health carrier or the carrier's designated URE shall have a process to ensure that utilization reviewers apply clinical review criteria consistently.

- 4) A health carrier or the carrier's designated URE shall routinely assess the effectiveness and efficiency of its utilization review program.
- 5) A health carrier's or the carrier's designated URE's data systems shall be sufficient to support utilization review program activities and to generate management reports to enable the health carrier or the carrier's designated URE to monitor and manage health care services effectively.
- 6) If a health carrier delegates any utilization review activities to a URE, the health carrier shall maintain adequate oversight, which shall include:
 - a) A written description of the URE's activities and responsibilities, including reporting requirements;
 - b) Evidence of formal approval of the URE program by the health carrier; and
 - c) A process by which the health carrier evaluates the performance of the URE.
- 7) A health carrier or the carrier's designated URE shall provide covered persons, participating providers, and other providers that are actively treating covered persons with access to its review staff by a toll-free number or collect call phone line. Telephone lines must be adequately staffed to provide providers and covered persons ready access to staff performing utilization review functions.
- 8) When conducting utilization review, the health carrier or the carrier's designated URE shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency and duration of services. The requirements of this subsection shall not be construed to prevent a carrier from collecting data for quality assurance purposes.
- 9) Compensation to persons providing utilization review services for a health carrier or the carrier's designated URE may not be based on the quantity of adverse health care treatment decisions rendered, or otherwise include incentives for reviewers to render inappropriate review decisions.

E. Procedures for Review Decisions

- 1) A health carrier or the carrier's designated URE shall maintain written procedures for making utilization review, prior authorization, experimental/investigational treatment, and preexisting condition decisions, and for notifying covered persons and providers acting on behalf of covered persons of its decisions. For purposes of this subsection, the term "covered person" includes the authorized representative of a covered person. Prior to release of medical information to a representative of a covered person, a health carrier or the carrier's designated URE may require execution of an appropriate release authorizing the representative's access to that information.
- 2) For initial determinations not involving exigent circumstances, a health carrier or the carrier's designated URE shall make the determination (whether adverse or not) and so notify the covered person and the actively treating provider within 72

hours or 2 business days, whichever is less, in accordance with the following standards:

- a) If the carrier or the carrier's designated URE responds with a request for additional information, the carrier shall make a determination and so notify the covered person and the provider within 72 hours or 2 business days, whichever is less, after receiving the requested information.
 - b) If the carrier or the carrier's designated URE responds that outside consultation is necessary before making a determination, the carrier shall make a determination within 72 hours or 2 business days, whichever is less, from the time of the carrier's initial response.
 - c) If a carrier or the carrier's designated URE does not grant or deny a request within the timeframes required, the request is granted.
 - d) A provider shall make best efforts to provide all necessary information to evaluate a request, and a carrier shall make best efforts to limit requests for additional information. A carrier or the carrier's designated URE shall make a good faith effort to obtain all necessary information expeditiously, and is responsible for expeditious retrieval of necessary information in the possession of a person with whom the health carrier contracts. A health carrier or the carrier's designated URE shall comply with the notification requirements of Title 24-A M.R.S.A. §4304(2). For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.
- 3) When exigent circumstances exist, a health carrier or the carrier's designated URE shall make the determination (whether adverse or not) and so notify the covered person and the provider within 24 hours after receiving the request.
- 4) For concurrent review determinations, a health carrier or the carrier's designated URE shall make the determination within one working day after obtaining all necessary information.
- a) In the case of a determination to certify an extended stay or additional services, the carrier or the carrier's designated URE shall so notify both the covered person and the provider rendering the service on the same day the determination is issued. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.
 - b) In the case of an adverse benefit determination, the carrier or the carrier's designated URE shall so notify the covered person and the provider rendering the service within one working day. The service shall be continued without liability to the covered person until the covered person has been notified of the determination.

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- 5) For retrospective review decisions, a health carrier or the carrier's designated URE shall make the decision within 30 days after receiving all necessary information.
- a) In the case of a certification, the carrier or the carrier's designated URE may notify in writing the covered person and the provider rendering the service.
 - b) In the case of an adverse health care treatment decision, the carrier or the carrier's designated URE shall, within 5 working days after making the adverse decision, notify in writing the provider rendering the service and the covered person. A health carrier or the carrier's designated URE shall not render an adverse decision with regard to health care services previously authorized pursuant to prospective review, without adequate written notice to the covered person prior to receipt of previously authorized services, except where fraudulent or materially incorrect information was provided to the carrier at the time prior approval was granted, and the information was relied upon by the carrier in rendering its approval.
- 6) A health carrier shall provide written notification of any adverse health care treatment decision, including a prior authorization denial, to the covered person and the actively treating provider. The notice shall include:
- a) the principal reason or reasons for the decision;
 - b) reference to the specific plan provisions on which the decision is based;
 - c) information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount if applicable), and a statement that the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, will be provided upon request;
 - d) a description of any additional material or information necessary for the covered person to perfect the claim and an explanation as to why such material or information is necessary;
 - e) the instructions and time limits for initiating an appeal or reconsideration of the decision;
 - f) if the adverse health care treatment decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
 - g) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse health care treatment decision, either the specific rule, guideline, protocol, or other similar criterion; or a

statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse decision and explaining that a copy will be provided free of charge to the covered person upon request;

- h) a phone number the covered person or authorized representative may call for information on and assistance with initiating an appeal or reconsideration and requesting clinical rationale and review criteria;
 - i) a description of the expedited review process applicable to claims involving exigent circumstances;
 - j) the availability of any applicable office of health insurance consumer assistance or ombudsman;
 - k) notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier's internal review process. In addition, an explanation of benefits (EOB) must comply with the requirements of 24-A M.R.S.A. §4303(13) and any rules adopted pursuant thereto; and
 - l) any other information required pursuant to the federal Affordable Care Act.
- 7) The carrier or the carrier's designated URE shall respond expeditiously to requests for information.
 - 8) A health carrier or the carrier's designated URE shall have written procedures to address the failure or inability of a provider or a covered person to provide all clinically relevant, necessary information for review. In cases where the provider or a covered person will not release necessary information, the health carrier or the carrier's designated URE may deny certification.

F. Requests for Reconsideration

- 1) In a case involving an initial health care treatment decision or a concurrent review decision, a health carrier or the carrier's designated URE shall give the provider rendering the service an opportunity to request by telephone, fax, electronically, or in writing on behalf of the covered person a reconsideration of an adverse decision by the reviewer making the adverse decision.
- 2) The reconsideration shall occur within one working day after the receipt of the request and shall be conducted between the provider rendering the service and the reviewer who made the adverse health care treatment decision, or between the provider rendering the service and a clinical peer of that provider, designated by the reviewer, if the reviewer who made the adverse decision cannot be available within one working day.
- 3) If the reconsideration process does not resolve the difference of opinion, the adverse health care treatment decision may be appealed by the covered person or the provider on behalf of the covered person. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an adverse decision.

G. Appeals of Adverse Health Care Treatment Decisions

For purposes of this subsection and subsection G-1, the term “covered person” includes an authorized representative of a covered person as defined in 24-A M.R.S.A. § 4301-A(2). A provider that is actively treating a covered person is an authorized representative unless the covered person objects in writing to the representation or the provider has failed to notify the covered person of the representation as required by this subsection.

1) Standard Appeals

- a) A health carrier or the carrier’s designated URE shall establish written procedures for a standard appeal of an adverse health care treatment decision. HMO enrollees shall retain the right to pursue an appeal directly with the HMO. Appeal procedures shall be available to the covered person and to the covered person’s authorized representative.
- i) A treating provider must give the covered person written notice at least 14 days before filing a standard appeal on the covered person’s behalf, and the filing must include an attestation that timely notice of intent to file an appeal has been provided. The provider must also notify the covered person in writing within 7 days after the appeal is filed that the appeal has been filed, and attest to the carrier that timely notice of filing has been provided. If the provider subsequently withdraws the appeal, written notice of the withdrawal must be provided to the covered person and attested to the carrier within 7 days after the appeal is withdrawn.
- ii) The carrier must allow the covered person or authorized representative to review the claim file and to present evidence and testimony as part of the internal appeals process.
- iii) The carrier must provide the covered person or authorized representative, free of charge, with any new or additional evidence considered, relied upon, or generated by the carrier (or at the direction of the carrier) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the decision to give the covered person or authorized representative a reasonable opportunity to respond.
- iv) Before a carrier can issue a final internal adverse benefit determination based on a new or additional rationale, the covered person or authorized representative must be provided with the rationale, free of charge, sufficiently in advance of the decision to give the covered person or authorized representative a reasonable opportunity to respond.
- v) The health carrier must provide the covered person or authorized representative the name, address, and telephone number of a person designated to coordinate the appeal on behalf of the health carrier.

- vi) The health carrier must make the rights in this subparagraph known to the covered person or authorized representative within 3 working days after receiving an appeal.
- b) An appeal of an adverse health care treatment decision, except for a rescission determination or an initial coverage eligibility determination, shall be evaluated by an appropriate clinical peer or peers of the treating provider. The clinical peer/s shall not have been involved in the initial adverse determination, unless additional information not previously considered during the initial review is provided on appeal. The clinical peer may not be a subordinate of a clinical peer involved in the prior decision.
- c) For standard appeals, the health carrier or the carrier's designated URE shall notify in writing both the covered person and the attending or ordering provider of the decision within 30 days following the request for an appeal. Additional time is permitted where the carrier or the carrier's designated URE can establish the 30-day time frame cannot reasonably be met due to the carrier's or designee's inability to obtain necessary information from a person or entity not affiliated with or under contract with the carrier. The carrier or the carrier's designated URE, shall provide written notice of the delay to the covered person and the attending or ordering provider. The notice shall explain the reasons for the delay. In such instances, decisions must be issued within 30 days after the carrier's or designee's receipt of all necessary information. An adverse health care treatment appeal decision shall contain:
 - i) An attestation that contains:
 - a) the credentials of the person or persons evaluating the appeal, and
 - b) a statement that no person evaluating the appeal was involved in the initial decision.
 - ii) The name, address, and telephone number of a point of contact to answer specific questions from the enrollee.
 - iii) A statement of the reviewers' understanding of the reason for the covered person's or authorized representative's request for an appeal.
 - iv) Reference to the specific plan provisions upon which the decision is based.
 - v) The reviewers' decision in clear terms and the clinical rationale in sufficient detail for the covered person or authorized representative to respond further to the health carrier's position.

- vi) A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination. The decision shall include instructions for requesting copies, free of charge, of information relevant to the claim, including any referenced evidence, documentation or clinical review criteria not previously provided to the covered person or authorized representative. Where a covered person or authorized representative had previously submitted a written request for the clinical review criteria relied upon by the health carrier or the carrier's designated URE in rendering its initial adverse decision, the decision shall include copies of any additional clinical review criteria utilized in arriving at the decision.
- vii) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse decision, either the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse decision and explaining that a copy will be provided free of charge to the covered person or authorized representative upon request.
- viii) Notice of any subsequent appeal rights, and the procedure and time limitation for exercising those rights. Notice of external review rights must be provided to the enrollee or authorized representative as required by 24-A M.R.S.A. §4312(3). A description of the process for submitting a written request for second level appeal must include the rights specified in subsection G-1.
- ix) Notice of the availability of any applicable office of health insurance consumer assistance or ombudsman.
- x) Notice of the covered person's right to contact the Superintendent's office. The notice shall contain the toll-free telephone number, website address, and mailing address of the Bureau of Insurance.
- xi) Any other information required pursuant to the federal Affordable Care Act.

2) Expedited Appeals

A health carrier or the carrier's designated URE shall establish written procedures for the expedited review of an adverse health care treatment decision, including a prior authorization denial, involving a situation where the time frame of the standard review procedures set forth in paragraph 1 would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. An expedited appeal shall be

available to, and may be initiated by, the covered person or the provider acting on behalf of the covered person.

- a) An expedited appeal of an adverse health care treatment decision, except for a rescission determination or an initial coverage eligibility determination, shall be evaluated by an appropriate clinical peer or peers of the treating provider. The clinical peer/s shall not have been involved in the initial adverse health care treatment decision, unless additional information not previously considered during the initial review is provided on appeal. The clinical peer may not be a subordinate of a clinical peer involved in the prior decision.
- b) A health carrier, or the carrier's designated URE shall provide expedited review to all requests concerning an admission, availability of care, continued stay or health care service for a covered person who has received emergency services but has not been discharged from a facility.
- c) In an expedited review, all necessary information, including the health carrier's or the carrier's designated URE's decision, shall be transmitted between the health carrier or the carrier's designated URE and the covered person or the provider acting on behalf of the covered person by telephone, facsimile, electronic means or the most expeditious method available.
- d) In an expedited review, a health carrier or the carrier's designated URE shall make a decision and notify the covered person and the provider acting on behalf of the covered person via telephone as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the review is initiated. If the expedited review is a concurrent review determination of emergency services under subsection H of this section or of an initially authorized admission or course of treatment, the service shall be continued without liability to the covered person until the covered person has been notified of the decision.
- e) If the initial notification was not in writing, a health carrier or the carrier's designated URE shall provide written confirmation of its decision concerning an expedited review within 2 working days after providing notification of that decision. An adverse decision shall contain the provisions specified in subparagraph 1(c) above.

A health carrier or the carrier's designated URE is not required to provide an expedited review for retrospective adverse health care treatment decisions.

G-1. Second Level Appeals of Adverse Health Care Treatment Decisions

- 1) A health carrier that subjects benefit decisions to utilization review or offers managed care plans shall provide the opportunity for a second level appeal to covered persons who are dissatisfied with a first level appeal decision. The covered person or authorized representative requesting a second level appeal has the right to appear in person before authorized representatives of the health carrier, and shall be provided adequate notice of that option by the carrier. If the

covered person does not request an in-person second level panel review, the decision must be issued within 30 days; if the covered person does request an in-person second level panel review, the timeline in paragraph (3) applies. Persons covered under individual health insurance plans must be notified of the right to request an external review without exhausting the carrier's second level appeal process. The same notice may be given to persons covered under group plans if the carrier permits them to bypass the second level of appeal. The health carrier's designated URE may fulfill the requirements of this subsection on the carrier's behalf, except that a person covered under an HMO plan, or the covered person's authorized representative, may exercise the right to pursue the appeal directly to the HMO.

- 2) The carrier shall appoint a panel for each second level appeal, which shall include one or more panelists who are disinterested clinical peers of the treating provider. For purposes of this paragraph, a provider is disinterested if the provider was not involved in the prior decision, is not a subordinate of a panelist involved in the prior decision, and has no financial or other personal interest in the outcome of the review. A second level appeal decision adverse to the covered person must have the concurrence of a majority of the disinterested clinical peers on the panel.
- 3) Whenever a covered person or authorized representative has requested the opportunity to appear in person before authorized representatives of the health carrier, a health carrier's procedures for conducting a second level panel review shall include the following:
 - a) The review panel shall schedule and hold a review meeting within 45 days after receiving a request from a covered person or authorized representative for a second level review. The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person or authorized representative. The health carrier shall offer the covered person or authorized representative the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. The covered person or authorized representative shall be notified in writing at least 15 days in advance of the review date. The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person or authorized representative.
 - b) Upon the request of a covered person or authorized representative, a health carrier shall provide to the covered person or authorized representative all relevant information that is not confidential and privileged from disclosure to the covered person.
 - c) A covered person or authorized representative has the right to:
 - i) Attend the second level review;
 - ii) Present the-case to the review panel;
 - iii) Submit supporting material both before and at the review meeting;

- iv) Ask questions of any representative of the health carrier;
 - v) Be assisted by a person of the covered person's-choice; and
 - vi) Obtain-the medical file and information relevant to the appeal free of charge upon request.
- d) If the health carrier will have an attorney present to argue its case against the covered person, the carrier shall so notify the covered person or authorized representative at least 15 days in advance of the review, and shall advise the covered person or authorized representative of the right to obtain legal representation.
 - e) The covered person's right to a fair review shall not be made conditional on the covered person's or authorized representative's appearance at the review.
 - f) The review panel shall issue a written decision to the covered person and to the authorized representative, if any, within 5 working days after completing the review meeting. A decision adverse to the covered person shall include the requirements set forth in subparagraph 8(G)(1)(c).

H. Emergency Services

When conducting utilization review or making a benefit determination for emergency services:

- 1) A health carrier shall cover emergency services necessary to screen and stabilize a covered person, and shall not require prior authorization of such services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. For purposes of this subsection, the terms "screening" and "stabilize" shall be interpreted consistent with Section 1867 of the Social Security Act at 42 U.S.C. §1395dd. With respect to care obtained from a non-contracting provider within the service area of a managed care plan, a health carrier shall cover emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of the services if a prudent layperson would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency, or if a provision of federal, state or local law requires the use of a specific provider.
- 2) A health carrier shall cover emergency services if the health carrier, acting through a participating provider or other authorized representative, has authorized the provision of emergency services.
- 3) If a participating provider or other authorized representative of a health carrier authorizes emergency services, the health carrier shall not subsequently retract its authorization after the emergency services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless the approval was based on fraudulent or materially incorrect information.

- 4) Coverage of emergency services shall be subject to applicable copayments, coinsurance and deductibles.
- 5) If an enrollee receives an emergency service that requires immediate post-evaluation or post-stabilization services, the carrier may not require prior authorization for the post-evaluation or post-stabilization services provided during the same encounter. If the post-evaluation or post-stabilization services require an inpatient level of care, the carrier shall make a utilization review determination within 24 hours after receiving a request for those services and the carrier is responsible for payment for those services for the duration until the carrier affirmatively notifies the provider otherwise. If the utilization review determination is not made within 24 hours, the services for which the utilization review was requested are deemed approved until the carrier affirmatively notifies the provider otherwise. If the patient is being treated by an out-of-network provider, network-level cost sharing in accordance with 24-A M.R.S.A. § 4320-C shall continue unless the enrollee has been offered a clinically appropriate opportunity to transition to a network provider and has knowingly elected to continue receiving out-of-network care.
- 6) Before a carrier denies benefits or reduces payment for an emergency service based on a determination of the absence of an emergency medical condition or a determination that a lower level of care was needed, the carrier shall conduct a utilization review done by a board-certified emergency physician who is licensed in this State, including a review of the covered person's medical record related to the emergency medical condition subject to dispute. If a carrier requests records related to a potential denial of benefits or payment reduction when emergency services were furnished to a covered person, a provider has an affirmative duty to respond to the carrier in a timely manner. This paragraph does not apply when a carrier makes a reduction in payment for health care services based on a contractually agreed upon adjustment.

I. Disclosure Requirements

- 1) A health carrier shall include a clear and reasonably comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse benefit determinations, and a statement of rights and responsibilities of covered persons with respect to those procedures in the certificate of coverage or member handbook provided to covered persons. The statement of rights shall disclose the member's or authorized representative's right to request in writing and receive copies of any clinical review criteria utilized in arriving at any adverse health care treatment decision pertaining to the member.
- 2) A health carrier shall include a summary of its utilization review procedures in materials intended for prospective covered persons. Health carriers who offer managed care plans shall include utilization review procedure summaries in materials intended for prospective network providers.
- 3) A health carrier requiring enrollees to initiate utilization review shall print on its membership cards a toll-free telephone number to call for utilization review decisions.

Section 9. Adverse Benefit Determinations not Involving Adverse Health Care Treatment Decisions

A. Notice of Adverse Benefit Determinations not Involving Health Care Treatment Decisions

Adverse benefit determinations involving medical issues (adverse health care treatment decisions) are subject to the written notice requirements of subsection 8(E). For any adverse benefit determination that does not involve medical issues, the carrier shall provide written notice that includes the information required below:

- 1) the principal reason or reasons for the determination;
- 2) reference to the specific plan provisions on which the determination is based;
- 3) information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount if applicable), and a statement that the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, will be provided upon request;
- 4) a description of any additional material or information necessary for the covered person to perfect the claim and an explanation as to why such material or information is necessary;
- 5) the instructions and time limits for initiating an appeal or reconsideration of the determination;
- 6) notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier's internal review process. In addition, an explanation of benefits (EOB) must comply with the requirements of 24-A M.R.S.A. §4303(13) and any rules adopted pursuant thereto.
- 7) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination and explaining that a copy will be provided free of charge to the covered person upon request;
- 8) a phone number the covered person may call for information on and assistance with initiating an appeal or reconsideration or requesting review criteria;
- 9) a description of the expedited review process applicable to claims involving exigent circumstances;
- 10) the availability of any applicable office of health insurance consumer assistance or ombudsman; and
- 11) any other information required pursuant to the federal Affordable Care Act.

B. First Level Review of Adverse Benefit Determinations not Involving Health Care Treatment Decisions

- 1) A grievance concerning any matter may be submitted by a covered person or a covered person's authorized representative. Appeals of adverse health care treatment decisions are subject to the requirements of subsections 8(G) and 8(G-1) of this rule. Review of other grievances is subject to this subsection and subsection C of this section.
- 2) A covered person does not have the right to attend, or to have an authorized representative in attendance, at the first level grievance review, but is entitled to submit written material to the reviewer. The health carrier shall provide the covered person or authorized representative the name, address and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier. The health carrier shall make these rights known to the covered person or authorized representative within 3 working days after receiving a grievance.
 - a) The person or persons reviewing the grievance shall not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance.
 - (b) The health carrier shall issue a written decision to the covered person or authorized representative within 30 days after receiving a grievance. Additional time is permitted where the carrier can establish the 30-day time frame cannot reasonably be met due to the carrier's inability to obtain necessary information from a person or entity not affiliated with or under contract with the carrier. The carrier shall provide written notice of the delay to the covered person or authorized representative. The notice shall explain the reasons for the delay. In such instances, decisions must be issued within 30 days after the carrier's receipt of all necessary information.
 - c) If the decision is adverse to the covered person, the written decision shall contain:
 - i) An attestation that contains:
 - a) the credentials of the person or persons participating in the grievance review process, and
 - b) a statement that no person participating in the grievance review process was involved in the initial decision.
 - ii) The name, address, and telephone number of a point of contact to answer specific questions from the enrollee.
 - iii) A statement of the reviewers' understanding of the covered person's grievance and all pertinent facts.

- iv) Reference to the specific plan provisions on which the decision is based.
- v) The reviewers' decision in clear terms, including the specific reason or reasons for the adverse benefit determination.
- vi) A reference to the evidence or documentation used as the basis for the decision. The decision shall include instructions for requesting copies, free of charge, of all documents, records and other information relevant to the claim, including any referenced evidence or documentation not previously provided to the covered person or authorized representative.
- vii) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination and explaining that a copy will be provided free of charge to the covered person or authorized representative upon request.
- viii) A description of the process to obtain a second level grievance review of a decision, the procedures and time frames governing a second level grievance review, and the rights specified in subparagraph C(3)(c). Notice to the enrollee describing any subsequent external review rights, if required by 24-A M.R.S.A. §4312(3).
- ix) Notice of the availability of any applicable office of health insurance consumer assistance or ombudsman.
- x) Notice of the covered person's right to contact the Superintendent's office. The notice shall contain the toll-free telephone number, website address, and mailing address of the Bureau of Insurance.
- xi) Any other information required pursuant to the federal Affordable Care Act.

C. Second Level Review of Adverse Benefit Determinations not Involving Health Care Treatment Decisions

- 1) A health carrier shall provide a second level grievance review process to covered persons who are dissatisfied with a first level grievance review determination under subsection B. The covered person or authorized representative has the right to appear in person before authorized representatives of the health carrier, and shall be provided adequate notice of that option by the carrier. If the covered person or authorized representative does not request an in-person second level panel review, the decision must be issued within 30 days; if the covered person

or authorized representative does request an in-person second level panel review, the timeline in subparagraph (3) applies.

- 2) The carrier shall appoint a second level grievance review panel for each grievance subject to review under this subsection. A majority of the panel shall consist of employees or representatives of the health carrier who were not previously involved in the grievance.
- 3) Whenever a covered person or authorized representative has requested the opportunity to appear in person before authorized representatives of the health carrier, a health carrier's procedures for conducting a second level panel review shall include the following:
 - a) The review panel shall schedule and hold a review meeting within 45 days after receiving a request from a covered person or authorized representative for a second level review. The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person or authorized representative. The health carrier shall offer the covered person or authorized representative the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. The covered person or authorized representative shall be notified in writing at least 15 days in advance of the review date. The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person or authorized representative.
 - b) Upon the request of a covered person or authorized representative, a health carrier shall provide to the covered person or authorized representative, free of charge, all relevant information that is not confidential and privileged from disclosure to the covered person.
 - c) A covered person or authorized representative has the right to:
 - i) Attend the second level review;
 - ii) Present the covered person's case to the review panel;
 - iii) Submit supporting material both before and at the review meeting;
 - iv) Ask questions of any representative of the health carrier; and
 - v) Be assisted by a person of the covered person's choice.
 - d) If the health carrier will have an attorney present to argue its case against the covered person, the carrier shall so notify the covered person or authorized representative at least 15 days in advance of the review, and shall advise the covered person or authorized representative of the right to obtain legal representation.

- e) The covered person's right to a fair review shall not be made conditional on the covered person's or authorized representative's appearance at the review.
- f) The review panel shall issue a written decision to the covered person or authorized representative within 5 working days after completing the review meeting. A decision adverse to the covered person shall include the information specified in subparagraph B(2)(c), except B(2)(c)(vii).

Section 10 Grievance Register and Grievance Procedures

A. Grievance Register

- 1) A health carrier shall maintain written records to document all grievances received during a calendar year (the register). Standard and expedited appeals pursuant to subsection 8(G) of this rule shall not be considered grievances for purposes of the grievance register. For each grievance the register shall contain, at a minimum, the following information:
 - a) A general description of the reason for the grievance;
 - b) Date received;
 - c) Date of each review or hearing;
 - d) Resolution at each level of the grievance;
 - e) Date of resolution at each level; and
 - f) Name of the covered person for whom the grievance was filed.
- 2) The register shall be maintained in a manner that is reasonably clear and accessible to the Superintendent.
- 3) A health carrier shall retain the register compiled by calendar year for the longer of 3 years or until the Superintendent has adopted a final report of an examination that contains a review of the register maintained for the period of the examination.

B. Grievance Procedure

A health carrier shall establish and implement written procedures for receiving and resolving grievances from covered persons consistent with the requirements of this section, and sections 8 and 9 as applicable. For purposes of this section, the term "covered person" includes the representative of a covered person. A description of the appeal and grievance procedure shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons. The appeal and grievance procedure description shall include a statement of a covered person's right to contact the Superintendent's office for assistance at any time. The statement shall include the toll-free telephone number, website address,

and mailing address of the Bureau of Insurance. The notification must include a statement that assistance may be available through an office of health insurance consumer assistance or ombudsman.

DRAFTING NOTE: The requirements of this section apply to grievances regarding medical issues (adverse health care treatment decisions) and also to grievances and adverse benefit determinations that do not involve medical issues.

Section 11. Reporting Requirements

The annual reports to the Superintendent required of HMOs pursuant to Title 24-A M.R.S.A. §§ 4211 and 4228, and of carriers pursuant to §4302(2), are due on March 1st of each year, except that an HMO or carrier which has been licensed less than 6 months as of March 1st shall not be required to report until the following year. The annual Access Plan updates required by this rule are due on March 1st of each year, except that a carrier which has filed its first access plan within 6 months of March 1st shall not be required to update its plan until the following year.

Section 12. Effective Date

The 2020 Amendments to this rule are effective May 24, 2020.

The 2025 Amendments to this rule are effective , 2025.

STATUTORY AUTHORITY: 24-A M.R.S. §§ 2772-2774, 4218, 4222-A, 4303 and 4309; Resolve 2007 ch. 160

EFFECTIVE DATE (AS CHAPTER 520):
February 9, 1991

EFFECTIVE DATE (ELECTRONIC CONVERSION):
January 14, 1997

CHAPTER 520 REPEALED, REPLACED BY CHAPTER 850:
October 25, 1997. (Note: As specified in Section 4 (A), this is 180 days after final adoption, which occurred on April 28, 1997.)

AMENDED:
March 19, 2002
January 3, 2004, filing 2003-485 - Subsection 7(G), routine technical language only

NON-SUBSTANTIVE CORRECTIONS:
February 4, 2004 - language restored in Section 7.C.3).c)
March 24, 2004 - minor punctuation and spacing

AMENDED:
June 9, 2004 - filing 2004-153, major substantive language

NON-SUBSTANTIVE CORRECTION:
August 31, 2004 - spelling in Section 3

AMENDED:
The 2007 Amendments to the rule are major substantive amendments and were provisionally adopted on December 6, 2007. Pursuant to 5 M.R.S.A. §8072 the rule has legal effect only after review by the Legislature followed by final adoption by the agency. The 2007 amendments to the rule are effective June 29, 2008, filing 2008-233.

AMENDED:
May 24, 2012 – filing 2012-111 (final adoption, major substantive)

AMENDED:
May 24, 2020 – filing 2020-120 (routine technical)

ACCESSIBILITY CHECK: July 10, 2025

AMENDED:
August 8, 2025 – filing 2025-141 (final adoption, major substantive)