§4305. Quality of care

A carrier offering or renewing a health plan that subjects payment of benefits for otherwise covered services to review for clinical necessity, appropriateness, efficacy or efficiency must meet the following requirements relating to quality of care. [PL 2007, c. 199, Pt. B, §14 (AMD).]

1. Internal quality assurance program. A health plan must have an ongoing quality assurance program for the health care services provided or reimbursed by the health plan.
[PL 1995, c. 673, §1 (NEW); PL 1995, c. 673, §2 (AFF).]

2. Written standards. The standards of quality of care must be described in a written document, which must be available for examination by the superintendent or by the Department of Health and Human Services.
[PL 1995, c. 673, §1 (NEW); PL 1995, c. 673, §2 (AFF); PL 2003, c. 689, Pt. B, §6 (REV).]

3. Coverage decisions. Following a determination that a particular service is covered, a carrier may not deny payment for that service based on the enrollee's age, nature of disability or degree of medical dependency.
[PL 1995, c. 673, §1 (NEW); PL 1995, c. 673, §2 (AFF).]

SECTION HISTORY

PL 1995, c. 673, §C1 (NEW). PL 1995, c. 673, §C2 (AFF). PL 1999, c. 742, §14 (AMD). PL 2003, c. 689, §B6 (REV). PL 2007, c. 199, Pt. B, §14 (AMD).