(3) "Member" does not include a Medicaid recipient.

15–10D–02.

(a) (1) Each carrier shall establish an internal appeal process for use by its members [and health care providers] OR THEIR AUTHORIZED REPRESENTATIVES to dispute coverage decisions made by the carrier.

(2) The carrier may use the internal grievance process established under Subtitle 10A of this title to comply with the requirement of paragraph (1) of this subsection.

(B) THE CARRIER'S INTERNAL APPEAL PROCESS SHALL ALLOW:

(1) AN AUTHORIZED REPRESENTATIVE TO FILE AN APPEAL; OR

(2) IN AN EMERGENCY CASE, A HEALTH CARE PROVIDER WITH KNOWLEDGE OF THE MEMBER'S MEDICAL CONDITION TO FILE AN APPEAL.

[(b)] (C) An internal appeal process established by a carrier under this section shall provide that a carrier render [a final] AN APPEAL decision in writing to a [member, and a health care provider acting on behalf of the member,] MEMBER AND AUTHORIZED REPRESENTATIVE within 60 [working] days after the date on which the [appeal is filed] CARRIER RECEIVES THE APPEAL OF A RETROSPECTIVE DENIAL.

(D) AN INTERNAL APPEAL PROCESS ESTABLISHED BY A CARRIER UNDER THIS SECTION SHALL PROVIDE THAT A CARRIER RENDER A FINAL DECISION IN WRITING TO A MEMBER AND AUTHORIZED REPRESENTATIVE WITHIN 30 DAYS AFTER THE DATE THE CARRIER RECEIVES THE APPEAL OF A HEALTH CARE SERVICE NOT YET PROVIDED.

[(c)] (E) Except as provided in subsection [(d)] (F) of this section, the carrier's internal appeal process shall be exhausted prior to filing a complaint with the Commissioner under this subtitle.

[(d)] (F) A member or [a health care provider filing a complaint on behalf of a member] AN AUTHORIZED REPRESENTATIVE may file a complaint with the Commissioner without first filing an appeal with a carrier only if the coverage decision involves an [urgent medical condition, as defined by regulation adopted by the Commissioner,] EMERGENCY CASE for which care has not been rendered.

[(e) (1) Within 30 calendar days after a coverage decision has been made, a carrier shall send a written notice of the coverage decision to the member and, in the case of a health maintenance organization, the treating health care provider.]

(G) (1) FOR A COVERAGE DECISION INVOLVING A NONEMERGENCY CASE FOR WHICH CARE HAS NOT BEEN PROVIDED, A CARRIER SHALL COMPLY WITH § 15–10A–02(I)(4) OF THIS TITLE.

(2) FOR A COVERAGE DECISION INVOLVING A RETROSPECTIVE DENIAL OF HEALTH CARE SERVICES, A CARRIER SHALL COMPLY WITH § 15–10A–02(I)(5) OF THIS TITLE.