(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) any other person that provides health benefit plans subject to regulation by the State.

(3) "CODE" MEANS:

(I) THE APPLICABLE CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE, AS ADOPTED BY THE AMERICAN MEDICAL ASSOCIATION;

(II) IF FOR A DENTAL SERVICE, THE APPLICABLE CODE ADOPTED BY THE AMERICAN DENTAL ASSOCIATION; OR

(III) ANOTHER APPLICABLE CODE UNDER AN APPROPRIATE UNIFORM CODING SCHEME USED BY A CARRIER IN ACCORDANCE WITH THIS SECTION.

(4) "CODING GUIDELINES" MEANS THOSE STANDARDS OR PROCEDURES USED OR APPLIED BY A PAYOR TO DETERMINE THE MOST ACCURATE AND APPROPRIATE CODE OR CODES FOR PAYMENT BY THE PAYOR FOR A SERVICE OR SERVICES.

~~(3)~~ *(5)* "Health care provider" means a person or entity licensed, certified or otherwise authorized under the Health Occupations Article or the Health – General Article to provide health care services.

~~(4) "IMPROPER CODING" MEANS THE USE OF A PROCEDURAL CODE FOR A PROCEDURE OR SERVICE DELIVERED, IN A SUBMISSION OF CLAIM INFORMATION, THAT DOES NOT CONFORM WITH:~~

~~(I) THE VERSION OF THE AMERICAN MEDICAL ASSOCIATION'S CLINICAL PROCEDURAL TERMINOLOGY CODE BOOK IN EFFECT ON THE DATE A CLAIM WAS SUBMITTED TO A CARRIER FOR REIMBURSEMENT; OR~~

~~(II) THE CODING GUIDELINES THAT A CARRIER HAS PROVIDED IN WRITING TO THE HEALTH CARE PROVIDER THAT ARE IN EFFECT ON THE DATE THAT THE CLAIM WAS SUBMITTED TO THE CARRIER FOR REIMBURSEMENT.~~

~~(4) "IMPROPER CODING" MEANS THE INACCURATE OR INAPPROPRIATE DESCRIPTION OF A SERVICE OR GROUP OF SERVICES BY A HEALTH CARE PROVIDER FOR PAYMENT BY A CARRIER THAT USES PROCEDURAL CODES FOR THE SERVICE OR GROUP OF SERVICES DELIVERED, WHERE THE DESCRIPTION DOES NOT CONFORM WITH:~~

~~(I) THE APPLICABLE CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE IN EFFECT ON THE DATE THE SERVICE OR GROUP OF SERVICES WERE RENDERED:~~