~~(i) uses codes that do not conform with the coding guidelines used by the carrier applicable as of the date the service or services were rendered; or~~

~~(ii) does not otherwise conform with the contractual obligations of the health care provider to the carrier applicable as of the date the service or services were rendered.~~

~~(c) If a carrier retroactively denies reimbursement for services as a result of coordination of benefits under provisions of subsection (b)(1)(i) of this section, the health care provider shall have 6 months from the date of denial, unless a carrier permits a longer time period, to submit a claim for reimbursement for the service to the carrier, Maryland Medical Assistance Program, or Medicare Program responsible for payment.~~

Article – Health – General

19–706.

(o) The provisions of [§ 15–1008] §§ 15–1008 AND 15–1009 of the Insurance Article [shall] apply to health maintenance organizations.

Article – Insurance

15–1009.

(A) IN THIS SECTION, "CARRIER" MEANS:

(1) AN INSURER;

(2) A NONPROFIT HEALTH SERVICE PLAN;

(3) A HEALTH MAINTENANCE ORGANIZATION;

(4) A DENTAL PLAN ORGANIZATION; OR

(5) ANY OTHER PERSON THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO REGULATION BY THE STATE.

~~(F)~~ (B) IF A ~~COURSE OF TREATMENT~~ HEALTH CARE SERVICE FOR A PATIENT HAS BEEN PREAUTHORIZED OR APPROVED BY A CARRIER *OR THE CARRIER'S PRIVATE REVIEW AGENT*, THE CARRIER MAY NOT DENY REIMBURSEMENT TO A HEALTH CARE PROVIDER FOR THE PREAUTHORIZED OR APPROVED ~~SERVICES~~ SERVICE DELIVERED TO THAT PATIENT UNLESS:

(1) THE INFORMATION SUBMITTED TO THE CARRIER REGARDING THE ~~SERVICES~~ SERVICE TO BE DELIVERED TO THE PATIENT WAS FRAUDULENT OR INTENTIONALLY MISREPRESENTATIVE ~~OR~~;

(2) CRITICAL INFORMATION REQUESTED BY THE CARRIER REGARDING ~~SERVICES~~ THE SERVICE TO BE DELIVERED TO THE PATIENT WAS OMITTED SUCH THAT THE CARRIER'S DETERMINATION WOULD HAVE BEEN DIFFERENT HAD IT KNOWN THE CRITICAL INFORMATION; ~~OR~~