(V) A MANAGED CARE ORGANIZATION, AS DEFINED IN § 15–101 OF THE HEALTH – GENERAL ARTICLE; OR

[(v)] **(VI)** 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.

(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.

(6) "Reimbursement" means payments made to a health care provider by a carrier on either a fee–for–service, capitated, or premium basis.

(b) This section does not apply to an adjustment to reimbursement made as part of an annual contracted reconciliation of a risk sharing arrangement under an administrative service provider contract.

(c) (1) If a carrier retroactively denies reimbursement to a health care provider, the carrier:

(i) may only retroactively deny reimbursement for services subject to coordination of benefits with another carrier, the Maryland Medical Assistance Program, or the Medicare Program during the 18–month period after the date that the carrier paid the health care provider; and

(ii) except as provided in item (i) of this paragraph, may only retroactively deny reimbursement during the 6–month period after the date that the carrier paid the health care provider.