

**§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).

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