**FINAL AND PROPOSAL**

**FINAL AAP**

**Maryland Register**

**Issue Date: May 8, 2020**

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**Title 10
MARYLAND DEPARTMENT OF HEALTH**

**Subtitle 14 CANCER CONTROL**

**10.14.02 Reimbursement for Breast and Cervical Cancer Diagnosis and Treatment**

Authority: Health-General Article, §§2-102, 2-104, and 2-105, Annotated Code of Maryland

**Notice of Final Action**

[19-207-F]

On April 28, 2020, the Secretary of Health adopted amendments to Regulations **.01—.07**, **.09**, **.10**, and **.12—.22** and new Regulations **.04-1** and **.04-2** under **COMAR 10.14.02 Reimbursement for Breast and Cervical Cancer Diagnosis and Treatment**. This action, which was proposed for adoption in 46:22 Md. R. 992—997 (October 25, 2019), has been adopted as proposed.

**Effective Date: May 18, 2020.**

ROBERT R. NEALL
Secretary of Health

**PROPOSAL**

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**Issue Date: October 25, 2019**

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**Notice of Proposed Action**

[19-207-P]

     The Secretary of Health proposes to amend Regulations **.01—.07**, **.09**, **.10**, and **.12—.22** and adopt new Regulations **.04-1** and **.04-2** under **COMAR 10.14.02 Reimbursement for Breast and Cervical Cancer Diagnosis and Treatment**.

**Statement of Purpose**

The purpose of this action is to add physician assistants and certified nurse midwives to the list of providers that may be reimbursed by the Breast and Cervical Cancer Diagnosis and Treatment Program (Program) under this chapter, update outdated references and definitions, and make clarifying changes throughout.

**Comparison to Federal Standards**

There is no corresponding federal standard to this proposed action.

**Estimate of Economic Impact**

The proposed action has no economic impact.

**Economic Impact on Small Businesses**

The proposed action has minimal or no economic impact on small businesses.

**Impact on Individuals with Disabilities**

The proposed action has no impact on individuals with disabilities.

**Opportunity for Public Comment**

Comments may be sent to Jake Whitaker, Acting Director, Office of Regulation and Policy Coordination, Maryland Department of Health, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499 (TTY 800-735-2258), or email to mdh.regs@maryland.gov, or fax to 410-767-6483. Comments will be accepted through November 25, 2019. A public hearing has not been scheduled.

**.01 Scope.**

A. (text unchanged)

B. This chapter also defines the:

(1) Responsibilities and duties of the Department, the participating local health department, the hospital-coordinated breast and cervical cancer screening program, the **[**medical**]** *health care*provider who determines patient eligibility and refers patients to the Program, and the following participating providers:

(a) (text unchanged)

*(b) Physician assistant;*

*(c) Certified nurse midwife;*

**[**(b)**]** *(d)*—**[**(k)**]** *(m)*(text unchanged)

(2) (text unchanged)

**.02 Definitions.**

A. (text unchanged)

B. Terms Defined.

(1)—(3) (text unchanged)

(4) “Applicant” means an individual who has applied to be eligible to have certain **[**medical**]** *health*care costs associated with the diagnosis and treatment of breast cancer, cervical cancer, or a precancerous cervical lesion paid for by the Department.

(5) (text unchanged)

**[**(6) “Breast and cervical cancer program” means a local health department program for the early detection of breast and cervical cancer.**]**

**[**(7)**]** *(6)*—**[**(8)**]***(7)*(text unchanged)

*(8) “Certified nurse midwife” means a registered nurse who:*

*(a) By reason of certification under COMAR 10.27.05, may practice in Maryland under the terms of those regulations; or*

*(b) Meets the certification requirements in the jurisdiction in which the service is provided, if the service is provided out-of-State.*

(9)—(24) (text unchanged)

**[**(25) “Health Services Cost Review Commission” means the independent organization within the Department which is responsible for reviewing and approving rates for hospitals pursuant to Health-General Article, Title 19, Subtitle 2, Annotated Code of Maryland.**]**

**[**(26)**]** *(25)*—**[**(29)**]** *(28)* (text unchanged)

**[**(30) “Initial referring agency” means the local health department, hospital, or medicalprovider which refers an eligible patient to a participatingmedical care provider.**]**

**[**(31)**]** *(29)*—**[**(37-1)**]** *(37)* (text unchanged)

(38) “Medical **[**assistance**]** *Assistance*” means the program administered by the State under Title XIX of the Social Security Act which provides comprehensive medical and other health-related care for eligible and medically needy low income individuals.

(39)—(46) (text unchanged)

**[**(47) “Oncology consultation” means the act of conferring with a physician who is a cancer specialist about the medical case management of a patient.**]**

**[**(48)**]** *(47)*(text unchanged)

**[**(49)**]** *(48)*“Participating **[**medical**]** *health*care provider” means a local health department, hospital, or a participating:

*(a) Certified nurse midwife;*

**[**(a)**]***(b)*—**[**(j)**]** *(k)*(text unchanged)

*(l) Physician assistant;*

**[**(k)**]** *(m)*(text unchanged)

**[**(l)**]** *(n)*Other appropriate **[**medical**]** *health*care providers.

**[**(50)**]** *(49)*—**[**(57)**]** *(56)*(text unchanged)

**[**(58) “Physical therapy provider” means an individual, association, partnership, or incorporated or unincorporated group of physical therapists who are licensed or registered to provide services for patients.**]**

**[**(59)**]** *(57)*(text unchanged)

*(58) “Physician assistant” means an individual who:*

*(a) Is licensed to practice medicine under the supervision of a physician under Health Occupations Article, Title 15, Annotated Code of Maryland; or*

*(b) Meets the licensure requirements in the jurisdiction in which the service is provided, if the service is provided out-of-State.*

**[**(60)**]** *(59)*“Prescriber” means a participating **[**medical**]** *health*care provider licensed to prescribe legend drugs in the state in which the service is provided.

**[**(61)**]** *(60)* (text unchanged)

**[**(62)**]** *(61)*“Program” means the Breast and Cervical Cancer Diagnosis and Treatment Program within the Department established to:

(a) Reimburse for breast and cervical cancer diagnostic and treatment services provided by participating **[**medical**]** *health*care providers to eligible patients; and

(b) Pay for MHIP coverage, if available, for eligible patients in lieu of providing direct reimbursement to participating **[**medical**]** *health*care providers.

**[**(63)**]** *(62)*—**[**(66)**]** *(65)*(text unchanged)

**[**(67) “Second surgical opinion” means an independent opinion obtained from another physician before the performance of a surgical procedure recommended by the initial physician.**]**

**[**(68)**]** *(66)*—**[**(71)**]** *(69)*(text unchanged)

**[**(72) “Usual source of supply” means the most frequently used pharmaceuticals located within the State that are obtained by a pharmacy provider from a wholesaler, distributor, or manufacturer.**]**

**[**(73)**]** *(70)*(text unchanged)

**.03 Patient Eligibility.**

A. To be eligible to have a covered service reimbursed under the Program, an applicant shall:

(1) Be a resident **[**of Maryland**]**;

(2) Be screened for breast cancer or cervical cancer, or both, by a:

(a)—(b) (text unchanged)

(c) **[**Medical**]** *Health care* provider;

(3)—(5) (text unchanged)

(6) Receive a medical service only from participating **[**medical**]** *health* care providers for breast cancer diagnosis, breast cancer treatment, cervical cancer diagnosis, or cervical cancer or precancer treatment, or any combination of these services.

B.—F. (text unchanged)

G. An eligible patient is responsible for the following:

(1) Keeping the Program, local health department, hospital, or **[**medical**]** *health care* provider who determines the patient’s eligibility for the Program informed of any change in health insurance status;

(2) Selecting and using only a participating **[**medical**]** *health* care provider; and

(3) (text unchanged)

**.04 Physician Services.**

A. To be considered a participating physician in the Program, the provider shall:

(1)—(6) (text unchanged)

(7) Agree to the following medical guidelines:

(a)—(f) (text unchanged)

(g) To consult an oncologist before any treatment is initiated for Stage **[**1**]** *I*or greater breast cancer or invasive cervical cancer; and

(h) (text unchanged)

(8)—(10) (text unchanged)

B.—D. (text unchanged)

E. The participating physician is responsible for the following:

(1) (text unchanged)

(2) Accepting a referral of an eligible patient from a local health department, hospital, or other **[**medical**]** *health care* provider;

(3)—(9) (text unchanged)

F.—G. (text unchanged)

***.04-1 Physician Assistant Services.***

*A. To be considered a participating physician assistant in the Program, the provider shall:*

*(1) Be licensed to practice as a physician assistant in Maryland or a jurisdiction bordering Maryland;*

*(2) Have a current written executed delegation agreement with a licensed supervising physician who is licensed to practice medicine in Maryland or a jurisdiction bordering on Maryland, if required by that jurisdiction;*

*(3) Agree to accept, for each reimbursed medical procedure performed or service provided, the following reimbursement including, if applicable, a medical management fee as described in Regulation .15 of this chapter:*

*(a) The current Medical Assistance approved rate in the State of an eligible patient who is uninsured or has insurance that does not provide coverage for a certain procedure or services;*

*(b) The reimbursement rate approved by the insurer plus the payment of the deductible and patient contribution amount by the Department for an eligible patient who has insurance, other than Medicare, that provides coverage for a certain procedure or service;*

*(c) The reimbursement rate approved by Medicare plus the payment of the deductible and patient contribution amount by the Department for an eligible patient who is covered by Medicare only; or*

*(d) For an eligible patient who has insurance that provides coverage for a reimbursed procedure or service that is less than the current Medical Assistance approved rate, the reimbursement rate approved by the insurer plus the difference between the reimbursement rate approved by the insurer, and the Medical Assistance approved rate in the State plus the payment of the deductible and patient contribution amount by the Department;*

*(4) Agree to abide by the provisions set forth in this section by signing and sending to the Department the designated Departmental form; and*

*(5) Agree to the medical, financial, and reporting requirements of the Program pursuant to Regulation .04A(5), (6), (7)(a)—(e), and (8)—(10) of this chapter.*

*B. An eligible health care provider may be a physician assistant.*

*C. The reimbursed medical services include services related to breast and cervical cancer rendered to participants in accordance with:*

*(1) The functions allowed under:*

*(a) The Physician Assistant’s Practice Act;*

*(b) COMAR 10.32.03; and*

*(c) The physician assistant’s written delegation agreement with a physician; or*

*(2) If out-of-State, the functions authorized in the state in which the services are provided.*

*D. Non-reimbursed medical procedures and services include a procedure or service not related to the diagnosis and treatment of breast and cervical cancer.*

*E. The participating physician assistant shall accept the responsibilities pursuant to Regulation .04E—G of this chapter.*

***.04-2 Certified Nurse Midwife Services.***

*A. To be considered a participating certified nurse midwife in the Program, the provider shall:*

*(1) Be a certified nurse midwife in Maryland or a jurisdiction bordering on Maryland and hold all certifications as required by the Maryland Board of Nursing;*

*(2) Agree to accept, for each reimbursed medical procedure performed or service provided, the following reimbursement including, if applicable, a medical management fee as described in Regulation .15 of this chapter:*

*(a) The current Medical Assistance approved rate in the State for an eligible patient who is uninsured or has insurance that does not provide coverage for a certain procedure or service;*

*(b) The reimbursement rate approved by the insurer plus the payment of the deductible by the Department for an eligible patient who has insurance, other than Medicare, that provides coverage for a certain procedure or service;*

*(c) The reimbursement rate approved by Medicare plus the payment of the deductible and patient contribution amount by the Department for an eligible patient who is covered by Medicare only; or*

*(d) For an eligible patient who has insurance that provides coverage for a reimbursed procedure or service that is less than the current Medical Assistance approved rate, the reimbursement rate approved by the insurer plus the difference between the reimbursement rate approved by the insurer, and the Medical Assistance approved rate in the State plus the payment of the deductible by the Department;*

*(3) Agree to abide by the provisions set forth in this section by signing and sending to the Department the designated Departmental form; and*

*(4) Agree to the medical, financial, and reporting requirements of the Program pursuant to Regulation .04A(5), (6), (7)(a)—(e), and (8)—(10) of this chapter.*

*B. If out-of-State, the provider shall meet the regulatory requirements of the state in which the services are provided.*

*C. The reimbursed medical procedure includes but is not limited to:*

*(1) Colposcopically directed cervical or vaginal biopsy or both:*

*(2) Colposcopy;*

*(3) Cyst aspiration;*

*(4) Endocervical curettage;*

*(5) Endometrial biopsy if the patient has taken Tamoxifen for the treatment of breast cancer or if cervical cancer has been documented;*

*(6) Medically necessary services within the provider’s scope of practice as described in COMAR 10.27.05; or*

*(7) If out-of-State, nurse midwife services authorized in the state in which the services are provided.*

*D. Non-reimbursed medical procedures and services include a procedure or service not related to the diagnosis and treatment of breast and cervical cancer.*

*E. The participating certified nurse midwife shall accept the responsibilities pursuant to Regulation .04E—G of this chapter.*

**.05 Nurse Practitioner Services.**

A. To be considered a participating nurse practitioner in the Program, the provider shall:

(1)—(2) (text unchanged)

(3) Agree to accept, for each reimbursed medical procedure performed or service provided, the following reimbursement including, if applicable, a medical management fee as described in Regulation .15 of this chapter:

(a) (text unchanged)

(b) The reimbursement rate approved by the insurer plus the payment of the deductible *and patient contribution amount*by the Department for an eligible patient who has insurance, other than Medicare, that provides coverage for a certain procedure or service;

(c)—(d) (text unchanged)

(4)—(5) (text unchanged)

B. An eligible **[**medical**]** *health care* provider may be a certified nurse practitioner.

C.—E. (text unchanged)

**.06 Nurse Anesthetist Services.**

A. To be considered a participating nurse anesthetist in the Program, the provider shall:

(1)—(2) (text unchanged)

(3) Agree to accept, for each covered medical procedure performed or service provided, the following reimbursement including, if applicable, a medical management fee as described in Regulation .15 of this chapter:

(a) (text unchanged)

(b) The reimbursement rate approved by the insurer plus the payment of the deductible *and the patient contribution amount*by the Department for an eligible patient who has insurance, other than Medicare, that provides coverage for a certain procedure or service;

(c)—(d) (text unchanged)

(4)—(5) (text unchanged)

B. An eligible **[**medical**]** *health care* provider may be a certified nurse anesthetist.

C.—E. (text unchanged)

**.07 Physical Therapy Services.**

A. To be considered a participating physical therapist in the Program, the provider shall:

(1)—(3) (text unchanged)

(4) Agree to the medical and reporting requirements of the Program pursuant to Regulation **[**.04A(6), (10), and (11)**]***.04A(5), (9), and (10)* of this chapter;

(5) Agree to accept, as payment in full, the amount paid by the Program pursuant to **[**§F**]** *§E*of this regulation plus the amount paid by the eligible patient’s health insurer, if applicable; and

(6) (text unchanged)

B.—G. (text unchanged)

**.09 Hospital Services.**

A.—B. (text unchanged)

C. Limitations. The limitations on coverage of some hospital inpatient and outpatient services contained in COMAR **[**10.09.06.05**]** *10.09.92.05*apply to this Program.

D.—F. (text unchanged)

G. Reimbursement Rates.

(1) A participating hospital located in Maryland shall be reimbursed by the Department:

(a) Pursuant to COMAR **[**10.09.06.09A(1), (2), (9), (10), and (12)**]** *10.09.92.07A(2)—(4) and B*for an eligible patient who is uninsured or who has insurance that does not provide coverage for the reimbursed service;

(b) Pursuant to COMAR **[**10.09.06.10K and L**]** *10.09.92.07A(8) and (9)*for an eligible patient who is covered by Medicare; or

(c) (text unchanged)

(2) A participating hospital located in a state bordering Maryland shall be reimbursed by the Department:

(a) Pursuant to **[**10.09.06.09A(1), (2), (9), (10), and (12)**]** *COMAR 10.09.92.07B*for an eligible patient who is uninsured or who has insurance that does not provide coverage for the reimbursed service;

(b) Pursuant to COMAR **[**10.09.06.10K and L**]** *10.09.92.07A(8) and (9)* for an eligible patient who is covered by Medicare; or

(c) (text unchanged)

(3) A participating hospital located in the District of Columbia shall be reimbursed by the Department:

(a) Pursuant to COMAR **[**10.09.06.15**]** *10.09.92.08A and B*for an eligible patient who is uninsured or who has insurance that does not provide coverage for the reimbursed service;

(b) Pursuant to **[**10.09.06.10K and L**]** *COMAR* *10.09.92.07A(8) and (9)*for an eligible patient who is covered by Medicare; or

(c) (text unchanged)

H. (text unchanged)

**.10 Disposable Medical Supplies and Durable Medical Equipment.**

A. (text unchanged)

B. The Department shall reimburse for the following:

(1) (text unchanged)

(2) Eligible durable medical equipment for purchase or rental **[**pursuant to COMAR 10.09.12.04A(2)**]**, including but not limited to:

(a)—(d) (text unchanged)

(e) Breast prosthesis, including surgical brassiere **[**with replacement of the prosthesis once every 3 years**]**; and

(f) (text unchanged)

C.—G. (text unchanged)

**.12 Medical Laboratory Services.**

A.—B. (text unchanged)

C. A non-reimbursed service includes but is not limited to the following:

(1) (text unchanged)

(2) A service for which there does not exist an order signed by a participating **[**medical**]** *health* care provider;

(3)—(6) (text unchanged)

D. Reimbursement Procedures. The participating medical laboratory is responsible for:

(1) (text unchanged)

(2) Keeping in the records, for each invoice, a copy of the signed orders from a participating **[**medical**]** *health care* provider requesting the service.

E.—F. (text unchanged)

**.13 Freestanding Ambulatory Surgical Center Services.**

A. To be considered a participating freestanding ambulatory surgical center in the Program, the provider shall:

(1)—(7) (text unchanged)

(8) Agree to the medical requirements of the Program pursuant to Regulation **[**.04A(8)—(11)**]** *.04A(8)—(10)*of this chapter.

B.—D. (text unchanged)

E. The Department shall pay the participating freestanding ambulatory surgical center for a reimbursed service:

(1) Pursuant to COMAR **[**10.09.42.06A—D-1**]** *10.09.42.06A, B, D, and E*for an eligible patient who is uninsured or has insurance that does not provide coverage for the reimbursed service;

(2) Pursuant to COMAR **[**10.09.42.06F—L**]** *10.09.42.06F*for an eligible patient who is covered by Medicare; or

(3) (text unchanged)

F. (text unchanged)

**.14 Occupational Therapy Services.**

A. To be considered a participating occupational therapist in the Program, the provider shall:

(1)—(3) (text unchanged)

(4) Agree to requirements of the Program set forth in Regulation **[**.04A(6), (10), and (11)**]** *.04A(5), (9), and (10)*of this chapter;

(5)—(6) (text unchanged)

B. The cost of an occupational therapist’s services are covered as set forth in COMAR **[**10.09.04.04B(1)**]** *10.09.04.04B(4)*.

C.—G. (text unchanged)

**.15 Medical Management Fee.**

A. A participating **[**medical**]** *health* care provider eligible to receive a medical management fee may be one of the following:

(1) (text unchanged)

*(2) Certified nurse midwife;*

**[**(2)**]** *(3)*—**[**(8)**]** *(9)*(text unchanged)

*(10) Physician assistant;*

**[**(9)**]** *(11)*—**[**(11)**]** *(13)*

**[**(12)**]** *(14)*Participating **[**medical**]** *health* care provider who renders services pursuant to §B of this regulation.

B. The Department shall reimburse a participating **[**medical**]** *health* care provider as outlined in §A of this regulation a medical management fee of $50 each time a reimbursed service:

(1) Is in compliance with the medical guidelines pursuant to Regulation **[**.04A(9)(a)—(f)**]** *.04A(7)(a)—(f)*of this chapter;

(2) Involves a consult with an oncologist pursuant to Regulation **[**.04A(9)(g) and (h)**]** *.04A(7)(g) and (h)*of this chapter;

(3) Is in compliance with the medical care management guidelines pursuant to Regulation **[**.04A(8)**]** *.04A(6)*of this chapter; or

(4) (text unchanged)

C. (text unchanged)

**.16 Department, Local Health Department, Hospital, and [Medical] *Health Care* Provider Responsibilities.**

A. The Department is responsible for the following:

(1) Developing the necessary administrative forms needed for the Program including, but not limited to, a:

(a)—(b) (text unchanged)

(c) Participating **[**medical**]** *health* care provider agreement form;

(2) Distributing the administrative forms to the following:

(a)—(b) (text unchanged)

*(c) Certified nurse midwife;*

**[**(c)**]** *(d)*—**[**(k)**]** *(l)*(text unchanged)

*(m) Physician assistant;*

**[**(l)**]** *(n*)—**[**(m)**]** *(o)*(text unchanged)

(3) Providing upon request a list of participating **[**medical**]** *health* care providers to local health department coordinators and **[**medical**]** *health care* providers for referral of eligible patients;

(4) Updating the list of participating **[**medical**]** *health* care providers not less than once a year;

(5) (text unchanged)

*(6) Reviewing and reimbursing a bill submitted by a participating physician assistant using the payment guidelines specified in Regulations .04-1 and .15 of this chapter;*

*(7) Reviewing and reimbursing a bill submitted by a participating certified nurse midwife using the payment guidelines specified in Regulations .04-2 and .15 of this chapter;*

**[**(6)**]** *(8)*—**[**(13)**]** *(15)*(text unchanged)

**[**(14)**]** *(16)*Receiving the application for an eligible patient from the local health department, hospital, or **[**medical**]** *health care* provider;

**[**(15)**]** *(17*)—**[**(19)**]** *(21)* (text unchanged)

**[**(20)**]** *(22)*Reviewing and reimbursing in accordance with Regulation .22 of this chapter a bill submitted by:

(a) (text unchanged)

(b) A participating **[**medical**]** *health care* provider; and

**[**(21)**]** *(23)*Ensuring compliance with the applicable regulations within this chapter by performing a periodic review of the records of a:

(a) (text unchanged)

(b) Participating **[**medical**]** *health* care provider.

B. The local health department, hospital, and a **[**medical**]** *health care* provider who refers a patient to the Program, are responsible for the following:

(1)—(5) (text unchanged)

(6) Assisting an eligible patient in selecting a participating **[**medical**]** *health* care provider and assisting in scheduling an appointment with the participating **[**medical**]** *health* care provider for the reimbursed medical procedure or service;

(7) (text unchanged)

(8) Providing an eligible patient with a copy of a temporary referral letter, identifying the patient as a participant in the Program, to be given to the participating **[**medical**]** *health* care provider until the card is issued to the eligible patient by the Department;

(9) (text unchanged)

(10) Evaluating patient progress through follow-up contact with the patient and the participating **[**medical**]** *health* care provider.

C. If an additional diagnostic or treatment procedure is necessary, the local health department, hospital, or **[**medical**]** *health care* provider who determines patient eligibility and refers an eligible patient to the Program shall repeat the procedure as set forth in §B(6) of this regulation.

D. The local health department, hospital, or other **[**medical**]** *health care* provider who determines patient eligibility and refers an eligible patient to the Program shall document in the patient’s medical record the result of the reimbursed diagnostic and treatment procedure performed.

**.17 Reimbursement.**

A. The Department shall reimburse a participating **[**medical**]** *health* care provider only for a medical service or procedure related to the diagnosis and treatment of breast cancer, cervical cancer, or a precancerous cervical lesion for an eligible patient.

B. The Department shall reimburse a participating **[**medical**]** *health* care provider a medical management fee pursuant to Regulation .15 of this chapter.

C. The participating **[**medical**]** *health* care provider shall reimburse the Department for an overpayment.

D. Insurance or Other Coverage.

(1) If the patient has insurance or other coverage, the participating **[**medical**]** *health* care provider shall first seek payment from that source.

*(2) The provider shall submit a copy of the insurance carrier’s notice or remittance advice with the invoice*.

*(3) If the insurance carrier provides coverage for a reimbursable procedure or service, the Department shall pay the deductible and patient contribution amount.*

**[**(2)**]** *(4)*If an insurance carrier rejects the claim or pays less than the amount of the allowed *Medical* Assistance Program rate, the provider may submit a claim to the Department.

**[**(3) The provider shall submit a copy of the insurance carrier’s notice or remittance advice with the invoice.**]**

**[**(4)**]** *(5)—***[**(5)**]** *(6)*(text unchanged)

E. (text unchanged)

**.18 Liability.**

Responsibility for liability for services provided, and for the availability of appropriate insurance coverage, rests with the participating **[**medical**]** *health* care provider.

**.19 Termination from the Program.**

A. If the Department determines that a participating **[**medical**]** *health* care provider has failed to comply with the applicable regulations of this chapter, the Department may terminate the written agreement with the provider by giving 30 days notice in writing to the participating **[**medical**]** *health* care provider.

B. The participating **[**medical**]** *health* care provider may terminate the provider agreement with the Department by:

(1)—(2) (text unchanged)

**.20 Appeal Procedures.**

A. A provider filing an appeal of the Department’s decision to terminate the provider’s agreement with the Program shall do so according to State Government Article, Title 10, Subtitle 2, Annotated Code of Maryland**[**, and Health-General Article, §§2-201—2-207, Annotated Code of Maryland**]**.

B. (text unchanged)

**.21 Billing and Reimbursement Time Limitations.**

A. (text unchanged)

B. To obtain reimbursement from the Program, a **[**medical**]** *health* care provider that originally submits a claim to Medicare or another health insurer shall also submit the claim to the Program within a period whereby the Program receives the claim within the latter of:

(1)—(2) (text unchanged)

C. The Program shall pay a claim that is originally rejected for payment due to improper completion or incomplete information only if:

(1) The **[**medical**]** *health* care provider properly completes and resubmits the claim to the Program; and

(2) (text unchanged)

D. When the Program initially rejects a claim for payment in error, the Program shall pay the claim if the participating **[**medical**]** *health* care provider resubmits the claim and the resubmitted claim is received by the Program within the same period specified in §C of this regulation.

**.22 Maryland Health Insurance Plan Coverage.**

A. In lieu of providing direct reimbursement to participating **[**medical**]** *health* care providers, the Program may pay MHIP, if available, to provide health coverage for individuals enrolled in the Program who are also eligible for MHIP.

B.—C. (text unchanged)

D. Fees Reimbursable to Participating Providers.

(1) The Program may reimburse participating **[**medical**]** *health* care providers for a bill the provider submits to the Department for patient contribution amounts and deductibles for services directly related to the treatment of breast and cervical cancer for individuals enrolled in MHIP through the Program, if funding is available for the payment of patient contribution amounts and deductibles under this section.

(2) (text unchanged)

(3) If MHIP does not provide coverage for a service covered by this chapter, the Program shall reimburse the participating **[**medical**]** *health* care provider as otherwise provided by this chapter.

(4) To obtain reimbursement, the participating **[**medical**]** *health* care provider shall submit to the Program:

(a)—(b) (text unchanged)

E. (text unchanged)

ROBERT R. NEALL
Secretary of Health