

MARYLAND'S HEALTH CARE APPEALS AND GRIEVANCE LAW



MARYLAND

**INSURANCE
ADMINISTRATION**

Who We Are

The Maryland Insurance Administration (MIA) is the state agency that regulates the business of insurance in the State of Maryland. If you have a question about insurance or experience a problem, contact the MIA.

How We Help Consumers

The MIA provides assistance to consumers, businesses, health care providers (including doctors and hospitals), and producers (agents or brokers) in all areas of insurance, including life, health, disability, automobile, homeowners, and property.

The MIA produces consumer guides, rate comparisons and frequently asked questions related to various types of insurance. The following is a partial list of available publications:

- *Consumer Guide to Health Insurance*
- *Health Carriers for Small Employers (with Sample Premiums)*
- *Annual Premiums for Medicare Supplement Policies*

Maryland's Appeals & Grievances Law

In 1998, Maryland enacted the Appeals and Grievances Law to provide a full and fair process for resolving disputes regarding the medical necessity of a proposed or delivered health care service.

The appeals and grievances process begins when a carrier makes an “adverse decision”, a determination that a proposed or delivered health care service is not medically necessary, appropriate or efficient.¹ The member or the provider on behalf of the member has the right to protest this decision through the carrier’s internal review process. When a protest is filed with the carrier, this is called a “grievance.” If the carrier again concludes the proposed or delivered health care service is not medically necessary, appropriate or efficient, the member or the provider on behalf of the member may ask the MIA to review the carrier’s grievance decision by filing a “complaint.” The carrier has the burden of persuasion that its grievance decision is correct.

The MIA has prepared this guide to help consumers and healthcare providers, including hospitals, understand the appeals and grievances process and the information needed to file a complaint with the MIA on behalf of a patient.

¹ A carrier includes a health insurer, nonprofit health service plan, a health maintenance organization or a dental plan.

● ● ● ● Using Maryland's Appeals & Grievances Law ● ●

Adverse Decision

When a carrier denies coverage for treatment because it was not medically necessary, appropriate or efficient, it must do so in writing within five (5) working days of the decision. Upon issuing an adverse decision, the carrier must give the member (patient) and the treating provider:

1. A detailed explanation of the factual basis for the denial;
2. References to the criteria and standards relied on for the denial;
3. The name, address and business telephone number of the medical director, associate medical director or the representative who made the decision or is responsible for the review process; and
4. The details of its internal grievance process so that the member or provider can file a grievance with the carrier.

State law permits the treating provider, including a hospital, to file a grievance on behalf of a patient. Be sure to follow the instructions provided by the carrier regarding its grievance process.

If you have a health-related emergency, make sure you follow the carrier's expedited grievance procedure so that you can get a decision within 24 hours of filing your grievance. If your appeal involves compelling circumstances, you may skip filing a grievance with the carrier and file your complaint with the MIA.²

You may contact the Health Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General of Maryland, at 877-261-8807, or www.oag.state.md.us/Consumer/heaau.htm for help filing a grievance or mediating a claim under the carrier's internal grievance process.

Grievance Decision

Once you have filed a grievance with a carrier, the carrier may uphold, modify or overturn its original adverse decision. By law, the carrier must render a final decision in writing within thirty (30) working days of the date that the grievance was filed.³ In cases where services have already been provided, the carrier must render its decision in writing within forty five (45) working days of the date the grievance was filed. If you are dissatisfied with the grievance decision, you may file a complaint with the MIA.

² By law, compelling circumstances exist where the potential delay in receipt of a health care service until after the member or health care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the member remaining seriously mentally ill with symptoms that cause the member to be in danger to self or others.

³ As noted previously, the decision must be rendered within 24 hours for an emergency

Filing a Complaint

You must file a complaint with the MIA within 30 working days of receiving the carrier's grievance decision. **All complaints must be in writing.** You may either write us a letter or complete a complaint form. Complaint forms are available on the MIA's website at www.mdinsurance.state.md.us/sa/documents/LH-AGComplaintForm-MedRel.pdf.

If you choose to write a letter, be sure to include:

- the patient's name, address and phone number;
- your name, address and daytime and evening phone number;
- the name of the patient's insurance company, type of insurance, policy number and claim number (if applicable);
- the name of any other insurance company, agent, adjuster, etc. involved in the patient's problem (provide as many names and phone numbers as possible);
- a copy of the patient's health insurance card or your policy;
- **a completed and signed MIA Medical Records Release form signed by the patient. You must use this form and not one that is provided by another entity. This form is available on the MIA's website at www.mdinsurance.state.md.us/sa/documents/LH-AGComplaintForm-MedRel.pdf;**
- a detailed explanation of the problem or situation; and
- copies of any documents that you think are important for the investigator to review. Do not send originals.

The MIA has 30 working days to investigate your case and issue a final decision. In emergency cases, a decision must be provided within 24 hours. And, in cases where services have already been provided, the MIA has 45 working days to investigate your case.

Important Tips

- The MIA cannot proceed with the investigation of a complaint unless you have obtained a completed and signed MIA Medical Records Release form. The MIA suggests that hospitals consider having each patient complete and sign this form upon admission so that the hospital may file a grievance and a complaint if necessary.
- Keep in mind the MIA does not have authority to investigate complaints involving health care coverage that is not regulated by the State of Maryland including:
 - Health care coverage provided by employers to their employees on a self-funded or self-insured basis
 - Medical Assistance (Medicaid)
 - Medicare and Medicare HMOs
 - Federal Employee Health Benefit Programs
 - Uniformed Services Family Health Plans
 - Contracts issued and delivered to the policyholder in another state
- Under federal law, all carriers must have a grievance process. Even if the MIA cannot investigate a complaint, you can ask the carrier to reconsider its adverse decision. Contact the carrier or refer to your plan documents to find out more information about the grievance process.

This consumer guide should be used for educational purposes only. It is not intended to provide legal advice or opinions regarding coverage under a specific insurance policy or contract; nor should it be construed as an endorsement of any product, service, person, or organization mentioned in this guide.

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