

## Summary of Maryland Grievance Law

In 1998, the General Assembly enacted the Appeals and Grievances Law to provide a process for patients to appeal their health insurance carriers' medical necessity "adverse decisions." The law includes guidelines that carriers must follow in notifying patients of denials, establishing appeals and grievances processes, and notifying members of grievance decisions.

In 2000, the legislature expanded the grievances process to include the right to appeal contractual "coverage decisions." As a result, patients in Maryland who have coverage from a State-regulated plan can challenge any decision by a carrier that results in the total or partial denial of a covered health care service.

In 2011, the definition of "coverage decisions" was expanded to include a carrier's decision that someone is ineligible for coverage or that results in the rescission of an individual's coverage. As a result, since July 1, 2011, patients have been able to challenge any decision by a carrier that results in the total or partial denial of a covered health care service, the denial of eligibility for coverage, or the rescission of coverage. As amended, Maryland law established two similar processes for patients to dispute carrier determinations, one for carriers' denials that proposed or delivered health care services are not or were not medically necessary ("adverse decisions") and another for carriers' determinations that result in the contractual exclusion of a health care service ("coverage decisions").

Maryland law requires the Maryland Insurance Administration to make a final decision on medical necessity complaints within 45 calendar days of receipt of the written complaint. However, the MIA can extend cases for an additional 30 working days if information requested by the MIA has not been received. For emergency or compelling cases, the MIA will conduct an expedited external review, completing the above process within 24 hours of receipt of the complaint. The MIA hotline number (800-492-6116) is available 24 hours a day, seven days a week to respond to these emergency or compelling cases.

In addition, the federal Patient Protection and Affordable Care Act (ACA) strengthened and expanded appeal rights for consumers, offering consumers in nearly all commercially insured plans, **not just Maryland-regulated plans**, internal appeal rights and the right to take their appeals to an independent third-party review organization for review of the insurer's decision (external review) for claims that involve (a) medical judgment (including those based on the plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational), as determined by the external reviewer, or (b) a rescission of coverage.