



Definitions of Terms used by the MIA and Overview of the MIA's Appeals and Grievance Process

Presenter: Louis S. Butler, Jr.

Director, Life and Health, Appeals and Grievance Unit

Maryland Insurance Administration

lbutler@maryland.gov



Workgroup Charges

HB 995/SB 776 (Chs. 672 & 671) of 2025

1. Make recommendations to improve State reporting on adverse decisions, including recommendations regarding:
 - a. standardized definitions of:
 - i. medical service categories;
 - ii. health settings;
 - iii. adverse decisions; and
 - iv. Medical necessity;
 - b. a standardized method for categorizing adverse decisions and prior authorization denials; and
 - c. a standardized process for reporting grievances or filing complaints and appealing adverse decisions;

Background/History

- In 1998, the Appeals and Grievance Law was enacted by the Maryland General Assembly to provide a full and fair process for resolving disputes regarding the medical necessity of a proposed or delivered healthcare service.
- The Appeals and Grievance process begins when a carrier renders an "adverse decision," which includes a determination that a proposed or delivered healthcare service is not medically necessary, appropriate or efficient. The member, the member's representative, or the treating 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 regarding an adverse decision, this is a "grievance." If the carrier again determines the proposed or delivered healthcare service is not medically necessary, the member, the member's representative, or the treating provider on behalf of the member may ask the Maryland Insurance Administration to review the carrier's grievance decision by filing a "complaint."

Defining Terms:

Coverage Decision vs. Adverse Decision

A Coverage Decision is an initial determination by a carrier or a representative of the carrier that results in noncoverage of a health care service; a determination by a carrier that an individual is not eligible for coverage under the carrier's health benefit plan; or any determination by a carrier that results in the recession of an individual's coverage under a health benefit plan (Maryland Insurance Article § 15-10D-01). A coverage decision includes a denial of all or part of a claim, but does not include an adverse decision as described on the following slides.

- Example: Orthotics are expressly excluded from the member's contract.
- Denials based on improper codes are coverage decisions.
- Payment of an out of network claim at an amount lower than the billed amount is considered a coverage decision, because it is a denial of part of the claim.

Providers or patients may file an appeal with the insurance company about a coverage decision.

- If the company upholds their decision, the provider or patient may file a complaint with the MIA.

Defining Terms:

Coverage Decision vs. Adverse Decision

- An adverse decision is a utilization review determination by a private review agent, a carrier, or a health care provider acting on behalf of a carrier that: a proposed or delivered health care service covered under the member's contract is or was not medically necessary, appropriate, or efficient; and may result in noncoverage of the health care service (Maryland Insurance Article § 15-10A-01)
- Adverse includes a utilization review determination based on a prior authorization or step therapy requirement (Insurance Article §15-10B-01)
- The member, the member's representative, or the treating provider on behalf of the member has the right to protest this decision through the carrier's internal review process.

Defining Terms: Medical Necessity

- When a carrier issues a denial it must state in detail in clear, understandable language the specific factual bases for the decision, referencing the specific criteria and standards, including interpretative guidelines, on which the decision was based.
- The decision and may not solely use generalized terms such as “experimental procedure not covered”, “cosmetic procedure not covered”, “service included under another procedure”, or “not medically necessary”...

Can AI be used in Claim Denials?

- Currently, AI may be used to approve requests and payment of claims, but **not** for denials based on medical necessity. § 15–10B–05.1(d) of the Insurance Article prohibits AI from denying, delaying, or modifying healthcare services.
- The Insurance Article requires that an adverse or grievance decision be made by a human physician with specified qualifications.
- Under § 15–10B–07 of the Insurance Article, all adverse decisions must be made by a licensed physician, or a panel of appropriate health care service reviewers with at least one physician on the panel.

How the Appeals & Grievance Law Works

- The Appeals and Grievance Law gives the MIA the authority to contract with three Independent Review Organizations ("IROs") to review these medical necessity complaints. When the MIA sends a complaint to an IRO for review, and the IRO assigns an expert reviewer for the complaint, Maryland law requires that the reviewer be an unbiased provider in the same specialty as the area or areas appropriate to the subject of review.
- The MIA's final decision on the complaint may be based on the opinion of the IRO. If the complainant remains dissatisfied with the MIA's decision, he or she may make a written request for a hearing to challenge the MIA's decision. Carrier's do not have the right to an administrative hearing, but may file a petition for judicial review with the Circuit Court.
- Generally, you must file a grievance with the carrier first before you can file a complaint with the MIA. In some cases, though, including, for example, when you have a compelling reason, you can file a complaint with the MIA first.

Jurisdiction of the MIA's Life & Health Unit and Appeals & Grievance Unit

- Jurisdiction means that the MIA has the authority to regulate these entities and individuals, including investigating complaints.
- The MIA has jurisdiction over all commercial, fully-insured health benefit plans and HMOs authorized or licensed to conduct business in Maryland.
- The MIA cannot address complaints or inquiries involving insurance contracts which are not regulated by the State of Maryland. Generally, this includes the following:
 - Self-funded or self-insured employer plans
 - Medical Assistance (Medicaid), except for delayed payments
 - Medicare and Medicare HMOs
 - Federal Employee Health Benefit Programs
 - Uniformed Services Family Health Plans
 - Contracts issued and delivered to the policyholder in another state.

What the Consumer Needs to do to Receive Assistance from the MIA

Complaints can be filed online, mailed in, or faxed.

Mail or fax your complaint to:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health/Appeals and Grievance
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Fax: 410-468-2260 (Life and Health)
or 410-468-2270 (Appeals and Grievance)

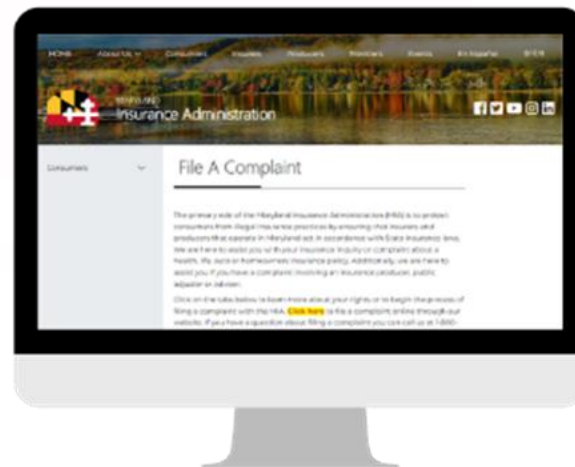
Forms to file a complaint are available on our website.

www.insurance.maryland.gov/Consumer/Pages/FileAComplaint.aspx



What the Consumer Needs to do to Receive Assistance from the MIA

- Online Complaint Portal
<https://enterprise.insurance.maryland.gov/consumer/ConsumerPortalWelcomePage.aspx>
- If you have a disability and need to file a complaint by phone, you can call the MIA at 410-468-2244.
- The patient's signed consent is required for an Appeals & Grievance complaint.



What a Consumer Should Expect as Part of the MIA's Complaint Process

- You should receive an acknowledgment of the complaint within a few days. The acknowledgment will include the contact information for the MIA's investigator.
- You can call the investigator any time you have questions.
- Appeals and Grievances complaint investigations are concluded within 45 days, unless an extension of an additional 30 days is granted.

Adverse Decisions Data Reported to the MIA

- Carriers submit self-reported adverse decisions data on a quarterly basis to the MIA.
- The quarterly Appeals and Grievance reports received by the MIA only contains data for commercial, fully-insured health benefit plans.
- The self-reported data submitted by carriers concerns only denials wherein the carrier conducted a utilization review to determine medical necessity.

Adverse Decisions Data Reported to the MIA

- Carriers must provide to the MIA, in accordance with the Commissioner's Report and Instructions ([carrier-reporting-form.pdf](#)):
 - Total number of enrolled members as of the last day of the quarter being reported entitled to health care benefits under a health benefit plan issued or delivered in the State of Maryland by the carrier;
 - Total number of clean claims received for reimbursement processed by the carrier under a health benefit plan issued or delivered in the State of Maryland
 - The total number of adverse decisions issued by the carrier;
 - Up to the five most common procedure codes for adverse decisions;
 - The total adverse decisions issued and grievances filed and outcome;
 - Up to the five most common procedure codes for adverse and grievance decisions;
 - The number and outcome of all other cases that resulted from an adverse decision involving the length of stay for inpatient hospitalization;

Adverse Decisions Data Reported to the MIA

New Data for 2025:

- Aggregated Zip Code Data

Data not included:

- Granular details about at what stage the coverage decision was denied

Categories of Service

Carriers code their adverse decisions and grievance decisions into one of twelve categories of service that are determined by the MIA. Those categories are:

1. Inpatient hospital services
2. Emergency room services
3. Mental health services
4. Physician services
5. Laboratory, radiology services
6. Pharmacy services
7. PT, OT, ST services (including inpatient rehab)
8. Skilled nursing facility
9. Durable medical equipment
10. Dental
11. Home health services
12. Obesity, IVF, Podiatry, Hearing and Vision

Categories of Service


- The twelve categories of service were established by the MIA based on the sort of complaints the MIA received on a consistent basis.
- Additional categories can be added as necessary based on complaint trends.



**MEDICAL NECESSITY &
EMERGENCY APPEALS**
1-800-492-6116

Contact Information

Maryland Insurance Administration









 800-492-6116 | 410-468-2000 | 800-735-2258 (TTY)

 insurance.maryland.gov



MIA WEBSITE

Connect on Social Media

-  MDInsuranceAdmin
-  en Español: MDInsuranceAdminES
-  Maryland Insurance Administration
-  Maryland Insurance Administration
-  MarylandInsuranceAdmin
-  MD_Insurance
-  <https://bit.ly/mdmiayoutube>
-  Maryland Insurance Administration



<https://qrco.de/miasocialmedia>

Questions?



Thank
you