PROVIDER PARITY RESOURCE GUIDE

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DRUG POLICY AND PUBLIC HEALTH STRATEGIES CLINIC

PROVIDER PARITY RESOURCE GUIDE
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HOW TO USE THIS RESOURCE GUIDE

This Resource Guide offers providers some essential guidance on the application of the parity law to your patient's plan. The ultimate goal is to help identify whether insurance companies are violating the parity law by limiting the scope or duration of treatment for mental health and substance use disorder (MH/SUD) coverage, or by requiring patients to pay more for their MH/SUD care.

Vicki Lung, Student-Attorney with the Drug Policy Clinic, prepared this Resource Guide. If you have any questions, please contact Ellen Weber at the University of Maryland School of Law Drug Policy Clinic: eweber@law.umaryland.edu.

INTRODUCTION TO FEDERAL PARITY LAW

INTRODUCTION TO THE FEDERAL PARITY LAW

- **Objective. —** The federal parity law, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, is intended to end discrimination in health insurance coverage for mental health and substance use disorders (MH/SUD). The law requires large employers to provide coverage for MH/SUD that is on par with coverage for medical/surgical (M/S) conditions.
- **Standards for Financial Requirements and Treatment Limitations. —**
  - The federal parity law prohibits large group health plans from imposing financial requirements (such as co-pays and deductibles) or treatment limitations (such as visit limits) on MH/SUD benefits that are **separate from** or **more restrictive** than the predominant requirements or limitations applied to **substantially all** M/S benefits.
  - Federal parity law does not mandate that a plan must provide MH/SUD benefits. But if a plan does provide MH/SUD benefits, then it must follow parity standards.
- **Standard for Medical Management. —** A health plan cannot impose medical management standards or processes for the MH/SUD benefit that are **not comparable** to the standards used for M/S benefits and cannot apply those standards **more stringently** for MH/SUD benefits.
  - **Exception. —** To the extent that recognized clinically appropriate standards of care drive the distinction between medical management standards, the law may permit the difference.
- **Scope. —** The federal parity law applies to all plans – except small group health plans and individually purchased health plans. This includes large group health plans that are self-insured as well as those that are non-self-insured.
- **Required Disclosures. —** Plans must make certain information available, free of charge, with regard to MH/SUD benefits and adverse decisions.
  - **Medical Necessity Criteria. —** Criteria for medical necessity determinations with regard to MH/SUD benefits must be made available to any current or potential participant, beneficiary, or contracting provider upon request.
  - **Denials of Reimbursement or Payment for Services. —** The reason for any denial of reimbursement or payment for services with regard to MH/SUD benefits must be made available within a reasonable time to the participant or beneficiary, upon request or as otherwise required.
  - Please see page 19 for more information on the required disclosures.

INTRODUCTION TO MARYLAND'S PARITY LAW

- **Standards. —** The Maryland parity law mandates certain minimum coverage for MH/SUD treatment in the categories of outpatient care, inpatient care, and partial hospitalization.
- **Scope. —** Maryland parity law applies to large group health plans that are non-self-insured and individually purchased health plans. It does not apply to small group health plans.
- **Effect. —** In Maryland, large group health plans that are non-self-insured must provide MH/SUD treatment and must comply with federal parity standards.

CHART: WHICH LAW APPLIES?		
PLAN TYPE	**MARYLAND PARITY LAW APPLIES**	**FEDERAL PARITY LAW APPLIES**
LARGE GROUP HEALTH PLANS more than 50 employees non-self insured	✔	✔
LARGE GROUP HEALTH PLANS more than 50 employees self-insured		✔
SMALL GROUP HEALTH PLANS 2-50 employees self-insured and non-self insured	**NEITHER LAW APPLIES**	
INDIVIDUAL HEALTH PLANS	✔	

SAMPLE PROVIDER REQUEST FORMS –

REASON(S) FOR DENIAL AND/OR MEDICAL NECESSITY CRITERIA

PROVIDER REQUEST FORM FOR REASON(S) FOR DENIAL AND/OR MEDICAL NECESSITY CRITERIA

Directions

If you believe that your patient's insurer may have violated the parity law by denying coverage for mental health or substance use disorders (MH/SUD) treatment or by applying discriminatory medical necessity criteria, please use this Provider Request Form as a guide when requesting the reason for denial and/or medical necessity criteria from the insurer over the phone.

This Provider Request Form identifies the disclosures that the insurer is required to provide under the parity law. In addition, this Form provides a space for you to document the insurer's response. The parity law requirement for such disclosures is provided on page 19.

PROVIDER INFORMATION			
Date of Call		**Staff Member**	
Time of Call			

INSURER INFORMATION	
Insurance Company	
Phone Number Called	
Person Spoke To	
TYPE OF PLAN	
□ **Large Group Plan**	□ **Self-insured** □ **Non-self-insured**
□ **Small Group Plan**	□ **Self-insured** □ **Non-self-insured**
□ **Individual Plan**	
PATIENT INFORMATION	
Patient/Insured's Name	
Insurance Policy Identification Number	
Group Number	
REQUESTED TREATMENT INFORMATION	
Level(s) of Care Requested	

Source: PARITY IMPLEMENTATION COALITION, PARITY TOOLKIT FOR ADDICTION & MENTAL HEALTH CONSUMERS, PROVIDERS & ADVOCATES (2010).

REASON(S) FOR DENIAL (OR PAYMENT) FOR MH/SUD TREATMENT

Please disclose the reason(s) for denial of reimbursement (or payment) for MH/SUD treatment, as required by the Mental Health Parity & Addiction Equity Act of 2008.

____
____
____
____

MEDICAL NECESSITY CRITERIA

Please disclose the criteria used for MH/SUD medical necessity determinations, as required by the Mental Health Parity & Addiction Equity Act of 2008. This includes any processes, strategies, evidentiary standards or other factors used by the insurer to deny authorization or reimbursement for treatment.

____
____
____
____

Source: PARITY IMPLEMENTATION COALITION, PARITY TOOLKIT FOR ADDICTION & MENTAL HEALTH CONSUMERS, PROVIDERS & ADVOCATES (2010).

SAMPLE PROVIDER REQUEST FOR REASON(S) FOR DENIAL AND/OR MEDICAL NECESSITY CRITERIA

Directions

If you believe that your patient's insurer may have violated the parity law by denying coverage for mental health or substance use disorders (MH/SUD) treatment or by using discriminatory medical necessity criteria, please use this sample letter when requesting the reason for denial and/or medical necessity criteria from the insurer via fax or mail.

The parity law requirement for such disclosures is provided on page 19.

SAMPLE LETTER

[*Date*]

[*Insurance Company and/or Managed Behavioral Health Company*]

[*Member Services Dep't or Other Relevant Dep't*]

[*Address*]

To Whom It May Concern:

[*Patient/Insured's Name*] is insured under [*Policy Identification Number*] and [*Group Number*], which is governed by the Mental Health Parity and Addiction Equity Act of 2008. The patient is a patient at [*Provider Name*], which is licensed or certified by the state of Maryland to provide [*type of*] treatment services.

1. Please disclose the criteria used for MH/SUD medical necessity determinations, as required by parity law.
2. Please disclose the reason(s) for denial of reimbursement for [*treatment*], as required by parity law. This includes any processes, strategies, evidentiary standards or other factors used by the insurer to deny or reimburse for treatment.

Please fax or mail this information immediately at: [*Provider Fax Number or Address*].

Sincerely,

[*Provider*]

Source: PARITY IMPLEMENTATION COALITION, PARITY TOOLKIT FOR ADDICTION & MENTAL HEALTH CONSUMERS, PROVIDERS & ADVOCATES (2010).

PARITY COMPLIANCE CHECKLIST

PARITY COMPLIANCE CHECKLIST

COMPARING COVERAGE FOR MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Objective

If you believe that your patient's insurer may have violated the parity law by using discriminatory coverage practices for mental health and substance use disorders (MH/SUD), please use this Checklist as a guide. By providing a series of potential questions to ask of insurers, this Checklist may help determine whether your patient's MH/SUD benefits are on par with those on the medical/surgical (M/S) side.

Directions

This checklist identifies commonly encountered financial restrictions, treatment limitations, and medical management standards. To determine if the parity law has been violated, you must compare the standards for MH/SUD with those for M/S benefits.

1. Obtain Description of the Patient's Benefits.

You will need a description of both the MH/SUD and M/S benefits under the patient's health insurance plan. The patient should have the benefit description or be able to request this from the plan administrator.

In addition, the patient and the "contracting provider" are entitled to request the medical necessity criteria used by the health insurance plan from the plan administrator.

2. Fill out the Checklist.

Please fill out the type and level of financial restriction(s), treatment limitation(s), and medical management standard(s) that are imposed in the appropriate boxes in the first and second columns.

Definitions are provided on the next page.

For example, if the copayment for MH/SUD treatment is $10 and the copayment for M/S treatment is $5, then note these amounts in the appropriate boxes in the first and second columns.

3. Conduct a Comparison.

In the third column, compare the financial restriction, treatment limitation, or medical management standard by checking the appropriate box.

In the example above, since the copayment for MH/SUD treatment is higher than the copayment for M/S illnesses, check the box for "higher." This is a flag that there may be a violation of the parity law.

4. Next Steps You Should Follow.

If you think that there may be a potential violation of the Parity Law, you should encourage the patient to initiate the insurer's internal grievance process.

Also, without disclosing any patient information, please email to us either:

- A copy of the checklist, or
- A brief description of the reason for a denial.

  Example: Insurance company (by name) refused coverage for intensive outpatient treatment because it wanted the patient to go to AA first.

DEFINITIONS	
FINANCIAL REQUIREMENTS	
Copayment	The dollar amount the patient is expected to pay at the time of service.
Coinsurance	A percentage of the cost of covered treatment that a patient must pay after the deductible is met.
Deductible	The dollar amount the patient must pay before the insurer will pay for any MH/SUD treatment.
Out-of-Pocket Maximum	The total amount a patient is required to pay towards the cost of MH/SUD treatment.
Admission Fee	The dollar amount that the patient is expected to pay at the time of admission for MH/SUD treatment.
Aggregate Lifetime Dollar Limits	The total dollar amount the plan will pay for MH/SUD treatment over the course of the patient's life.
Annual Dollar Limits	The total dollar amount the plan will pay for MH/SUD treatment in a 12-month period.
LIMITS ON TREATMENT	
Limits on Frequency of Treatment	A numerical limit on the frequency of MH/SUD treatment that the patient may receive.
Limits on Number of Visits	A limit on the number of visits for MH/SUD treatment allowed under the patient's plan, usually for outpatient treatment.
Limits on Number of Days	A limit on the number of days for MH/SUD treatment or service allowed under the patient's plan, usually for inpatient treatment.
Length of Stay Per Episode	A limit on the length of MH/SUD treatment or service allowed per episode.
MEDICAL MANAGEMENT STANDARDS	
Exclusions	Specific conditions, services, or treatments the health insurance plan will not provide coverage for, including court-ordered treatment (where coverage is excluded for those who have been ordered by the court into treatment).
Authorization	▪ Pre-Authorization: the insurer reviews care before treatment begins for medical necessity. ▪ Concurrent Authorization: the insurer reviews care periodically to assess continued medical necessity. ▪ Retrospective Authorization: the insurer reviews care after the treatment has been performed for medical necessity.
Medical Necessity Criteria	Criteria used by health insurance plan to determine whether treatment or services are "medically necessary" before providing reimbursement or coverage.
"Fail First" Policies	The patient must fail using one medication or level of treatment before another is approved.
Step Therapy Protocols	The patient must first try the least expensive care before being allowed to try the next least expensive care.

PARITY COMPLIANCE CHECKLIST

COMPARING COVERAGE FOR MENTAL HEALTH AND SUBSTANCE USE DISORDERS

PROVIDER INFORMATION			
Date of Call		Staff Member	
Time of Call			

INSURER INFORMATION	
Insurance Company	
Phone Number Called	
Person Spoke To	

TYPE OF PLAN	
□ Large Group Plan	□ Self-insured □ Non-self-insured
□ Small Group Plan	□ Self-insured □ Non-self-insured
□ Individual Plan	

PATIENT INFORMATION	
Patient/Insured's Name	
Insurance Policy Identification Number	
Group Number	

REQUESTED TREATMENT INFORMATION	
Level(s) of Care Requested	

FINANCIAL RESTRICTIONS			
RESTRICTION	**MH/SUD**	**M/S**	**COMPARISON**
Copayment	□ Y □ N Amount:	□ Y □ N Amount:	□ MH/SUD copayment is **higher**. □ MH/SUD copayment is **lower**. □ MH/SUD copayment is **the same**.
Coinsurance Amount	□ Y □ N Amount:	□ Y □ N Amount:	□ MH/SUD coinsurance is **higher**. □ MH/SUD coinsurance is **lower**. □ MH/SUD coinsurance is **the same**.
Deductible Amount	□ Y □ N Amount:	□ Y □ N Amount:	□ There is a **separate, higher** deductible for MH/SUD treatment. □ There is a **separate, lower** deductible for MH/SUD treatment. □ There is a **separate, but identical** deductible for MH/SUD treatment. □ There is **no separate** deductible for MH/SUD treatment.
Out-of-Pocket (OOP) Maximum Amount	□ Y □ N Amount:	□ Y □ N Amount:	□ There is a **separate, higher** OOP maximum for MH/SUD treatment. □ There is a **separate, lower** OOP maximum for MH/SUD treatment. □ There is a **separate, but identical** OOP maximum for MH/SUD treatment. □ There is **no separate** OOP maximum for MH/SUD treatment.
Admission Fee Amount	□ Y □ N Amount:	□ Y □ N Amount:	□ MH/SUD admission fee is **higher**. □ MH/SUD admission fee is **lower**. □ MH/SUD admission fee is **the same**.
Aggregate Lifetime Dollar Limits on Care	□ Y □ N Amount:	□ Y □ N Amount:	□ Dollar limit on MH/SUD care is **higher**. □ Dollar limit on MH/SUD care is **lower**. □ Dollar limit on MH/SUD care is **the same**.
Annual Dollar Limits on Care	□ Y □ N Amount:	□ Y □ N Amount:	□ Dollar limit on MH/SUD care is **higher**. □ Dollar limit on MH/SUD care is **lower**. □ Dollar limit on MH/SUD care is **the same**.

LIMITS ON TREATMENT			
TREATMENT LIMITATION	**MH/SUD**	**M/S**	**COMPARISON**
Limits on Frequency of Treatment	☐ Y ☐ N Amount:	☐ Y ☐ N Amount:	☐ **More** MH/SUD treatment allowed. ☐ **Less** MH/SUD treatment allowed. ☐ **Same amount** of MH/SUD treatment allowed.
Limits on Number of Visits	☐ Y ☐ N Amount:	☐ Y ☐ N Amount:	☐ **More visits** for MH/SUD treatment allowed. ☐ **Fewer visits** for MH/SUD treatment allowed. ☐ **Same amount** visits for MH/SUD treatment allowed.
Limits on Number of Days	☐ Y ☐ N Amount:	☐ Y ☐ N Amount:	☐ **More days** for MH/SUD treatment allowed. ☐ **Fewer days** for MH/SUD treatment allowed. ☐ **Same number of days** for MH/SUD treatment allowed.
Length of Stay Per Episode	☐ Y ☐ N Amount:	☐ Y ☐ N Amount:	☐ **Longer** length of stay per episode for MH/SUD treatment. ☐ **Shorter** length of stay per episode for MH/SUD treatment. ☐ **Same** length of stay per episode for MH/SUD treatment.

MEDICAL MANAGEMENT STANDARDS			
MEDICAL MANAGEMENT TOOLS	**MH/SUD**	**M/S**	**STANDARD — *Please describe the standard(s) applied for both MH/SUD and M/S benefits in this column.***
Authorization	☐ Pre-Authorization ☐ Concurrent Authorization ☐ Retrospective Authorization	☐ Pre-Authorization ☐ Concurrent Authorization ☐ Retrospective Authorization	
Exclusions from Coverage	☐ Y ☐ N	☐ Y ☐ N	
Medical Necessity Criteria	☐ Y ☐ N	☐ Y ☐ N	
“Fail First” Policies	☐ Y ☐ N	☐ Y ☐ N	
Step Therapy Protocols	☐ Y ☐ N	☐ Y ☐ N	

SAMPLE PROVIDER SCRIPT

PHONE-BASED REQUEST FOR
"SUBSTANTIALLY ALL" AND "PREDOMINANT" INQUIRIES

PROVIDER REQUEST FORM FOR “SUBSTANTIALLY ALL” AND “PREDOMINANT” INFORMATION

Directions

If you believe that your patient’s insurer may have violated the parity law by applying separate or more restrictive financial requirements or treatment limitations on mental health and substance use disorders (MH/SUD) treatment, please use this sample script to ask the insurer about what types of financial requirements or treatment limitations are applied to the medical/surgical (M/S) side. This form also provides a space for you to document the insurer’s response.

PROVIDER INFORMATION			
Date of Call		**Staff Member**	
Time of Call			

INSURER INFORMATION	
Insurance Company	
Phone Number Called	
Person Spoke To	

TYPE OF PLAN	
□ **Large Group Plan**	□ **Self-insured** □ **Non-self-insured**
□ **Small Group Plan**	□ **Self-insured** □ **Non-self-insured**
□ **Individual Plan**	

PATIENT INFORMATION	
Patient/Insured’s Name	
Insurance Policy Identification Number	
Group Number	

REQUESTED TREATMENT INFORMATION		
Level(s) of Care Requested		
Classification	□ **Inpatient, In-Network** □ **Inpatient, Out-of-Network** □ **Outpatient, In-Network**	□ **Outpatient, Out-of-Network** □ **Emergency Care** □ **Prescription Drugs**

FINANCIAL REQUIREMENTS (e.g., copayment, coinsurance, deductible)	
Substantially All Inquiry	
Does this financial requirement apply to more than 2/3rd of the proposed plan costs for medical/surgical benefits in the same classification?	☐ **Yes** — Proceed to the next step. ☐ **No** — Stop here. The financial requirement may NOT be applied to the MH/SUD treatment at all.
Predominant Level Inquiry	
What level of financial requirement applies to more than ½ of the medical/surgical benefits in this classification, based on the proposed plan costs?	**Predominant Level:**
Is this level greater or less than the level of the financial requirement applied to the MH/SUD side?	☐ **Greater** — The financial requirement applied to the MH/SUD side is **not more restrictive** than that applied to the M/S side and is **permissible under parity law**. ☐ **Less** — The financial requirement applied to the MH/SUD side is **more restrictive** than that applied to the M/S side and **violates parity law**.

LIMITS ON TREATMENT (e.g., day limits, limits on frequency of treatment, visit limits)	
Substantially All Inquiry	
Does this treatment limitation apply to more than 2/3rd of the proposed plan costs for medical/surgical benefits in the same classification?	☐ **Yes** — Proceed to the next step. ☐ **No** — Stop here. The treatment limitation may NOT be applied to the MH/SUD treatment at all.
Predominant Level Inquiry	
What level of treatment limitation applies to more than ½ of the medical/surgical benefits in this classification, based on the proposed plan costs?	**Predominant Level:**
Is this level greater or less than the level of the treatment limitation applied to the MH/SUD side?	☐ **Greater** — The treatment limitation applied to the MH/SUD side is **not more restrictive** than that applied to the M/S side and is **permissible under parity law**. ☐ **Less** — The treatment limitation applied to the MH/SUD side is **more restrictive** than that applied to the M/S side and **violates parity law**.

DISCLOSURE PROVISIONS

REQUIRED DISCLOSURES FROM INSURERS TO PARTICIPANTS, BENEFICIARIES, AND CONTRACTING PROVIDERS

Objective

Federal and Maryland parity laws and regulations require an insurer to provide certain disclosures, upon request and free of charge, to requesting participants, beneficiaries, and contracting providers.

If an insurer is unwilling to provide reason(s) for denial and/or medical necessity criteria, **this document provides the essential standards to support the disclosures of such information. The citation to the law is identified below.**[1]

REQUIRED DISCLOSURES UNDER PARITY LAW

1. **The criteria used for MH/SUD <u>medical necessity determinations</u> must be made available to current and potential participants, beneficiaries, or contracting providers, upon request.**

   The specific language from the law is:

   > The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request.

2. **The <u>reasons for denial of reimbursement or payment</u> for MH/SUD services must be made available to participants or beneficiaries, upon request.**

   The specific language from the law is:

   > The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

REQUIRED DISCLOSURES UNDER ERISA REGULATION

For plans regulated under ERISA, documents with the medical necessity criteria for both M/S benefits and MH/SUD benefits are **plan documents**, and copies of plan documents must be furnished within 30 days of request.[2]

REQUIRED DISCLOSURES UNDER MARYLAND LAW

In Maryland, a copy of the specific criteria and standards used in conducting utilization review of proposed or delivered services must be furnished by the reviewing agent upon written request of any person or healthcare facility.[3]

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1 Parity in Mental Health and Substance Use Disorder Benefits, 26 U.S.C. § 9812(a)(4), 29 U.S.C. § 1185a(a)(4), 42 U.S.C. § 300gg-5(a)(4).

2 Disclosures, 29 CFR 2520.104b-1; Dept. Health and Human Services, Affordable Care Act – Fifth Set of FAQ's, Question 10.

3 MD. CODE ANN. INS. § 15-10B-05(c).

GUIDANCE FOR APPEALS

APPEALS

<table>
<tr><td rowspan="1">EXHAUST INTERNAL APPEALS PROCESS</td><td colspan="2">

For adverse benefit determinations, Maryland state law requires patients to exhaust the plan's internal appeals process first.
The Maryland Attorney General's Health Advocacy Unit can assist with the internal appeals process.
Note: The appeal may address two different issues —

The appeal may address the merits of the claim (i.e., the patient does, in fact, meet medical necessity criteria for the denied treatment); or
The appeal may address violations of parity (i.e., the medical management criteria used to deny coverage violates parity).

</td></tr>
<tr><td rowspan="3">FILE AN APPEAL WITH STATE OR FEDERAL AGENCY</td><td colspan="2">If the patient is not satisfied after exhausting the internal appeals process, an appeal may be filed with the following government agencies, depending on the type of insurance plan involved.</td></tr>
<tr><td colspan="2">

For non-self-insured plans, file an appeal with the Maryland Insurance Administration (MIA).
For more details, go to: http://www.mdinsurance.state.md.us/sa/jsp/consumer/FileComplaint.jsp
</td></tr>
<tr><td colspan="2">

For self-insured plans, file an appeal with the Department of Labor.
For more details, go to: http://www.dol.gov/ebsa/publications/how_to_file_claim.html
</td></tr>
<tr><td rowspan="2">AGENCIES TO GO TO FOR HELP</td><td>If state law or both federal and state laws apply…</td><td>

Contact Maryland Insurance Administration, Life and Health Complaint Unit, at (410) 468-2000 or (800) 492-6116.
You can also contact the Health Advocacy Unit at (877) 261-8807.
</td></tr>
<tr><td>If only federal law applies…</td><td>

Only the U.S. Department of Labor can address these appeals.
Contact an ERISA benefit advisor at (202) 693-8700.
</td></tr>
</table>

RELEVANT TIMEFRAMES
FOR FILING AND APPEALING CLAIMS

1.	**File a Request for Services with Your Insurer**
	File a service request with your insurer to determine whether the insurer will authorize or certify a course of treatment.
	The insurer must render its decision and get back to you: • Within 2 hours for emergency treatment, including residential crisis services for a MH/SUD. • Within 2 working days for non-emergency treatment.
2.	**File a Grievance with Your Insurer**
	If you are dissatisfied with the insurer's adverse decision, you may file a **grievance** with the insurer. • However, you are allowed to bypass this step by filing a complaint directly with the Commissioner of MIA if you have a **compelling reason**.[1] If you have a compelling reason, then skip directly to Step Three, *File a Complaint with the Commissioner of the MIA*.
	The insurer must render its decision on your grievance and get back to you: • Within 24 hours of being filed for emergency treatment. • Within 30 working days of being filed for non-emergency treatment or services that have not yet been delivered. • Within 45 working days of being filed for non-emergency treatment or services that have already been delivered (a retrospective denial).
	If the insurer does not render its decision and get back to you within these timeframes, you may file a complaint directly with the Commissioner of the MIA within **4 months**.
3.	**File a Complaint with the Commissioner of the Maryland Insurance Administration (MIA)**
	You may file a complaint with the Commissioner if: • You have a compelling reason (see above); • The insurer did not get back to you within the appropriate time frames (see above); or • You are dissatisfied with the insurer's final decision, and you file a complaint with the Commissioner within **4 months of receiving the decision**.
	After you file a **complaint**, the Commissioner must render its decision: • Within 24 hours for emergency treatment. • Within 45 days for non-emergency treatment.
4.	**Appeal the Commissioner's Decision**
	If you are dissatisfied with the Commissioner's decision, you may appeal within **30 days** of receiving the Commissioner's decision for: • **Administrative review by the MIA (**usually delegated to the Office of Administrative Hearings); or • **Judicial review** with the appropriate circuit court.

[1] A compelling reason includes a showing that potential delay imposed by filing with the insurer could result in loss of life, serious impairment or 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.