THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.2213 Internal formal grievance procedure; approval by director; provisions; person authorized to act on behalf of insured or enrollee; section inapplicable to provider complaint and insurance listed in right to independent review act; written notice to be culturally and linguistically appropriate; definitions.

Sec. 2213. (1) Except as otherwise provided in subsection (4), an insurer that delivers, issues for delivery, or renews in this state a policy of health insurance shall establish an internal formal grievance procedure for approval by the director for persons covered under the policy that provides for all of the following:

(a) A designated person responsible for administering the grievance system.

(b) A designated person or telephone number for receiving grievances.

(c) A method that ensures full investigation of a grievance.

(d) Timely notification to the insured or enrollee as to the progress of an investigation of a grievance.

(e) The right of an insured or enrollee to appear before a designated person or committee to present a grievance.

(f) Notification to the insured or enrollee of the results of the insurer's investigation of a grievance and of the right to have the grievance reviewed by the director or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(g) A method for providing summary data on the number and types of grievances filed under this section. The insurer or health maintenance organization shall annually file the summary data for the prior calendar year with the director on forms provided by the director.

(h) Periodic management and governing body review of the data to ensure that appropriate actions have been taken.

(i) That copies of all grievances and responses are available at the principal office of the insurer for inspection by the director for 2 years following the year the grievance was filed.

(j) That when an adverse determination is made, a written statement containing the reasons for the adverse determination is provided to the insured or enrollee along with written notifications as required under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(k) That a final determination will be made in writing by the insurer not later than 30 calendar days after a formal preservice grievance is submitted or 60 calendar days after a formal postservice grievance is submitted in writing by the insured or enrollee. The 30-calendar-day period or 60-calendar-day period, as applicable, may be tolled, however, for any period of time the insured or enrollee is permitted to take under the grievance procedure and for a period of time that must not exceed 10 business days if the insurer has not received requested information from a health care facility or health professional. If the insurer's procedure for insureds or enrollees covered under a group policy or plan includes 2 steps to resolve the grievance, the time for the first step must be no longer than 15 calendar days for a preservice grievance or 30 calendar days for a postservice grievance.

(*l*) That a determination will be made by the insurer not later than 72 hours after receipt of an expedited grievance. Within 10 days after receipt of a determination, the insured or enrollee may request a determination of the matter by the director or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929. If the determination by the insurer is made orally, the insurer shall provide a written confirmation of the determination to the insured or enrollee not later than 2 business days after the oral determination. An expedited grievance under this subdivision applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subdivision (k) would seriously jeopardize the life or health of the insured or enrollee or would jeopardize the insured's or enrollee's ability to regain maximum function.

(m) That the insured or enrollee has the right to a determination of the matter by the director or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(2) An insured or enrollee may authorize in writing any person, including, but not limited to, a physician, to act on his or her behalf at any stage in a grievance proceeding under this section.

(3) This section does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services.

(4) This section does not apply to a policy, certificate, care, coverage, or insurance listed in section 5(2) of the patient's right to independent review act, 2000 PA 251, MCL 550.1905, as not being subject to the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(5) A written notice required to be given under this section must be provided in a culturally and linguistically appropriate manner, as required under 45 CFR 147.136(b)(2)(ii)(e).

(6) As used in this section:

(a) "Adverse determination" means any of the following:

(*i*) A determination by an insurer or its designee utilization review organization that a request for a benefit, on application of any utilization review technique, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.

(*ii*) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by an insurer or its designee utilization review organization of a covered person's eligibility for coverage from the insurer.

(*iii*) A prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit.

(*iv*) A rescission of coverage determination.

(*v*) Failure to respond in a timely manner to a request for a determination.

(b) "Grievance" means a formal complaint on behalf of an insured or enrollee submitted by an insured or enrollee concerning any of the following:

(*i*) The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.

(*ii*) Benefits or claims payment, handling, or reimbursement for health care services.

(*iii*) Matters pertaining to the contractual relationship between an insured or enrollee and the insurer.

(c) "Insurer" includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

(d) "Postservice grievance" means a grievance relating to services that have already been received by the insured or enrollee.

(e) "Preservice grievance" means a grievance relating to services for which the insurer conditions receipt of the services, in whole or in part, on approval of the services in advance of receiving the service.

History: Add. 1996, Act 517, Eff. Oct. 1, 1997;—Am. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 707, Imd. Eff. Dec. 30, 2002;—Am. 2012, Act 445, Imd. Eff. Dec. 27, 2012;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218