MARYLAND
INSURANCE ADMINISTRATION

NEGOTIATING THE APPEALS AND COMPLAINTS PROCESS FOR DENIED CLAIMS

Mary M. Kwei
Chief, Complaints, Appeals and Grievance
Maryland Insurance Administration

Who is the MIA?

The Maryland Insurance Administration is a state agency that regulates Maryland's Insurance Industry. We do the following:

- License insurance companies and producers;
- Conduct examinations of the business practices of licensees;
- Monitor solvency of insurance companies;
- Review/Approve insurance policies and rates;
- Investigate consumer and provider complaints and allegations of fraud.

Which complaints can the MIA handle?

The MIA can review complaints involving health benefit plans issued in Maryland, including:

- Claim denials based on medical necessity;
- Denials of all or part of a claim for other reasons;or
- Other possible violations of Maryland Insurance law.

The MIA cannot handle all complaints

The MIA cannot handle complaints about:

- Health benefit plans that were issued in another state;
- Federal programs, including Medicare, Medicaid, or the Federal employee health benefit plan; or
- Employee benefit plans self-funded by an employer, even if an insurer is used to administer claims.

What should you do when a request for authorization is denied?

- If the service has not been provided, AND
- A delay 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 a danger to self or others, THEN
- Call the MIA.

What should you do when a request for authorization is denied?

- If the service has already been provided, or
- If the service has not been provided, but it is not an emergency, then
- Follow the health benefit plan's instructions to file an appeal. The instructions are normally on the notice of denial.

What should you do if a claim is denied?

- File a written appeal with the health benefit plan. The instructions are normally on the notice of denial.
- Make sure you use the address or fax number for appeals.
- Have the patient's authorization to file an appeal on their behalf.

What should you avoid doing if a claim is denied?

- Don’t allow multiple denied claims to pile up.
- Don’t call your provider representative.
- Don’t wait until the time to file an appeal has expired.
- Don’t bill an HMO member for services.

How to file a complaint with the MIA.

- Have copies of the notice of the claim denial and the notice of appeal denial.
- Include the patient's authorization to release medical records. Do not sign your name to the authorization.
- Use our complaint form or write a letter explaining the problem.

Medical Necessity Complaints

Medical necessity determinations include:

- A determination that a service is not medically necessary, efficient, or appropriate;
- A determination that a service is cosmetic
- A determination that a service is investigational/experimental.

Review of medical necessity denials – emergency cases

- The MIA can review a medical necessity denial in an emergency case within 24 hours.
- You do not need to exhaust the appeals process to file a complaint in an emergency.
- The MIA is always available.

Review of medical necessity denials – all cases

- The MIA will send medical records and the other complaint documents to the health benefit plan.
- If the MIA does not have jurisdiction over the health benefit plan, the MIA will try to refer the complaint to the correct agency.
- The health benefit plan may reverse their decision.

Review of medical necessity denials – all cases

- The MIA will send the medical records and the health benefit plan's criteria to an independent review organization (IRO).
- The IRO will use a physician with the appropriate specialty to review the denial.
- If the IRO determines the service is medically necessary, the denial is overturned.

Review of medical necessity denials – all cases

- The IRO can also review the criteria used by the health benefit plan.
- The MIA can require a change to the criteria if the criteria are not: objective, clinically valid, compatible with established principles of health care, or flexible enough to allow deviations from the norms when justified on a case by case basis.

Review of medical necessity denials – all cases

- If the IRO finds that the services were medically necessary, normally the health benefit plan will just pay the claim.
- If the IRO finds that the services were not medically necessary, the MIA will normally issue a determination finding no violation.
- The MIA offers the right to a hearing when there is a finding of no violation.

Special Notes for Mental Health and Substance Use Disorder

- Health benefit plans subject to Maryland law are required to accept the Uniform Treatment Plan.
- In an emergency, for an inpatient admission or admission for residential crisis services, a health benefit plan subject to Maryland law must make a decision within 2 hours of receipt of all information.

What to include in your complaint

For medical necessity complaints, you need to include:

- Medical records;
- The patient's authorization to release the medical records;
- An explanation of the issue;
- Copies of the notices denying the claim and the grievance/appeal.

Review process for other complaints

Most complaints do not involve medical necessity. For those complaints:

- The MIA assigns an investigator to the file.
- The investigator sends an acknowledgment letter to you, and a copy of the complaint to the health benefit plan.

Review process for other complaints

- The health benefit plan has 15 working days to respond.
- The investigator reviews the response, and may ask for additional information from the health benefit plan or from you.
- When all information is collected, the investigator drafts a determination letter, and it is reviewed by a supervisor.

Review process for other complaints

In cases that don't involve medical necessity, the MIA reviews the information to determine:

- Did the health benefit plan issue the correct notices on time?
- Did a claim denial follow the terms of the member's policy?
- Is there a mandated benefit or other requirement that applies?

Review process for other complaints

At the end of a complaint, the MIA may:

- Find that the health benefit plan reversed its decision, and close the file;
- Issue an order finding a violation, but not require payment of a claim;
- Issue an order requiring payment of the claim; or
- Find no violation and offer the right to a hearing.

What if you don’t participate with a health benefit plan?

- If the patient is enrolled in a health maintenance organization, and the services are covered by the HMO, you cannot balance bill the patient. This may happen if a patient is referred to you by a participating provider, or you are providing emergency services or services where the patient has no choice.

What if you don't participate with a health benefit plan?

If the patient is in a PPO, and you accept assignment of benefits, then for regular office visits, the patient should be given a disclosure that:

- the physician is not in-network,
- the patient may be billed for non-covered services and balance billed, and
- An estimate of the services and terms of payment, including interest.

Example 1

- A claim is partially paid; one CPT code is denied as included in the primary code.
- First, file an appeal. The health benefit plan has 60 working days to respond.
- The appeal decision is received, and the denial is upheld.
- File a complaint with the MIA.

Example 1 continued

- The MIA will enter the complaint into the tracking system and assign an investigator.
- The investigator will send an acknowledgment letter to you and an initial letter to the health benefit plan.
- The health benefit plan has a deadline of 15 working days to respond.

Example 1 continued

When the investigator receives a response, they look for:

- Whether the notices (EOB or Notice of payment, Appeal Decision) were timely and included all required information;
- Whether the coding guidelines were published in advance and give notice that the code would be considered included.

Example 1 continued

Possible outcomes:

- The health benefit plan decides to pay the claim based on the complaint;
- The health benefit plan shows that they have published guidelines and the notices are correct;
- There is a possible violation; or
- The MIA lacks jurisdiction.

Example 1 continued

The MIA may find:

- There was no violation; you will have the right to a hearing.
- The claim denial cannot be overturned, but a notice was incomplete or late. An order with an administrative penalty may be issued, but the claim will not be paid.
- The guidelines weren't published, or weren't followed. An order may be issued requiring payment of the claim.

Example 1 continued

The MIA looks for compliance with the Insurance Article. The Insurance Article requires health plans to provide their coding guidelines, not to follow specific practices. If the health plan doesn’t have a specific guideline published, it may rely on another common source such as Medicare.

Example 2

You receive authorization for a procedure code. When you submit the claim for the procedure code with the authorization number, the claim is denied.

You appeal, and the denial is upheld on appeal.

Example 2 continued

When you file a complaint, it will be entered and assigned to an investigator.

- You will be sent an acknowledgment letter, and an inquiry will be sent to the health benefit plan.
- The health benefit plan has 15 working days to respond.

Example 2 continued

When a response is received, the investigator will review:

- Whether the health benefit plan complied with § 15-1009 of the Insurance Article, which requires payment for pre-authorized services unless specific exceptions are met.
- Whether the notices are timely and complete.

Example 2 continued

Possible outcomes:

- The health benefit plan pays the claim;
- The health benefit plan refuses to pay the claim, and an order is issued requiring them to pay it;
- The health benefit plan justifies the denial based on an exception; or
- The MIA lacks jurisdiction.

Example 3

You do not have a contract with the health benefit plan. You fax the Uniform Treatment Plan to request pre-authorization of mental health services. Additional information is requested and provided.

You receive approval of half the requested services, but no notice about the denial of the other half. You file an appeal, which is denied, saying the additional visits are not approved.

Example 3 continued

The MIA will enter the complaint into the system and assign an investigator. It appears that the visits may have been denied based on medical necessity, so it will be assigned to the Appeals and Grievance unit.

You will be required to provide the patient's authorization to release records.

Example 3 continued

The MIA will send the complaint to the health benefit plan, which has 7 working days to respond.

If the health benefit plan does not reverse their decision, the complaint will be sent to an IRO for review. The IRO may be asked to review the criteria used to make the decision.

Example 3 continued

The MIA will review:

- The decision of the IRO;
- Whether the health benefit plan sent the correct notices;
- Whether the health benefit plan required information additional to the Uniform Treatment Plan in violation of Maryland law.

Example 3 continued

The MIA may:

- Issue an order based on violation of the notice law or requiring information in addition to the Uniform Treatment Plan;
- Close the file and ask Market Conduct to review the health benefit plan;
- Require the health benefit plan to pay for medically necessary services.

Hearings

If the MIA makes a determination that you disagree with, you may have the right to a hearing. Your request must be received within 30 days of the date of the MIA's letter to you. A form is included with a determination letter that finds no violation.

Hearings

- Hearings may be held at the MIA's offices or at the Office of Administrative Hearings;
- A corporation must be represented by an attorney;
- The complaint file is sent to the hearing officer, but the hearing is a fresh look at the matter.

Contact information

- For assistance in preparing an appeal or complaint: Health Education and Advocacy Unit, Office of the Attorney General, 1-877-261-8807 or 410-528-1840
- Maryland Insurance Administration:

1-800-492-6116 or 410-468-2244

QUESTIONS?