REPORT ON SEMI-ANNUAL

CLAIMS DATA FILING

FOR CALENDAR YEARS 2006 - 2009

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INSURANCE ADMINISTRATION

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ABOUT THIS REPORT

In November 2000, the Maryland Insurance Administration (MIA) issued regulations required by §15-1003(d) of the Insurance Article Annotated Code of Maryland (Insurance Article) that govern how third-party payors process and pay claims made by health care providers. The resulting regulation, Code of Maryland Regulations (COMAR) 31.10.11.14, established uniform standards for claims submission by health care providers to expedite and simplify claims processing, in an effort to reduce disputes between providers and third-party payors. The regulations apply to all third-party payors[1] which include insurers and non-profit health service plans[2], HMOs, and dental plan organizations.

Twice each year, Payors must compile and report the required claim data from their own health claim processing operation, as well as claim data from all *delegated agents* who process health claims on their behalf.

Under the regulations, the Insurance Commissioner is responsible for providing the public a summary of information submitted by Payors to the MIA. This report is the summary of claims data filings for insurers and HMOs for calendar years 2006 - 2009.

Semi-Annual Claims Data Filing

Using a format developed by the MIA, Payors file a report of their Maryland health care claims for the period of January 1 through June 30 by September 1 of the same calendar year. By March 1 of each year, Payors must report health care claims processing data for the period July 1 through December 31 of the previous calendar year.

Payors are required to provide information regarding claims received and processed for health care benefits under a policy, contract, plan, or certificate issued or delivered in Maryland. Medicare, Federal Employee Health Benefit Plans, self-insured employer health care programs and other types of accident and health insurance (e.g., long-term care, disability) are not required to submit data and are excluded from this report. Payors must report health care claims data for medical, dental behavioral health, vision, and prescription drug claims.

[1] Third-party payors, insurers, non-profit health service plans, HMOs and dental plan organizations are collectively referred to as "Payors" in this Report.

[2] Insurers and non-profit health service plans are collectively referred to as "*insurers"* in this Report.

Payors not filing the required claims data reports or filing inaccurate data may violate Maryland insurance laws and regulations and may be subject to penalties imposed by the Insurance Commissioner. Penalties may include more frequent or detailed reporting.

Certain Payors with minimal or no health business in the State may be exempted from the filings at the discretion of the Commissioner. As in past filing periods, a number of Payors representing a negligible segment of the Maryland market received filing exemptions for 2009.

Base Group

To facilitate effective and meaningful data analysis, the MIA established a *Base Group* of Payors. This Base Group included 33 insurers and 8 HMOs and had remained relatively consistent since 2006. Because of changes in business and operations for several Payors (e.g., consolidation of companies or reduced marketing in Maryland), the Base Group for the 2009 report period is adjusted from the previous period and includes 28 insurers and 7 HMOs. No dental or vision plan organizations are included in the Base Group. A list of the Base Group Payors can be found in Exhibit 3 of this report.

In 2009, the Base Group wrote approximately $6.2 billion in accident and health premium, accounting for about 65 percent of the total accident and health insurance market in Maryland. In previous report periods, the Base Group accounted for approximately 80 percent of the total accident and health premium written in Maryland.

As a result of this decrease in the Base Group from 80 percent market share to 65 percent market share, direct comparison of the numbers of total claims received, total clean claims received and total benefits paid from year to year will not reflect actual trends in the market and should not be used for that purpose. The statistics presented in this report, however, remain valid because they reflect a ratio based on the companies actually reporting in that time period Therefore, the ratios or percentages tracked in this report do provide some insight into trends within the Maryland market.

Clean Claims

A key element of the semi-annual claims data filing and the subject of this report are *Clean Claims.* Clean Claims are those health care claims submitted by a health

care provider that contain all essential information needed by a Payor for claims processing. COMAR 31.10.11 sets forth the *essential data elements for Clean Claims.* Payors may use this data set to determine what constitutes a Clean Claim, or they may choose to define Clean Claims using their own set of requirements that contains fewer elements than all of the essential data elements detailed in COMAR 31.10.11. Payors may require fewer data elements to determine Clean Claims, but may not require more data elements than those detailed in COMAR 31.10.11.

Clean Claims must be submitted on one of two industry standard billing forms or their electronic equivalents. In Maryland, *CMS Form 1500* (used by doctors) and *CMS Form 1450/UB04 (formerly known as UB 92* and used by hospitals) are considered *Uniform Claim Forms*. The acronym "CMS" refers to the Federal Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

By regulation, these CMS forms are the sole instruments for health care providers to file health claims with third-party payors for professional, hospital and related services in Maryland.

Although patients may file health care claims with Payors for reimbursement for professional, hospital and related services, they are not considered to be Clean Claims according to COMAR 31.10.11 and are not required to contain all the *essential data elements*. These patient-submitted claims are included in the information filed by third-party payors, but are not part of the data incorporated into Clean Claims for the purpose of this report.

Semi-Annual Claims Data Filing Reports

There are specific instructions for completing the claims data filing form designed by the MIA. Beginning with the 2007 claims data filing, Payors were given an option of submitting data electronically in lieu of submitting data in the traditional paper format. Instructions for completing the paper form remain unchanged since inception and are found on the MIA's website: www.mdinsurance.state.md.us Instructions for electronic claims data filing are also found on the MIA's website, as are instructions for filing amended reports.

For 2009 claims data filing, Payors were encouraged to file electronically to promote uniformity and verification of data reporting, as well as efficiency and

accuracy of compilation by the MIA. Nearly all 2009 claims data filings were received electronically and mandatory electronic filing is planned for the future.

In general, Payors are required to submit information on the total number of health claims received and denied, the number of Clean Claims received and denied, the inventory of unprocessed claims, the number of claims processed and the benefit amounts paid, and processing time. Payors must also provide information on the most prevalent reasons for their denials of claims submitted.

Completion of the claims data filing requires Payors to affirm whether they use the essential data elements specified by COMAR 31.10.11 to determine Clean Claims, or whether the COMAR 31.10.11 data set is not used. As previously stated, Payors may require fewer data elements to determine Clean Claims, but may not require more data elements than mandated by the regulations.

Prompt Payment

Another key element of the semi-annual claims data filing is *prompt payment.* According to the Insurance Article, §15-1005(c), Insurers and HMOs must take certain action on a claim within 30 days. If payment is due on the claim and payment is not made within 30 calendar days from the date a Payor receives the claim, an interest penalty must be paid to the person entitled to reimbursement pursuant to Insurance Article, §15-1005(f).

As part of their filing, Payors must report the number of health claims processed within certain timeframes, the total dollar amount of health benefits paid within those timeframes and the total interest amount paid on claims processed in excess of 30 calendar days.

Denied Claims

Part of the claims data filing requires that Payors report the number of claims denied according to the five most prevalent reasons for claim denials. To simplify this process and to promote uniform reporting for comparison, Payors must report data based on a set of 16 denial codes established by the MIA. In 2009, these 16 denial codes accounted for approximately 74 percent of all claims denied. The list of codes can be found in Exhibit 2 of this report.

Verification of Data Reported

Data is self-reported by Payors and by delegated agents on behalf of the Payors they serve. However, reporting is ultimately the responsibility of the Payor. Some Payors collect reports from their delegated agents for submission along with their internally-generated reports while other delegated agents submit reports directly to the MIA on behalf of their contracting insurers or HMOs.

In the course of its analysis, the MIA identified duplicate filings and certain other data anomalies. In these cases, the affected Payors were contacted for clarification or revised data.

Confidentiality of Information

Claims data filings are used, in part, by the Insurance Commissioner to monitor the general business practices of Payors and their delegated agents. The information provided to the MIA in these filings is considered confidential commercial information and is protected under State Government Article, §10-617 and Insurance Article §2-209(g), Annotated Code of Maryland except when aggregated with data from all other respondents in a manner that does not permit the identification of individual respondent information.

Thus, semi-annual claims data filings of specific Payors are not available to the public. Pursuant to Insurance Article §2-205, however, Payor claims data filings may be used by the Commissioner as a basis for analysis or investigation of a Payor's business practices. Further, based on the analysis or assessment of a Payor's semi-annual claims data filing, the Commissioner may issue an Order or take any other action authorized or reasonably implied by the Insurance Article, including the imposition of an administrative penalty and/or requiring payment of interest due.

Effect of Changes to Economy

The 2008 and 2009 report periods encompass significant changes to the national and Maryland economies. Of interest to the MIA was whether the national economic downturn had affected the marketplace and if the data collected would show significant changes due in whole or part to the economic down turn. These issues are addressed in the "Conclusions" section of this report.

SUMMARY OF 2006 - 2009 CLAIMS DATA FILINGS

Table 1 highlights information from the claims data filings of the Base Group for Calendar Year 2009 compared to the previous three years. Actual data used to create the following tables is found in Exhibit 1 of this report.

Table 1 – Summary of Base Group

Data Class	2009	2008	2007	2006
Total claims received	39.2 million	41.4 million	40.5 million	38.9 million
Total clean claims received	30 million	32.8 million	30.5 million	28.5 million
Total benefits paid	$5.7 billion	$7.2 billion	$5.8 billion	$3.5 billion
Clean claims as a percentage of total claims received	76.5%	79.2%	75.4%	73.3%
Denied claims as a percentage of total claims received	14.9%	14.9%	15.7%	16.1%
Denied clean claims as a percentage of total clean claims received	0.6%	0.9%	5.3%	1.5%
Percentage of all claims processed within 30 days	99%	97.9%	98.6%	98.4%

As previously described, due to changes in business and operations for several Payors (e.g., consolidation of companies or reduced marketing in Maryland), the Base Group for the 2009 report period is adjusted from the previous periods to reflect a 15 percent decrease in market share.

As a result of this decrease in the Base Group market share over the past 4 years, from 80 percent to 65 percent, a direct comparison of the numbers of total claims received, total clean claims received and total benefits paid from year to year will not reflect actual trends in the market and should not be used for that purpose. The percentages presented in this report, however, may be compared from year to year to provide some insight into trends within the Maryland market.[3] A list of the Base Group Payors can be found in Exhibit 3 of this report.

Recognizing that the adjustment to the Base Group resulted in a 15 percent reduction in the percentage of the Maryland health care market represented, the

[3] Since each percentage is a comparison of the data submitted to the actual Base Group in existence during that particular year, each percentage has already taken into account the appropriate decrease in market share among the Base Group companies.

data filed continues to show a number of pertinent relationships between the current and previous years. Over the four year period, while the market share of the Base Group decreased by 15%, the number of claims received increased by about one percent and the total benefits paid increased by 63 percent. Much of the increase in payments occurred between 2006 and 2008 when the total benefits paid more than doubled.

Although the percentage of clean claims received by companies had been steadily increasing from 2006 to 2008, in 2009, the percentage of Clean Claims received by the Base Group decreased by 2.7 percent. With the exception of 2006, the percentage of clean claims that are paid by the Base Group has also been steadily increasing. In 2009, 99.4 percent of clean claims received were paid; 0.6 percent were denied. In contrast, 85.1 percent of all claims received by the Base Group were paid; 14.9 percent were denied. In 2008 the same 85.1 percent of claims were paid, an increase from 2006 when 83.9 percent of all claims received were paid. Finally, the average amount paid per processed claim decreased from approximately $174 in 2008 to $146 in 2009, a decrease of 16 percent.

These numbers indicate that in Maryland a lower percentage of clean claims are being received by the Base Group, but a higher percentage of the clean claims received are being paid, and a higher percentage of all claims received are being paid and processed within 30 days.

In 2009, Payors reported the most prevalent reasons for claim denials were:

- Duplicate claim submission (30 percent, a modest decrease from 32 percent in 2007)
- Expense exceeded the usual and customary fee, was miscoded or otherwise resulted from an incidental procedure not covered by the benefit plan (17 percent, a significant increase from 5.5 percent in 2007)
- Service exceeded plan maximum or limitations for covered services (10 percent, a slight increase from 9 percent in 2007)
- Noncovered expense or service – not reimbursable under the plan due to deductible, copayment or co-insurance (9 percent, a noticeable increase from 5.5 percent in 2007

The percentage of the most common reasons for denied claims[4] remained the same. Only 1 percent of all claims were denied because the insurer or HMO

[4] Exhibit 2.

required additional information not otherwise identified by one of the remaining 15 denial codes.

Regarding the most common reasons for claim denials, the most significant change is the decrease in claims denied because a pre-treatment authorization or referral for services was not obtained or unauthorized services were performed. In 2009, the number of denials for failing to obtain proper pre-treatment authorization or referral was 3 percent compared to 20 percent in 2007. Part of this decrease may be related to (1) the mix of claim types processed by the current Base Group compared to the previous Base Group, (2) changes in the requirements of certain Payors for obtaining a pre-treatment authorization or referrals, (3) improvements to Payor administrative practices, and (4) an increase in provider submissions of completed pre-treatment authorizations.

The percentage of claims denied for miscellaneous reasons[5] increased from 8 percent in 2007 to more than 16 percent in 2009. Significant changes in the numbers of claims denied or the reasons for denial often reflect changes in the administrative practices of Payors. Such changes may lead to delayed claims processing and corresponding interest payments, the number and amount of claim payments and consumer complaints.

Of note, the percentage of all claims processed within 30 days reached its highest reported level to date at 99 per cent.

HMO RESULTS

Table 2 displays information from the claims data filings of the HMOs in the Base Group for 2009 compared to the previous three years. Actual data is found in Exhibit 1 of the report.

[5]" Miscellaneous other conditions or reasons for denial" is number 16 on the Claim Submission Denial Reason Codes in Exhibit 2.

Table 2 – Summary of HMOs in the Base Group

Data Class	2009	2008	2007	2006
Total claims received	13.6 million	16.1 million	15.4 million	15.4 million
Total clean claims received	5.8 million	8.9 million	7.5 million	6.9 million
Total benefits paid	1.6 billion	2.2 billion	$1.9 billion	$2.0 billion
Clean claims as a percentage of total claims received	42%	55%	49%	45%
Denied claims as a percentage of total claims received	21.7%	19.8%	21.3%	20.3%
Denied clean claims as a percentage of total clean claims received	1.6%	1.3%	3.5%	3.3%
Percentage of all claims processed within 30 days	99.4%	99.3%	99.1%	98.8%

As previously described, due to changes in business and operations for several Payors (e.g., consolidation of companies or reduced marketing in Maryland), the HMO Base Group for the 2009 report period is adjusted from the previous periods to reflect a 15 percent decrease in market share.[6]

The trend towards a decrease in the percentage of clean claims received is more pronounced in the HMO Base Group. The percentage of clean claims received by the HMO Base Group had been steadily increasing until 2009 when it decreased by 13 percent. In the HMO Base Group, the data indicates that Clean Claims are significantly less likely to be denied; in 2009, 21.7 percent of all claims received were denied compared to 1.6 percent of Clean Claims.

The average amount paid per processed claim decreased from approximately $137 in 2008 to $118 in 2009, a decrease of 13.8 percent. HMOs accounted for 34.7 percent of the total claims in the Base Group in 2009 and 28 percent of the total benefit amount paid.

There has been a continued improvement in the percentage of claims processed by HMOs in 30 days or less. In 2009, as in 2008, more than 99 percent of all

[6] As a result of this decrease in the Base Group market share over the past 4 years, from 80 percent to 65 percent, a direct comparison of the numbers comprising total claims received, total clean claims received and total benefits paid from year to year will not reflect actual trends in the market and should not be used for that purpose.

claims were processed within 30 days. HMOs have typically outperformed insurers in this area by approximately one to two percent.

INSURER RESULTS

Table 3 highlights information from the claims data filings of the insurers in the Base Group for 2009 compared to the previous three years. Actual data is found in Exhibit 1 of the report.

Table 3 – Summary of Insurers in the Base Group

Data Class	2009	2008	2007	2006
Total claims received	25.6 million	25.3 million	25.0 million	23.4 million
Total clean claims received	24.3 million	23.4 million	22.9 million	21.6 million
Total benefits paid	4.1 billion	4.9 billion	$3.9 billion	$1.5 billion
Clean claims as a percentage of total claims received	95.1%	94.4%	91.6%	92.0%
Denied claims as a percentage of total claims received	11.3%	11.8%	12.2%	13.3%
Denied clean claims as a percentage of total clean claims received	0.6%	0.7%	5.9%	0.9%
Percentage of all claims processed within 30 days	98.0%	97.0%	98.3%	97.9%

As previously described, due to changes in business and operations for several Payors (e.g., consolidation of companies or reduced marketing in Maryland), the Base Group for the 2009 report period is adjusted from the previous periods to reflect a 15 percent decrease in market share.[7]

The percentage of Clean Claims received has steadily improved every year since 2007 and remains substantially higher than for HMOs at approximately 95 percent compared to 42 percent. The percentage of claims processed in 30 days or less remained relatively constant during the four year period.

[7] As a result of this decrease in the Base Group market share over the past 4 years, from 80 percent to 65 percent, a direct comparison of the numbers comprising total claims received, total clean claims received and total benefits paid from year to year will not reflect actual trends in the market and should not be used for that purpose.

The average amount paid per processed claim decreased from approximately $194 in 2008 to $160 in 2009, a decrease of 17.5 percent. Insurers accounted for 65.3 percent of total claims received by the Base Group in 2009 and 72 percent of the total benefits paid.

Over the four year period, the number of claims received by insurers in the Base Group increased about 8 percent while the total benefits paid increased over 275 percent. The average amount paid per processed claim increased from $64 in 2006 to $160 in 2009, a shift not seen in the HMO data.

The percentage of Clean Claims received has increase from approximately 92 percent in 2006 and 2007 to over 95 percent in 2009. As stated before, Clean Claims are significantly less likely to be denied. In 2009, 11.3 percent of all claims received were denied while only 0.6 percent of all Clean Claims received were denied.

The percentage of claims processed in 30 days or less also remained relatively constant during the four year period. In 2009, 98.0 percent of all claims were processed in 30 days or less compared to 97.0 percent in 2008.

CONCLUSIONS

Overall, in 2009 the Base Group represented 65 percent of the total written premium in the accident and health market in Maryland compared to 80 percent in 2008. Thus, direct comparisons of the numbers of claims received and benefits paid in 2009 are illustrative only. Comparisons of the percentages of Clean Claims, paid claims, denied claims and timely processing of claims, however, remain relevant for the reasons stated above.

In 2009 the Base Group received 39.2 million claims and paid $5.7 billion in benefits. The HMOs accounted for 34.7 percent of the received claims and 28 percent of the total benefits paid; the insurers accounted for 65.3 percent of the received claims and 72 percent of the total benefit paid.

In 2009, 14.9 percent of the total claims received by the Base Group were denied. This number has remained relatively consistent, showing only a slight decline of about one percent, over the period of 2006 through 2009. Denied Clean Claims as a percentage of total claims received accounted for only 0.6 percent of the total

number of claims denied, a number that has shown great improvement since it 2007 high of 5.3 percent.

The percentage of Clean Claims received by the Base Group decreased notably from 79.2 percent of the total claims received in 2008 to 76.8 percent of the total claims received in 2009. HMOs accounted for this decrease in Clean Claims received as a percentage of total claims received. Insurers showed a slight increase of about half of one percent in the proportion of Clean Claims received in 2009. HMOs, however, have had consistently poor numbers relative to insurers with 2009 registering a 24 percent decrease in the proportion of Clean Claims received, representing the worst year in the sample period of 2006 to 2009.

The total benefits paid by the Base Group increased by about 23 percent between 2007 and 2008 and then in 2009 fell back to the level seen in 2007. This number is more significant when combined with the total number of claims received producing an average benefit paid per processed claim. This calculation illustrates a decrease from $194 per processed claim in 2008 to $160 in 2009 for insurers while the HMO average benefit paid per processed claim decreased from $138 in 2008 to $118 in 2009 for the same period.

Of interest to the MIA was whether claims data filed would show evidence that the national economic downturn had affected the marketplace and if the decline would result in a noticeable change in health benefit claims received, processed and paid during calendar year 2009. Based on the semi-annual claims data filings of the Base Group of Payors, it appears that some Payors may have experienced a significant decrease in the average cost per claim. This is demonstrated by the decrease in the average benefit paid per processed claim by 13.8 percent for HMOs and 17.5 percent for insurers. While a singular cause can not be identified using the data contained in this filing, this trend is consistent with the national observation that individuals are or were postponing expensive procedures due to their inability to make co-payments or their reluctance to submit large claims to their insurer.

However, most of the areas monitored by this report did not appear to be greatly altered by the economic downturn. The overall health insurance market trends regarding the total number health claims received, processed, paid or denied have remained relatively consistent.

Regarding the reasons for claim denials, duplicate claim submissions decreased slightly from past years, but remains the most common reason for claim denial at 30 percent in 2009. The second most prevalent reason cited by the Base Group for claims denials was based on benefit determinations related to usual and customary fees of providers. This reason accounted for 17 percent of all denials in 2009 compared to only 5.5 percent in 2007. As the overall percentage of total claims denied has not changed significantly during the comparative period, however, it appears that changes to the reasons for denial have not noticeably affected the processing and payment of claims.

EXHIBIT 1

SUMMARY OF BASE GROUP CLAIMS DATA FILINGS FOR CALENDAR YEARS 2006 - 2009

HMO Claims Reported	Total 2009	Total 2008	Total 2007	Total 2006
Total Claims Received	13,578,886	16,087,805	15,413,706	15,446,306
Total Claims Denied	2,951,041	3,177,152	3,282,419	3,129,519
Total Claims Processed	13,609,942	16,102,501	15,419,980	13,518,820
Clean Claims Received	5,751,210	8,900,022	7,546,681	6,949,417
Clean Claims Denied	93,878	112,712	260,891	227,896
Total Benefit Amount Paid	1,611,055,195	$2,216,552,614	$1,932,048,502	$2,024,874,945
Total Claims Processed <30 Days	13,528,517	15,972,291	15,278,011	13,362,814
Total Claims Processed >30 Days	81,425	130,210	141,969	156,006
Interest Paid on Delayed Claims	$336,148	$810,030	$268,038	$450,262
Processed by Delegated Agents	2,676,165	5,787,323	6,300,914	4,611,164
Benefit Amount Paid by Delegated Agents	$196,401,401	$313,337,157	$339,076,858	$354,818,377
Interest Paid by Delegated Agents	$15,507	$896	$1,663	$7,178
Total Ending Claim Inventory	104,824	271,088	146,308	198,801
Insurer Claims Reported	**Total 2009**	**Total 2008**	**Total 2007**	**Total 2006**
Total Claims Received	25,578,578	25,290,740	25,031,410	23,440,252
Total Claims Denied	2,884,310	2,987,774	3,052,764	3,128,061
Total Claims Processed	25,768,541	25,361,123	25,141,605	11,630,953
Clean Claims Received	24,317,116	23,890,443	22,928,790	21,557,304
Clean Claims Denied	148,104	169,439	1,360,089	199,850
Total Benefit Amount Paid	4,133,508,550	4,974,329,766	$3,905,549,411	$1,498,337,389
Total Claims Processed <30 Days	25,260,223	24,531,362	24,718,246	11,384,702
Total Claims Processed >30 Days	508,318	829,761	422,359	246,251
Interest Paid on Delayed Claims	$808,822	$812,547	$604,275	$519,075
Processed by Delegated Agents	586,238	399,324	890,689	200,834
Benefit Amount Paid by Delegated Agents	$32,419,137	$26,146,490	$117,769,769	$19,480,692
Interest Paid by Delegated Agents	$3,256	$6,841	$9,641	$8,312
Total Ending Claim Inventory	460,619	468,443	324,046	294,187
All Claims Reported	**Total 2009**	**Total 2008**	**Total 2007**	**Total 2006**
Total Claims Received	39,157,464	41,378,545	40,445,116	38,886,558
Total Claims Denied	5,835,351	6,164,926	6,335,183	6,257,580
Total Claims Processed	39,378,483	41,463,624	40,561,585	25,149,773
Clean Claims Received	30,068,326	32,790,465	30,475,471	28,506,721
Clean Claims Denied	241,982	282,151	1,620,980	427,746
Total Benefit Amount Paid	$5,744,563,745	$7,190,882,380	$5,837,597,913	$3,523,212,334
Total Claims Processed <30 Days	38,788,740	40,503,653	39,996,257	24,747,516
Total Claims Processed >30 Days	589,743	959,971	564,328	402,257
Interest Paid on Delayed Claims	$1,144,970	$1,622,577	872,313	969,337
Processed by Delegated Agents	3,262,403	6,186,647	7,191,603	4,811,998
Benefit Amount Paid by Delegated Agents	$228,820,538	$339,483,647	456,846,627	374,299,069
Interest Paid by Delegated Agents	$18,763	$7,737	11,304	15,490
Total Ending Claim Inventory	565,443	739,531	470,354	492,988

EXHIBIT 2

CLAIM SUBMISSION DENIAL CODES

CLAIM SUBMISSION DENIAL REASON CODES

The following claim submission denial codes were established by the MIA for Payors to use when reporting the five most prevalent reasons for denying claims.

1. Accident details (including workers compensation) or explanation required
2. Additional information from member or provided needed
3. Provider billing error or discrepancy; billing information missing
4. Coordination of benefits information or primary Payor EOB needed
5. Provider not contracted or covered by plan; not covered due to provider global or capitation fee arrangement
6. Expense previously considered or paid; duplicate submission
7. Service exceeds plan frequency of services limitation
8. Patient not covered or ineligible for benefits; coverage not effective
9. Expense or services not approved or covered by Medicare; Medicare deductible not covered by plan
10. Expense or services not covered by plan (other than Medicare related items)
11. Pre-treatment authorization or referral not obtained; unauthorized services not covered by plan
12. Pre-existing condition not covered by plan
13. Coverage terminated, cancelled or lapsed
14. Expense exceeds usual and customary fee; miscoded service, unbundled fee or incidental procedure not covered by plan
15. Untimely filed claim by provider not accepted for reimbursement
16. Miscellaneous other conditions or reasons for denial

EXHIBIT 3

BASE GROUP PAYORS FOR CALENADAR YEARS

2006 - 2009

PAYORS – 2006 - 2009 BASE GROUP

The following is a list, in alphabetical order, of the 7 HMOs and the 28 insurers that make up the Base Group for the 2009 Claims Data Filing. The Base Group had remained relatively consistent since 2006. No dental or vision plan organizations are included in the base group. Maryland domestic companies are highlighted in **bold**.

HMOs

CareFirst BlueChoice, Inc.
CIGNA HealthCare Mid-Atlantic, Inc.
Coventry Health Care of Delaware, Inc.
Kaiser Permanente Insurance Company
MD – Individual Practice Association, Inc.
Optimum Choice, Inc.
United Healthcare of the Mid-Atlantic, Inc.

Insurers, Non-Profit Health Service Plans

Aetna Life Insurance Company
American Republic Insurance Company
Ameritas Life Insurance Company
CareFirst of Maryland, Inc.
Combined Insurance Company of America
Connecticut General Life Insurance Company
Golden Rule Insurance Company
Graphic Arts Benefit Corporation
Group Hospitalization and Medical Services, Inc.
Guardian Life Insurance Company of America
MAMSI Life & Health Insurance Company
Mega Life and Health Insurance Company
Monumental Life Insurance Company
Nationwide Life Insurance Company
New York Life Insurance Company
Physicians Mutual Insurance Company
Principal Life Insurance Company
Prudential Insurance Company of America

State Farm Mutual Automobile Insurance Company
Sun Life and Health Insurance Company
Time Insurance Company
Transamerica Life Insurance Company
Unicare Life & Health Insurance Company
Union Labor Life Insurance Company
Union Security Insurance Company
United HealthCare Insurance Company
United of Omaha Life insurance Company
USAA Life Insurance Company