

Instructions for Completing Supplemental Data Report Form

The instructions provided below pertain to a supplemental request for in-operation data to verify the audits, reviews, and analyses performed pursuant to § 15-144(e)(4) of the Insurance Article

The NQTL analysis report requires carriers to report the results of the audits, reviews, and analyses performed to ensure compliance with the Parity Act in operation. To verify the narrative responses provided in the NQTL report, this supplemental report of data standardized among carriers is a required portion of the NQTL analysis report.

A supplemental data report is required for the NQTLs of prior authorization, concurrent review, retrospective review, and pharmacy services.

Carriers are required to enter data in the supplemental data report form, organized by classification, based on the definitions and instructions provided below. Section 15-830 of the Insurance Article requires carriers to have a process for members to request referrals to an out of network provider. Section 15-830(d)(5) of the Insurance Article requires carriers to have a system in place to document all requests to obtain such a referral, and to provide the information to the Commissioner on request. The out of network exceptions requests under line 1 refer to the provisions of § 15-830 of the Insurance Article.

Children ages 0-12 are children who have not attained age 13. Adolescents ages 13 – 17 are individuals who have attained age 13, but have not attained age 18. Adults are individuals who have attained age 18.

Carriers should refer to the definitions below when preparing the supplemental data report:

“Prior authorization” has the meaning in COMAR [insert regulation number when completed].

“Approved” means that the request was approved in full or the provider agreed to accept the carrier’s approval of a modification of the request. “Approved” does not include a request for which an adverse decision or coverage decision was issued.

“Peer-to-peer or physician-to-physician review” includes the review described in § 15-10B-06(b) of the Insurance Article, regardless of whether the conversation took place within 24 hours after the request by the health care provider seeking the reconsideration.

“Adverse decision” has the definition in § 15-10A-01(b) of the Insurance Article.

“Concurrent review” has the meaning in COMAR [insert regulation number when completed].

“Grievance” has the meaning in § 15-10A-01(f) of the Insurance Article.

“Hospital inpatient” means inpatient care following admission to a hospital, usually designated with place of service code 21 on a claim.

“Other inpatient” means care in an inpatient facility that is not a hospital. Examples include a skilled nursing facility, hospice, or residential treatment center.

Outpatient care is divided into office visits and all other. “Office visits” refers to health care services provided in a health care provider’s office, usually designated on a claim with place of service code 11.

“Other outpatient” services are outpatient services that are not provided in a health care provider’s office. Examples include a hospital emergency department (without an admission), ambulatory surgical center, or non-residential substance abuse treatment facility.

“Fail-first” means a protocol established by a carrier that a member must unsuccessfully attempt a different drug or treatment before the health benefit plan provides coverage for the recommended drug or treatment.

In counting the numbers of requests for authorization, use the number of requests received during the prior calendar year. The number of adverse decisions and grievances shall be those arising from the reported requests.

Any disparities in the data between M/S and MH/SUD providers should be explained in Step 7 of the template for the applicable NQTL.