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BULLETIN 08-31

Date: October 28, 2008

To: Insurers (providing health insurance in the State), Nonprofit Health Service Plans, Health Maintenance Organizations, and Dental Plan Organizations

Re: Coverage Decisions

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The Maryland Insurance Administration (MIA) has received inquiries about Title 15 Subtitle 10D of the Insurance Article. This subtitle requires insurers providing health insurance in the State, nonprofit health service plans, health maintenance organizations (HMOs) and dental plan organizations (hereinafter "carriers") to send certain notices and maintain an internal appeals process for coverage decisions.

1. What is a coverage decision?

A coverage decision is defined in *Ins.* §15-10D-01 to mean "an initial determination by a carrier *or a representative of the carrier* that results in noncoverage of a health care service." (emphasis added) A coverage decision includes nonpayment of all or any part of a claim but does not include an adverse decision as defined under *Ins.* §15-10A-01.

2. Does a coverage decision apply to pharmacy benefits?

Yes. Health care service means a health or medical care procedure or service rendered by a health care provider, including dispensing drugs. (See *Ins.* §15-10D-01.) The definition of health care service makes this subtitle applicable to pharmacy benefits.

3. Does a coverage decision include a determination by a carrier that a claim is improperly coded?

If the carrier's determination that a claim is improperly coded results in noncoverage of a health care service, this is a coverage decision. If the carrier's determination that a claim is improperly coded does not result in noncoverage of a health care service, it is not a coverage decision.

For example, if a carrier determines that the covered service is bundled into payment for another service and reimburses the provider for the other service, this is not a coverage decision. However, if the carrier denies payment for the covered service because the provider did not code the service correctly, this is a coverage decision.

4. Is it a coverage decision if the member has no financial liability as a result of the nonpayment of all or any part of the claim?

It is a coverage decision if the determination results in noncoverage of a health care service, irrespective of the member's liability.

5. Is it a coverage decision when a pharmacist refuses to fill a prescription absent payment of the entire cost of the prescription medication by the member?

It is a coverage decision if the pharmacist submits information to a carrier or the carrier's representative following the electronic transaction standards established by the Department of Health and Human Services for retail pharmacy claims and the carrier or the carrier's representative (including a pharmacy benefits manager) denies payment for the prescription medication in full or in part resulting in noncoverage of a health care service.

7. If a carrier makes a coverage decision, what notice must be given?

Within 30 days after the date the coverage decision was made, the carrier (or the carrier's representative) must send a written notice to the member that gives the specific factual basis for the decision, the member's appeal rights and information about the Health Advocacy Unit. In addition, HMOs must provide a written notice of a coverage decision to the member's treating provider. See *Ins.* §15-10D-02 for more detail. In the case of a coverage decision for prescription drugs, the HMO must provide a written notice of a coverage decision to the member's prescribing physician.

Questions about this bulletin may be directed to the Life/Health Section at 410-468-2170.

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