2000 Report on the Health Care Appeals & Grievance Law
February 2001

I. EXECUTIVE SUMMARY

The Appeals & Grievance Law passed by the General Assembly in 1998 established a procedure for consumers to appeal decisions made by health maintenance organizations (HMO's), insurers and nonprofit health service plans (also referred to as "Carriers" or "health plans") that a covered health service is not "medically necessary." The law took effect January 1, 1999, and was codified at § 15-10A *et seq.* of the Insurance Article. One key component of the legislation is a consumer's right to internal and external review where care is denied on the grounds that it is not "medically necessary." This law also gave the Administration regulatory authority over Private Review Agents and established a new statutory process to certify Medical Directors of HMOs. Regulatory oversight of Private Review Agents and Medical Directors is codified as Title 15, Subtitle 10B and Subtitle 10C, respectively.

Chapter 371 of the Acts of the General Assembly of 2000, revised the Appeals & Grievance law to clarify that Carriers must send written notice of the adverse decision to the member and the member's healthcare provider within five days. The law also requires that the written notice inform the member that the Health Education and Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General ("HEAU") is available to assist the member.

Chapter 465 of the Acts of the General Assembly of 2000, establishes the authority of the Commissioner to conduct market conduct examinations of Private Review Agents.

Chapter 123 of the Acts of the General Assembly of 2000, clarified the Private Review Agent law so that the Commissioner could implement the Private Review Agent statute in accordance with the provisions established by the enactment of Chapter 112, Acts of 1998.

This report summarizes the data reported to the Administration by the Carriers for calendar year 2000 as required by § 15-10A-06 of the Insurance Article. This report also summarizes complaint information and the enforcement activity of the Insurance Administration for calendar year 2000.

Pursuant to § 15-10A-08, the HEAU is also required to submit a report in November of each year. The HEAU report is based on a fiscal year and as such, the data contained in the Administration's report and HEAU's report do not measure activity for comparable periods of time.

II. MARYLAND'S APPEALS & GRIEVANCE LAW

The process is divided into two parts: a) the internal review which is conducted by the Carrier; and b) the external review which is conducted by the Insurance Administration and

occurs if the member is dissatisfied with the Carrier's decision at the internal level and files a complaint with the Administration.

A. Internal Review: The Carrier's Internal Grievance Process

The Appeals & Grievance Law requires that if the Carrier denies services based on lack of medical necessity, the Carrier must provide the member a written "adverse decision" within five (5) working days of the decision.

The written adverse decision must:

- State in clear language the specific factual basis for the decision.
- Reference the specific criteria relied on to make the decision.
- State the name, address and phone number of the person making the decision.
- Explain the Carrier's internal grievance process.
- Inform the member that the HEAU can assist them.
- Provide address and phone number of the HEAU.
- Inform the member that they have a right to file a complaint with the Commissioner within 30 days after receipt of a Carrier's grievance decision if the member is dissatisfied with the outcome.
- Inform the member that a complaint may be filed without first filing a grievance with the Carrier if there is a compelling reason.
- Provide the Commissioner's address, telephone number and facsimile number.

If the member, or a provider acting on behalf of the member, wishes to challenge the adverse decision of the Carrier, the member must go through an internal process which is established by the Carrier. However, if the case involves a compelling reason, the appeal may be filed directly with the Administration.

This internal grievance process must provide:

- An expedited procedure for use in an emergency case for purposes of rendering a grievance decision within 24 hours of the date a grievance is filed with the Carrier.
- That a Carrier render a final decision in writing on a grievance within 30 working days after the date the grievance is filed. If the grievance involves a retrospective denial, the Carrier has 45 working days to render a decision.

The grievance decision shall:

- State in clear language the specific factual bases for the decision.
- Reference the specific criteria relied on to make the decision.
- State the name, business address and business telephone number of the person making the decision.

- Inform the member that they have a right to file a complaint with the Commissioner within 30 days after receipt of a Carrier's decision if the member is dissatisfied with the decision.
- Provide the Commissioner's address, telephone number and facsimile number.

Consumers may receive assistance through the internal grievance process from the HEAU. The HEAU will attempt to mediate disputes between the member and the Carrier or, in the appropriate case, help the member with the internal process.

B. External Review: Appeals & Grievance Complaint Process at the Insurance Administration.

If the complainant is dissatisfied with the grievance decision, the complainant may file a written complaint with the Insurance Administration. The Administration will conduct an investigation by examining all relevant information including the patient's medical records and information from the Carrier.

Once the Carrier's response and all relevant information is received, the case is reviewed to determine if it needs to be referred to an Independent Review Organization (IRO) for medical review. A matter may not be referred to external review for several reasons, including the absence of jurisdiction by the MIA, or because the Carrier has decided to provide the services in question. It may also be determined that a complaint is not within the jurisdiction of the Administration either because of ERISA, which preempts the State in cases involving self-insured health plans, or because the complaint involves the Medicare or Medicaid programs, etc. (Appendix C1,C2). If so, the complainant is notified of this determination by mail, and the complaint is transferred to the appropriate agency. Complaints that relate to quality of care are referred to the Department of Health & Mental Hygiene ("DHMH") for review (Appendix C3). If a complaint has a medical necessity component and a quality of care component, then both the DHMH and the Administration will investigate the portions of the case over which these respective agencies have jurisdiction.

If the MIA determines it has jurisdiction and the complaint involves a denial based on the lack of medical necessity (as opposed to denials based on specific contractual exclusions), the case will be referred to the IRO. When complaints are referred to an IRO, the IRO is requested to examine the utilization review criteria applied in the case, as well as the specific judgment of the Medical Director made under the utilization review criteria. If the IRO's recommendation is to overturn the Carrier's denial, an Order is issued against the Carrier. The Order is forwarded to the Carrier and accompanied by a notice that the Carrier has the right to request a hearing. At the same time, the complainant is notified of the outcome. Orders may also be issued as a result of failure to comply with the procedural requirements of the law, i.e., failure to issue a written notice of adverse or grievance decision.

If the IRO's recommendation is to uphold the Carrier's denial, the complainant is notified by mail and informed that he or she has the right to request a hearing. The Carrier is also informed of this decision.

Complainants may withdraw their complaints during the investigation. Also, some complaints are closed because the complainant fails to respond to a request for information. This only occurs after at least one written warning is issued to the complainant stating that the file will be closed unless additional information is provided. In addition, Carriers may reverse their original denials for a number of reasons, including following a review of information submitted during the appeals process. Maryland law allows health care providers to file complaints on behalf of the patients being treated.

III.SUMMARY OF CARRIER DATA ON GRIEVANCES REPORTED TO THE ADMINISTRATION BY CARRIER

Section 15-10A-06 of the Insurance Article, requires Carriers to submit quarterly reports which provides:

- The outcome of each grievance filed with the Carrier;
- The number and outcomes of cases that were considered emergency cases under §15-10A-02(b)(2)(i) of this subtitle;
- The time within which the Carrier made a grievance decision on each emergency case;
- The time within which the Carrier made a grievance decision on all other cases that were not considered emergency cases; and
- The number of grievances filed with the Carrier that resulted from an adverse decision involving length of stay for inpatient hospitalization as related to the medical procedure involved; and
- The number and outcome of all other cases that resulted from an adverse decision involving the length of stay for inpatient hospitalization as related to the medical procedure involved.

Based on the information provided by the Carriers, in 2000 the largest volume of complaints involve denials of inpatient hospital days. (Appendix B2, B3). In 1999, the largest volume of complaints also were concerning inpatient hospital days. (Appendix B2). While there has been a slight increase in the percentage of complaints dealing with physician services, there has been a substantial decrease in the complaints regarding pharmacy services. (Appendix B2). The Carriers also report the number of internal appeal decisions they overturn themselves. (Appendix B5, B6). The data reveals that in 1999 the majority of the reversals occurred for pharmacy services. (Appendix B5). In year 2000, the majority of the reversals have involved lab services, home health services, emergency room services, and pharmacy services. (Appendix B6).

IV. SUMMARY OF STATISTICAL DATA BASED ON COMPLAINTS FILED WITH THE ADMINISTRATION

A. Number Of Complaints Filed

The Appeals & Grievance Unit received a total of 1526 complaints asserting a denial of care of coverage based on the lack of medical necessity. (Appendix C1). As a point of comparison, in 2000 the Insurance Administration received more than 8,000 complaints in its Life & Health Unit involving non-medical necessity disputes. These complaints include disputes over whether a benefit is covered under a contract, the amount of reimbursement, as well as payments under life or disability insurance policies.

Complaints may be filed by providers on behalf of complainants. From January 1, 2000, through December 31, 2000, approximately one third of the complaints were filed by providers on behalf of patients. This includes individual doctors as well as facilities, such as hospitals.

B. Jurisdictional Issues

As indicated above, the Unit received a total of 1526 complaints that dealt with or alleged medical necessity denials. The initial investigation of these cases revealed that the Administration did not have jurisdiction in 507 cases. (Appendix C1). In 225 cases, ERISA preempted the State's jurisdiction. ERISA's preemption applies to employer sponsored benefit plans, where the health benefits are self-insured. In addition, at least one federal circuit court cases has held that ERISA's preemption of state external review laws extends to insured ERISA plans. That interpretation has been rejected by at least one other federal circuit court, and the Supreme Court has been asked to resolve the conflict. Maryland's law has also been challenged on the grounds it is preempted as to all ERISA plans, whether insured or self-insured. That case is on appeal. If it is determined that the complaint is one which falls outside of the regulatory authority of the Administration, the complainant is referred to the appropriate Agency which has jurisdiction to review their complaint. In the case of ERISA, the 225 complaints were referred to the Department of Labor.

During Calendar year 2000, the Administration also referred:

- 81 cases to OPM (FEHBP)
- 65 cases to Medicaid
- 75 cases to Medicare
- 39 cases to Insurance Department in Another State
- 22 cases to other state agencies including DHMH and the Workers Compensation Commission

In addition, the Administration's initial investigation revealed that no "adverse decision" denying care had been rendered in 420 of the cases. Examples are where a carrier has indicated that it will conduct concurrent review of hospital days or a carrier asks for more information before it will approve services. Also, in 256 cases, the complainants had not exhausted their internal grievances and thus the complaint was referred to the HEAU. (Appendix C1).

Complainants chose to withdraw their complaints in 17 cases, and 71 cases were closed because the complainants had failed to provide information that was necessary to complete the investigation. An example of this occurs where signed consent forms were not provided to the Administration, enabling the Administration to obtain medical records, or where the provider or patient failed to provide medical records which are essential for the review.

C. Synopsis Of Complaints Investigated By The Administration

The Administration investigated a total of 255 cases. In 120 cases, the Carrier reversed its initial denial during the course of the Administration's investigation. These reversals occurred for several reasons including receipt of more information by the carrier or an administrative decision to provide care. (Appendix C5).

As indicated in Appendix C6 and C7, the majority of the 255 complaints investigated by the Administration fell into five categories: inpatient hospital stays (15%), pharmacy services (13%), mental health services (12%), emergency room services (11%), and physician services (9%).

Of those 255 cases, 135 cases were investigated to completion, including review by an IRO. The Administration upheld the Carrier 69 times, required the Carrier to modify their decisions 16 times, and reversed the Carrier 50 times. (Appendix C1).

D. Enforcement Activities

The statutory authority for the Commissioner to enforce the Appeals & Grievance law is found in § 15-10A et al, § 15-10B et al, §4-113, and § 27-303. These provisions allow the Commissioner to require the payment of medically necessary services and to fine Carriers for failure to authorize medically necessary treatment; sending an adverse or grievance decision letter which did not comply with the law; failure to timely authorize medically necessary services; and failure to have the appropriate physician conduct the utilization review.

The Administration issued 68 Orders based on the complaints which it received. (Appendix D1). These Orders were issued based on the Carrier's inappropriate denial of medically necessary services; the Carrier's failure to send statutory complaint notices when services are denied as not medically necessary; and when Carriers fail to timely authorize services. The services that are the subject of these orders include mental health treatment, pharmacy services, and durable medical equipment. The Administration also entered into Consent Agreements in 15 cases.

A summary of the Orders issued during 2000 is attached at Appendix D2.

E. Consumer Survey

Surveys were sent to 883 individuals who had filed complaints with the Unit; the Administration received 243 responses. The surveys revealed that, overall, consumers were

satisfied with the assistance they received from the HEAU and the Administration, although most did not feel that the Carrier's internal process was fair. (See Appendix C10). The consumers who responded indicated that they would use the process again if the need arose.

V. CERTIFICATION AND OVERSIGHT OF MEDICAL DIRECTORS OF HEALTH MAINTENANCE ORGANIZATIONS AND PRIVATE REVIEW AGENTS

A. Medical Director Certification Procedure

- The medical directors or their designees are required to submit an application on or before the initial date of employment.

- Portions of the applications are sent to a Credentials Verification Organization. The CVO's task is to verify the following information:

    - Medical school education
    - Advanced health degree education, when applicable
    - Board certification
    - Clinical experience
    - Training
    - Licensure status in Maryland and other states
    - Disciplinary actions or sanctions

- Upon completion of the credentials verification, the CVO drafts a narrative report. The narrative report includes all relevant information verified by the CVO and the source of the information. The narrative report is then forwarded to the Chief of the MD/PRA Unit.
- The MIA investigates the following information in the medical director application for certification:

    - Financial compensation of medical directors is monitored to ensure that medical directors are not receiving any direct or indirect financial compensation that deters the delivery of medically appropriate care.
    - The utilization management policies and procedures are monitored for compliance with § 15-10A, § 15-10B, and § 15-10C of the Insurance Article.
    - The professional and character references of medical directors are reviewed in conjunction with the application materials as indicia of character and trustworthiness.

- If the applicant meets statutory and regulatory requirements, a certificate is issued.

- If the applicant does not meet statutory and regulatory requirements, the certificate is not issued, and a letter is sent to the applicant advising him/her of the specific grounds for denial.

- GROUNDS FOR DENIAL--An applicant does not qualify as a medical director if there is a history of disciplinary action or sanction taken by any hospital, professional board or regulating entity that raises a substantial question as to the applicant's physical, mental or professional competence. A certificate may also be denied in the instance where the applicant has not met the requisite qualifications.

- GROUNDS FOR REVOCATION--The Commissioner may suspend, revoke or refuse to renew the certificate of a medical director if he finds a pattern that the utilization management procedures and policies used by the medical director in making utilization review decisions or used by a private review agent employed by or under contract with the health maintenance organization over whose utilization review decisions the medical director has responsibility 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.

- ADDITIONAL GROUNDS FOR REVOCATION--The Commissioner may revoke the certificate of a medical director who:

    - Violates any of the Laws
    - Obtains certification based on inaccurate information.
    - Fraudulently or deceptively obtains, attempts to obtain, or uses a certificate.

B. Summary Of Regulatory Action For Medical Directors For Calendar Year 2000

Currently, there are fifteen (15) HMOs licensed to do business in Maryland. During calendar year 2000, the MIA received twenty-nine (29) applications for medical director certification. Of the twenty-nine applications received, twenty (20) certificates were issued. Four (4) applications were denied because the applicants were not licensed to practice medicine in Maryland. Two (2) applicants were terminated before the certification process was completed, and the remaining applications are currently under review.

Thirty-four (34) certificates were revoked on the basis that the medical director no longer met the qualifications to act as a medical director due to illness; failure to renew Maryland licensure; or termination or resignation from employment. During the past two (2) years of regulatory

oversight of medical directors, no complaints have been filed against a medical director of a health maintenance organization.

As of February 1, 2001, there were (82) certified medical directors in Maryland.[1] The number of certified medical directors per HMO is as follows[2]:

- Aetna US HealthCare, Inc. 6
- Capital Care, Inc. 2
- Cigna HealthCare of the Mid-Atlantic, Inc. 4
- Coventry Health Care of Delaware, Inc. 1
- Delmarva Health Plan, Inc. 1
- Elder Health Maryland HMO, Inc. 2
- FreeState Health Plan, Inc. 32
- George Washington University Health Plan, Inc. 2
- Kaiser Foundation Health Plan of the Mid-Atlantic States 3
- MD-Individual Practice Association, Inc. 9
- Optimum Choice, Inc. 9
- PHN-HMO, Inc. 2
- Prime Health Corporation 2
- Prudential Health Care Plan, Inc. 6
- United Health Care of the Mid-Atlantic, Inc. 1

C. Oversight of Private Review Agents

Title 15, Subtitle 10B of the Insurance Article was enacted to transfer, from the Department of Health and Mental Hygiene to the Administration, authority to regulate private review agents. The Act also enlarged the scope of regulation over private review agents and enacted standards for conducting utilization review.

Before the transfer of authority to the Insurance Administration, regulation was limited to utilization review of inpatient hospitalization only, since the former law defined "utilization review" to mean "a system for reviewing…hospital resources and services". Subtitle 10B Act removed the limitation and redefined utilization review to encompass all health care services. Now utilization review is defined as:

> "a system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a patient or group of patients."

[1] The number of medical directors has decreased significantly. There were as many as 93 certified medical directors during the 2000 calendar year.

[2] These statistics do not include medical directors that were appointed after January 1, 2001. Nor do the statistics include medical director applications currently under consideration.

The law establishes a number of requirements relating to utilization review, including that:

- All decisions to authorize non-emergency treatment be made within two working days of the receipt of all necessary information;

- All decisions to authorize extended stays or additional services be made within one working day of necessary information; and

- Limit retroactive denials of treatment previously authorized.

Subtitle 10B also establishes a four-prong test by which the review standards of a private review agent are judged. Under Subtitle 10B, the Commissioner may impose sanctions for a violation of the law if criteria and standards used in conducting utilization review are not:

(1) Objective
(2) Clinically valid
(3) Compatible with established principles of health care; or
(4) Flexible enough to allow deviations from norms when justified on a case-by-case basis.

When an application for certification is submitted to the Administration, the same four-prong test applies. Accordingly, an applicant must submit documentation of criteria and standards. The documentation is merely prima facia evidence of the manner in which utilization review is conducted. In order to determine the actual business practices of private review agents, market conduct examinations must be conducted.

Any person or entity who violates any provision of §15-10B may be subject to criminal and administrative penalties. The Commissioner may also deny, suspend, or revoke a certificate to do business as a private review agent; issue a cease and desist order; or require a private review agent to make restitution to a patient who has suffered economic damage as a result of a violation.

D. Private Review Agents Certification Procedure

- Application packets and correspondence are sent "Certified, Return Receipt Requested." The application packet includes a cover letter that specifies a due date, an application, a copy of the Title 15, Subtitles 10A, 10B and 10C, of the Insurance Article, COMAR 31.10.18--Denials of Coverage Based on Medical Necessity, COMAR 31.10.21--Private Review Agents, general instructions and procedures for filing a compliant application.

- Renewal applications are mailed approximately 60 days before the certificate.

- A "delinquent" letter is sent to applicants when an application is past due. The letter includes a request to have the application sent to the MIA within 5 calendar days. The applicant must respond to the "past due notice" in writing. The applicant must state the reason(s) why the application is late, and provide the date in which the MIA can reasonably expect receipt of the application.

- If an extension is necessary, the applicant must submit a letter that specifies the reason(s) for the extension, and the date in which the MIA can reasonably expect receipt of the application.

- The application for certification is reviewed by an analyst for compliance. Typically an application does not demonstrate compliance upon initial review. Comment letters are sent to applicants which outline any areas of deficiency in policies and procedures. An average of five (5) comment letters are generated for each application reviewed.

- Upon receipt of an application that contains supporting documentation which complies with Maryland law, a certificate is issued.

E. Summary Of Regulatory Action For Private Review Agents For Calendar Year 2000

The MD/PRA Unit reviewed one hundred and forty-nine (149) private review agent applications for certification during the 2000 calendar year. As of February 1, 2001, seventy-seven (77) private review agent applications were approved, and 77 certificates were issued. Of the applications filed, thirty (30) companies elected to withdraw their applications during the review process. The majority of the application withdrawals were due to the company's inability to meet determination timeframes and the requirements of the appeal and grievance laws. The remaining 42 applications are under review.

The quality of applications that were ultimately filed directly affected the length of application review and certification. These factors include the preparer's knowledge of Maryland's statutory and regulatory requirements, turnover rate of personnel responsible for filing the application, Maryland's requirements versus American Accreditation HealthCare Commission/URAC Standards, and terminology differences.

Enforcement Activity:

- MIA required modification of a Carrier's utilization review criteria for breast reduction surgery based on MIA and IRO review of a complaint.

- Chapter 465 of the Acts of the General Assembly of 2000 established the authority of the Commissioner to conduct market conduct examinations of private review agents. There are three (3) market conduct examinations in progress. The primary focus of the examinations is to assess compliance with §15-10A, §15-10B, and §15-10C of the Insurance Article.

- Provider community complaints precipitated a market conduct examination to examine compliance with the timeliness of pre-authorization requests under §15-10A-06. That audit is currently underway.

- **MIA v. Guardian Life Insurance Company of America**--The Administration found that the Carrier failed to file an internal grievance process, and failed to issue compliant adverse and grievance decision notices. The Administration also found that the Carrier failed to use certified private review agents to conduct utilization review on its behalf. The Carrier was fined an administrative penalty of $125,000. A hearing has been requested.

- The MIA's peer review contractor is examining internally developed utilization criteria and standards of a behavioral health private review agent to determine compliance with §15-10B-11.

- Adoption of the Uniform Treatment Plan Form Regulations

- Summary of Bulletins Issued

  Life and Health Bulletin 00-11-The Administration issued a bulletin to private review agents, health maintenance organizations, non-profit health service plans and health insurers regarding the disclosure of utilization review criteria and standards to health care providers.

  Life and Health Bulletin 00-19-The Administration issued a bulletin to private review agents, health maintenance organizations, non-profit health service plans and health insurers regarding the adoption of the uniform treatment plan form for behavioral health services.

VI. CONCLUSIONS

The MD/PRA Oversight Unit, Life & Health Complaint Unit, and Appeals & Grievance Unit work collectively to ensure regulatory compliance and protection of Maryland citizens. This is accomplished by:

- Weekly joint meetings of the members of units to discuss the activity of regulated entities including private review agents, Carriers and medical directors who make utilization review determinations.
- Monitoring the implementation of utilization management policies and procedures via consumer complaint management and market conduct examinations.
- Effective and efficient oversight of regulated entities and handling consumer complaints.
- Consistent review of utilization management policies and procedures and review criteria that medical directors approve.

Although only two years of data has been collected, it is evident that this law has had a positive effect on the ability of consumers to promptly obtain appropriate medically necessary services.