

MARYLAND INSURANCE ADMINISTRATION

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REPORT ON THE REGULATION OF MENTAL HEALTH BENEFITS

MARCH 2002

TABLE OF CONTENTS

I. Responsibility of Maryland Insurance Administration	3
II. Summary of Maryland Mental Health Parity Law	3-4
III. Resolution of Consumer Complaints	5-7
IV. Market Conduct Examinations	8
V. Next Steps	9
Appendices	
Appendix A	10-15
Mental Health/Substance Abuse Law Applicable to Insurers and Nonprofit Health Service Plans (other than small employer plans)	
Appendix B	16-25
Mental Health and Substance Abuse Orders Issued by The Complaints Section, Appeals & Grievance Unit 1999-2002	
Appendix C	26-29
Market Conduct Examinations	
Appendix D	30-31
Case Illustrations	

I. RESPONSIBILITY OF MARYLAND INSURANCE ADMINISTRATION

The Maryland Insurance Administration (MIA) regulates insurance companies, health maintenance organizations, and nonprofit health service plans. Since January 1, 1999, the MIA also has had authority to regulate private review agents and to resolve consumer complaints about health care services when denial for payment of the services is based on a determination that the services are not medically necessary. To carry out its regulatory responsibilities, the MIA reviews contracts and related materials to ensure compliance with Maryland law, investigates and resolves consumer complaints, and examines market practices to ensure compliance with Maryland law.

Under its regulatory authority, the MIA has taken steps to help ensure appropriate coverage for mental health and substance abuse for consumers whose health benefit plans are governed by Maryland law.

II. SUMMARY OF MARYLAND MENTAL HEALTH PARITY LAW

Mental health parity is codified in two different places in Maryland law: §15-802 of the Insurance Article applies to insurers and nonprofit health service plans; §19-703.1 of the Health-General Article applies to health maintenance organizations. Neither codified provision applies to small employer plans because those plans are subject to the parity provision established by regulation for the comprehensive standard health benefit plan. A copy of the law and regulations can be found in Appendix A.

Maryland's mental health mandate provides benefits as follows:

Large Group and Individual Market

§15-802 of the Insurance Article (applies to nonprofit health service plans and insurers)

§19-703.1 of the Health-General Article (applies to health maintenance organizations)

Benefits are required for services only if:

- the treatment is medically necessary *and*
- the illness or disorder is treatable.

Benefits may be delivered under a managed care system.

Inpatient benefits – for services provided in a licensed or certified facility, including a hospital, provided at same level (same deductible and coinsurance) as inpatient benefits for physical illness.

Partial hospitalization - minimum of 60 days, with benefits payable under the same terms and conditions as for physical illness.

Outpatient benefits – minimum benefits are:

- 80% of allowable charges for the first 5 visits
- 65% of allowable charges for visits 6 through 30
- 50% of allowable charges for visits 31 and beyond

Medication management visits are required to be covered the same as an office visit for a physical illness, and may not be counted as one of the visits under outpatient benefits.

Benefits may be subject to the general deductible under the policy, but there may not be a separate deductible for mental illness/substance abuse.

Small Employer Group Market

COMAR 31.11.06.03, .05, and .06

Benefits are required for services only if the treatment is medically necessary. The regulation excludes benefits if an illness or disorder is not treatable.

Inpatient benefits – for services provided through a carrier’s managed care system, up to a maximum of 60 days per covered person per year in a hospital or related institution, same level (same deductible and coinsurance) as inpatient benefits for physical illness.

Partial hospitalization – covered at same level as inpatient (two partial hospitalization days may be substituted for one inpatient day).

Maximum of 60 inpatient days per benefit year for inpatient and partial hospitalization combined.

Outpatient benefits – 70% of allowable charges for in-network providers
50% of allowable charges for out-of-network providers

Medication management visits are required to be covered the same as an office visit for a physical illness, and may not be counted as one of the visits under outpatient benefits.

Benefits may be subject to the general deductible under the policy, but there may not be a separate deductible for mental illness/substance abuse.

III. RESOLUTION OF CONSUMER COMPLAINTS

The Maryland Insurance Administration operates as a single point of entry for consumers with complaints about health care and health insurance issues. The Complaint and Investigation Section of the MIA handles written complaints and telephonic inquiries. Health complaints are assigned to one of two distinct units: the Life and Health Complaint Unit receives complaints about claims payment for health care services, contractual issues and other coverage disputes; the Appeals and Grievance Unit receives complaints when authorization for a health care service is withheld or payment is denied, based on a determination that the service is not medically necessary.

Maryland law requires a consumer to exhaust a carrier's internal grievance process before filing a complaint with the MIA unless, in the case of a coverage dispute, an urgent medical condition exists or, in the case of a medical necessity dispute, an emergency or compelling reason exists. After a complaint is filed with a written confidentiality release, an investigator determines if the MIA has jurisdiction over the complaint. Whenever jurisdiction rests with another agency, the investigator refers the complainant to the appropriate agency, *i.e.*, the Department of Health and Mental Hygiene or the Department of Labor.

After an investigation, if a determination is made to reverse a carrier's decision, the MIA may issue an order to require the carrier to do so. Many Orders impose an administrative penalty against the carrier, in addition to mandating approval or payment of a health care service.

In 1999, the Life and Health Complaint Unit issued one order concerning behavioral health services. This complaint arose from a denial of medically necessary services that occurred before the effective date of the Appeals and Grievance law. The carrier was ordered to provide payment for the services.

In 2000, the Life and Health Complaint Unit issued a total of six Orders arising from complaints from behavioral health providers. One order concerned violations of § 15-112 of the Insurance Article, governing provider panels, by a behavioral health managed care company. The Complaint Unit issued five Orders concerning violations of the prompt pay laws by carriers and behavioral health managed care companies acting on behalf of the carriers.

A summary of MIA medical necessity Orders that Appeals and Grievance Unit has issued and that result from mental health/substance abuse complaints can be found in Appendix B. Examples and illustrations of complaints received by the complaint and investigations section can be found in Appendix D.

Independent Review of Medical Necessity Disputes

When the complaint arises from a dispute about the medical necessity of the health care service, the investigator forwards all necessary information about the case to an Independent Review Organization ("IRO"). The IRO assigns review of the case to a health care provider, usually a physician, with expertise in treatment of the condition that is the subject of the complaint. After expert review, the IRO submits its recommendation whether the health care service is medically

necessary. The Commissioner may accept the recommendation of the IRO and use it as the basis for the final decision of the MIA. By law, the carrier that is the subject of the complaint is responsible for paying the cost of the review. The MIA contracts with several IROs, all of which retain professional reviewers with expertise in treatment of illnesses and conditions related to mental health and substance abuse.

COVERAGE COMPLAINTS

TABLE 1+
Reasons for Mental Health/Substance Abuse Complaints

	1998	1999	2000	2001	2002	Total
Delays	17	41	167	155	4	384
Denial of Claims	50	37	38	114	0	239
Unsatisfactory Settlement/Offer	3	2	9	64	1	79
(Outpatient) Services	0	31	9	6	2	48
Delays/No Response	1	5	19	4	12	41
(Inpatient) Services	0	26	6	1	0	33
Coverage Question	6	3	11	6	0	26
Information Requested	1	4	12	8	0	25
Denial Authorization/Adverse Decision	0	15	3	2	0	20
Policy Service	0	5	11	0	0	16
Utilization Review	7	2	3	3	0	15
Retroactive Denial	2	2	2	7	0	13
Other*	30	45	17	22	2	116
Total	87	173	290	370	19	1055

*Other includes primary care provider referrals, quality of care issues, denial of hospital days and reversal of pre-authorization for treatment.

TABLE 2+
Disposition for Mental Health/Substance Abuse Complaints

	1998	1999	2000	2001	2002	Total
Carrier Decision Reversed	65	84	84	98	2	333
Carrier Decision Upheld	12	22	28	27	0	89
No Jurisdiction	16	47	112	159	10	344
Other*	24	65	83	108	9	289
Total	117	218	307	392	21	1055

*Other includes insufficient information, failure to exhaust internal grievance process and complaint withdrawn.

+ For Tables 1 and 2 the statistics for 1998 cover the period from May 1, 1998-December 31, 1998. The system that tracks MIA complaint data was installed May 1, 1998.

**MEDICAL NECESSITY COMPLAINTS
MENTAL HEALTH/SUBSTANCE ABUSE**

**TABLE 3
Disposition for Complaints: Inpatient Services**

	1999	2000	2001	2002	Total
Carrier Decision Reversed	16	24	31	1	69
Carrier Decision Upheld	4	7	19	1	31
No Jurisdiction	18	26	24	2	70
Other*	37	25	36	5	103
Total	75	82	110	9	276

*Other includes insufficient information, failure to exhaust internal grievance process and complaint withdrawn.

**TABLE 4
Disposition for Complaints: Outpatient Services**

	1999	2000	2001	2002	Total
Carrier Decision Reversed	23	17	9	1	50
Carrier Decision Upheld	5	4	4	0	13
No Jurisdiction	8	21	13	1	43
Other*	27	36	18	2	83
Total	63	78	44	4	189

*Other includes insufficient information, failure to exhaust internal grievance process and complaint withdrawn.

IV. MARYLAND INSURANCE ADMINISTRATION MARKET CONDUCT EXAMINATIONS

The Life and Health Market Conduct Unit examines the market practices of life and health insurers, nonprofit health service plans, and health maintenance organizations who operate in Maryland. Beginning May 11, 2000, the Market Conduct Unit obtained statutory authority to examine the practices of private review agents. Examiners determine how a company behaves in the market place by reviewing sales practices, advertising materials, underwriting practices, and processing of claims. When an examination uncovers practices that violate Maryland law, the MIA may issue an order and assess a penalty.

To determine whether companies comply with Maryland law governing mental health benefits, market conduct exams have focused on market practices related to coverage for services for mental health and substance abuse, including:

- inclusion in provider directories of the names of psychologists, psychiatrists, and pediatric psychiatrists;
- filing of contracts for review and approval by the MIA;
- timely approval of treatment plans;
- prompt payment of claims for mental health/substance abuse services and payment of interest on those claims not processed within 30 days; and
- clinical validity of utilization review criteria.

Companies the Market Conduct Unit has examined for practices related to mental health/substance abuse benefits and claims include:

Aetna US Healthcare, Inc.;

American Psych Systems

Capital Care, Inc.;

CIGNA Behavioral Health;

CIGNA HealthCare of the Mid-Atlantic, Inc.;

Coventry Health Care of Delaware, Inc.;

Delmarva Health Plan, Inc.;

Freestate Health Plan, Inc.;

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.;

Magellan Behavioral Health, Inc.;

The Preferred Health Network, Inc.;

United Behavioral Health;

United Health Care of the Mid-Atlantic, Inc.

Summaries of the examinations and resulting Orders can be found in Appendix C of this report.

V. NEXT STEPS

The MIA is seeking budget approval to modernize its complaint tracking system and to incorporate complaint tracking into its agency-wide database. More efficient tracking will enhance the ability of the MIA: (1) to identify patterns of practice that give rise to consumer complaints; and 2) to conduct effective targeted market conduct examinations based on specific types of complaints, especially in the area of mental health and substance abuse in which managed behavioral health organizations and private review agents play a significant role in approving payment for services, conditioned on the manner in which services are rendered.

The Market Conduct Unit is in the process of examining utilization review determinations of inpatient services for mental health/substance abuse. Since utilization review involves determinations of medical necessity, the Unit is conducting the exam in partnership with Delmarva Foundation, a peer review organization under contract with the MIA.

APPENDIX A

Mental Health/Substance Abuse Law Applicable to Insurers and Nonprofit Health Service Plans (other than small employer plans)

§ 15-802.

- (a) (1) In this section the following words have the meanings indicated.
- (2) "Alcohol abuse" has the meaning stated in § 8-101 of the Health - General Article.
- (3) "Drug abuse" has the meaning stated in § 8-101 of the Health - General Article.
- (4) "Managed care system" means a system of cost containment methods that a carrier uses to review and preauthorize a treatment plan developed by a health care provider for a covered individual in order to control utilization, quality, and claims.
- (5) "Partial hospitalization" means the provision of medically directed intensive or intermediate short-term treatment:
- (i) to an insured, subscriber, or member;
 - (ii) in a licensed or certified facility or program;
 - (iii) for mental illness, emotional disorders, drug abuse, or alcohol abuse; and
 - (iv) for a period of less than 24 hours but more than 4 hours in a day.
- (b) This section applies to each health insurance policy or contract that is delivered or issued for delivery in the State to an employer or individual on a group or individual basis and that provides coverage on an expense-incurred basis.
- (c) A policy or contract subject to this section may not discriminate against an individual with a mental illness, emotional disorder, drug abuse disorder, or alcohol abuse disorder by failing to provide benefits for the diagnosis and treatment of these illnesses under the same terms and conditions that apply under the policy or contract for the diagnosis and treatment of physical illnesses.
- (d) It is not discriminatory under subsection (c) of this section if at least the following benefits are provided:
- (1) with respect to inpatient benefits for services provided in a licensed or certified facility, including hospital inpatient benefits, the total number of days for which benefits are payable and the terms and conditions that apply to those benefits are at least equal to those that apply to the benefits available under the policy or contract for physical illnesses;

(2) subject to subsection (g) of this section, with respect to benefits for partial hospitalization, at least 60 days of partial hospitalization are covered under the same terms and conditions that apply to the benefits available under the policy or contract for physical illnesses; and

(3) with respect to outpatient coverage, other than for inpatient or partial hospitalization services, benefits for covered expenses arising from services provided to treat mental illnesses, emotional disorders, drug abuse, or alcohol abuse are at a rate that, after the applicable deductible, is not less than:

(i) 80% for the first five visits in a calendar year or benefit period of not more than 12 months;

(ii) 65% for the 6th through 30th visit in a calendar year or benefit period of not more than 12 months; and

(iii) 50% for the 31st visit and any subsequent visit in a calendar year or benefit period of not more than 12 months.

(e) (1) The benefits under this section are required only for expenses arising from the treatment of mental illnesses, emotional disorders, drug abuse, or alcohol abuse if, in the professional judgment of health care providers:

(i) the mental illness, emotional disorder, drug abuse, or alcohol abuse is treatable; and

(ii) the treatment is medically necessary.

(2) The benefits required under this section:

(i) shall be provided as one set of benefits covering mental illnesses, emotional disorders, drug abuse, and alcohol abuse;

(ii) shall have the same terms and conditions as the benefits for physical illnesses covered under the policy or contract subject to this section, except as specifically provided in this section; and

(iii) may be delivered under a managed care system.

(3) Except for the coinsurance requirements under subsection (d)(3) of this section, a policy or contract subject to this section may not have:

(i) separate lifetime maximums for physical illnesses and illnesses covered under this section;

(ii) separate deductibles and coinsurance amounts for physical illnesses and illnesses covered under this section; or

(iii) separate out-of-pocket limits in a benefit period of not more than 12 months for physical illnesses and illnesses covered under this section.

- (4) Any copayments required under a policy or contract subject to this section for benefits for illnesses covered under this section shall be:
- (i) actuarially equivalent to any coinsurance requirements under this section; or
 - (ii) if there are no coinsurance requirements, not greater than any copayment required under the policy or contract for a benefit for a physical illness.
- (f) An office visit to a physician or other health care provider for medication management:
- (1) may not be counted against the number of visits required to be covered as a part of the benefits required under subsection (d)(3) of this section; and
 - (2) shall be reimbursed under the same terms and conditions as an office visit for a physical illness covered under the policy or contract subject to this section.
- (g) This section does not prohibit exceeding the minimum benefits required under subsection (d)(2) of this section for any partial hospitalization day that is medically necessary and would serve to prevent inpatient hospitalization.

Mental Health/Substance Abuse Law Applicable to HMOs (other than small employer plans)

§ 19-703.1.

- (a) (1) In this section the following terms have the meanings indicated.
- (2) "Alcohol abuse" has the meaning stated in § 8-101 of this article.
 - (3) "Drug abuse" has the meaning stated in § 8-101 of this article.
 - (4) "Managed care system" means a method that a carrier uses to review and preauthorize a treatment plan that a health care practitioner develops for a covered person using a variety of cost containment methods to control utilization, quality, and claims.
 - (5) "Partial hospitalization" means the provision of medically directed intensive or intermediate short-term treatment for mental illness, emotional disorders, drug abuse or alcohol abuse for a period of less than 24 hours but more than 4 hours in a day for a member or subscriber in a licensed or certified facility or program.
- (b) (1) Subject to the provisions of this section, each contract or certificate issued to a member or subscriber by a health maintenance organization that provides health benefits and services for diseases may not discriminate against any person with a mental illness, emotional disorder or a drug abuse or alcohol abuse disorder by failing to provide benefits for treatment and diagnosis of these illnesses under the same terms and conditions as provided for covered benefits offered under the contract or certificate for the treatment of physical illness.

(2) It shall not be considered to be discriminatory under paragraph (1) of this subsection if at least the following benefits are provided:

(i) With respect to inpatient benefits provided in a licensed or certified facility, which shall include hospital inpatient benefits, the total number of days for which benefits are payable shall be:

1. Except as provided in subsection (d) of this section, from July 1, 1994 through June 30, 1995, at least 60 days in any calendar year or benefit period of not more than 12 months under the same terms and conditions that apply to benefits available under the contract or certificate for physical illness; and

2. On or after July 1, 1995, at least equal to the same terms and conditions that apply to the benefits available under the contract or certificate for physical illness;

(ii) Subject to subsection (f) of this section, with respect to benefits for partial hospitalization, at least 60 days of partial hospitalization shall be covered under the same terms and conditions that apply to the benefit available under the contract or certificate for physical illness; and

(iii) With respect to outpatient coverage, other than for inpatient or partial hospitalization services, benefits for covered expenses arising from services which are rendered to treat mental illness, emotional disorders, drug abuse and alcohol abuse shall be at a rate which is, after the applicable deductible, not less than:

1. 80 percent for the first 5 visits in any calendar year or benefit period of not more than 12 months;

2. 65 percent for the 6th through 30th visit in any calendar year or benefit period of not more than 12 months; and

3. 50 percent for the 31st visit and any visit after the 31st visit in any calendar year or benefit period of not more than 12 months.

(c) (1) The benefits under this section shall be required only for expenses arising for treatment of mental illnesses, emotional disorders, drug abuse and alcohol abuse which in the professional judgment of practitioners is medically necessary and treatable.

(2) The benefits required under this section shall be provided as one set of benefits covering mental illnesses, emotional disorders, drug abuse and alcohol abuse.

(3) The benefits required under this section may be delivered under a managed care system.

(4) Except as specifically provided in this section, benefits for illnesses covered by this section and the benefits for physical illnesses covered under a contract or certificate shall have the same terms and conditions.

(5) Except for the coinsurance provisions in subsection (b)(2)(iii) of this section, a contract or certificate that is subject to this section may not have:

(i) Separate lifetime maximums for physical illnesses and illnesses covered under this section;

(ii) Separate deductibles and coinsurance amounts for physical illnesses and illnesses covered under this section; or

(iii) Separate out-of-pocket limits in a benefit period of not more than 12 months for physical illnesses and illnesses covered under this section.

(6) Any copayments required under a contract or certificate for benefits for illnesses covered under this section shall be:

(i) Actuarially equivalent to any coinsurance requirements under this section; or

(ii) Where there are no coinsurance requirements, not greater than a copayment required for a benefit under the contract or a certificate for a physical illness.

(d) Notwithstanding the provisions of subsection (b)(2)(i)1 of this section, until July 1, 1995, a contract or certificate that is subject to this section that offers less than 60 days coverage for inpatient care for health care for physical illness must only include coverage for mental illness, emotional disorders, drug abuse and alcohol abuse that is at least equal to the benefit offered for those other types of health care. On and after July 1, 1995, the provisions of subsection (b)(2)(i)2 of this section shall apply.

(e) An office visit to a physician or other health care provider for the purpose of medication management may not be counted against the number of visits required to be covered as a part of the benefits required under subsection (b)(2)(iii) of this section and shall be reimbursed under the same terms and conditions as an office visit for physical illnesses covered under the contract or certificate.

(f) Nothing in this section shall be construed to prohibit exceeding the minimum benefits required under subsection (b)(2)(ii) of this section for any partial hospitalization day that is medically necessary and would serve to prevent inpatient hospitalization.

Mental Health/Substance Abuse Regulations Applicable to Small Employer Plans

COMAR 31.11.06.03

A. The comprehensive standard health benefit plan includes the following:

(4) Inpatient mental health and substance abuse services provided through a carrier's managed care system up to a maximum of 60 days per covered person per year in a hospital or related institution;

(5) Outpatient mental health and substance abuse services provided through a carrier's managed care system;

COMAR 31.11.06.05

A. General Cost-Sharing Arrangement for Outpatient Mental Health and Substance Abuse Services.

(1) Except as provided in §B of this regulation, for outpatient mental health and substance abuse, the carrier shall pay for each service 70 percent of allowable charges.

(2) A carrier may substitute a copayment for these services at an actuarially equivalent amount to the coinsurance percentages described in this regulation subject to the approval of the Insurance Commissioner and the Maryland Health Care Commission.

(3) For purposes of the cost-sharing arrangement set forth in §A(1) of this regulation, a carrier shall treat a visit made solely for medication management purposes for mental health or substance abuse treatment as a covered service under Regulation .03A(1) of this chapter and may not count the visit as a mental health or substance abuse service described in Regulation .03A(5) of this chapter.

B. Out-of-Network Cost-Sharing Arrangements for Outpatient Mental Health and Substance Abuse Services.

(1) For outpatient services for mental health and substance abuse received out-of-network in a preferred provider delivery system or point-of-service delivery system, triple option delivery system, or PPO/MSA, the carrier shall pay for each service 50 percent of allowable charges.

(2) A carrier may substitute a copayment for these services at an actuarially equivalent amount to the coinsurance percentages described in this regulation subject to the approval of the Insurance Commissioner and the Maryland Health Care Commission.

(3) For purposes of the uniform cost-sharing arrangements set forth in §B(1) of this regulation, a carrier shall treat a visit made solely for medication management purposes for mental health or substance abuse treatment as a covered service under Regulation .03A(1) and may not count the visit as a mental health or substance abuse service described in Regulation .03A(5) of this chapter.

COMAR 31.11.06.06

A. A carrier shall apply the limitations and exclusions specified in §B of this regulation to the covered services specified in Regulation .03 of this chapter.

B. The following is an exclusion and limitation to the covered services:

...(51) Treatment for mental health or substance abuse not authorized by the carrier through its managed care system, or a mental health or substance abuse condition determined by the carrier through its managed care system to be untreatable.

APPENDIX B

Mental Health and Substance Abuse Orders Issued by the Complaint Unit, Appeals & Grievance 1999-2002

1999 ORDERS

MIA v. Blue Cross Blue Shield – Case No: 889-4/99

This case involved a 14-year-old that had a history of two suicide attempts. The Carrier denied the request for partial hospitalization for the child. The Administration concluded that due to the child's condition, in-patient treatment was medically necessary. The Carrier was ordered to pay for this treatment as long as it was medically necessary.

MIA v. Prudential – Case No: 982-6/99

This was a complicated mental health case where the physician's request for weekly group therapy and individual therapy sessions had been denied. The IRO determined that the individual therapy sessions were medically necessary but determined that group therapy was properly denied by the Carrier. Prudential's adverse decision did not meet the requirements of the law. The Carrier was ordered to pay a \$5,000 penalty and to provide the medically necessary services.

MIA v. Aetna – Case No: 1035-7/99

The Administration ordered coverage of 24-hour supervised services for treatment of an adolescent for substance abuse and significant dependence illness. The Carrier requested a hearing that was held. The hearing has not been concluded.

MIA v. Kaiser - Case No: 1036-7/99

The Administration determined that it was medically necessary for the child to receive inpatient treatment at a mid to long-term residential treatment facility. The Administration also determined that the Adverse Decision did not comply with the law and a \$1,500 administrative penalty was imposed.

MIA v. Prudential – Case No: 1174-10/99

The Administration ordered payment for medically necessary hospital services. The Carrier originally requested a hearing; however, on November 9, 1999 the Carrier withdrew its request.

MIA v. CareFirst - Case No: 1227-11/99

The Administration found that although inpatient hospitalization was not medically necessary, partial hospitalization was medically necessary and ordered the Carrier to pay for the partial hospitalization. The Carrier requested a hearing. A hearing was held on February 14, 2000. A hearing was conducted and a Final Order was issued upholding the MIA's original order.

2000 ORDERS

MIA v. CareFirst of Maryland - Case No: 179-3/00

The Administration found that the Carrier had improperly denied coverage for inpatient detoxification and rehabilitation. The Administration also found the Carrier in violation of §15-10A-02(b)(2) of the Insurance Article for failing to render a final decision on the grievance within 45 days. The Carrier was ordered to immediately authorize payment for inpatient detoxification and rehabilitation and to pay an administrative penalty of \$2,500 for violation of §15-10A-02 of the Insurance Article.

MIA v. Prudential Healthcare of the Mid-Atlantic, Inc. - Case No: 184-3/00

The Administration found that the Carrier had improperly denied coverage for inpatient hospital services. The Carrier was ordered to issue payment for the medically necessary inpatient hospital services.

MIA v. Capital Care, Inc. - Case No: 188-3/00

The Administration found that the Carrier failed to pay for an inpatient hospital stay. The Administration also found that the Carrier had failed to send an adverse decision and grievance decision in compliance with §15-10A-02 of the Insurance Article; violated §15-10A-02(f) of the Insurance Article by not sending the member information about the Health Advocacy Unit; and had failed to render a grievance decision within 45 days. The Carrier was ordered to pay an administrative penalty of \$2,500 for each violation of §§15-10A-02(b); 15-10A-02(f) and 15-10A-02(i) of the Insurance Article, for a total of \$7,500. The Carrier was also ordered to authorize payment for the inpatient hospital days.

Mia V. Group Hospitalization & Medical Services - Case No: 275-5/00

The Administration found the Carrier had failed to authorize inpatient rehabilitation. The Carrier also violated § 15-10A-02(i)(2)(i)(ii)(ii) and (iv) by not advising the member of her right to file a complaint with the Commissioner within 30 days after receipt of the Carrier's grievance decision and her right to file a complaint with the Commissioner without first filing a grievance with the Carrier if a compelling reason exists; failing to reference the specific criteria on which its decisions were based and state the name address and telephone number of the designated employee responsible for its grievance process; and failing to provide the member with the Commissioner's correct address and telephone number. The Carrier was ordered to immediately authorize payment for inpatient rehabilitation, pursuant to § 15-10A-04(c)(2) of the Insurance

Article. The Carrier was also ordered to pay an administrative penalty of \$2,500 for violation of § 15-10A-02(i)(2)(i)(ii)(iii) and (iv) of the Insurance Article and to immediately comply with said Section.

Mia V. Prudential Healthcare of the Mid-Atlantic - Case No: 327-6/00

The Administration determined that the Carrier failed to authorize medically necessary inpatient psychiatric treatment. The Carrier was ordered to immediately authorize payment for inpatient psychiatric treatment, pursuant to § 15-10A-04(c)(2) of the Insurance Article.

MIA v. United Healthcare of the Mid-Atlantic - Case No: 428-8/00

The Administration found that United Healthcare's failure to pay benefits for outpatient psychotherapy services deemed medically necessary, was a direct violation of §15-10A-04(c)(2) of the Insurance article. The Administration ordered the Carrier to immediately authorize payment for the services.

MIA v. United Healthcare of the Mid-Atlantic - Case No: 574-11/00

The Insurance Administration determined that the adverse decision letter issued by United Behavioral Health dated September 15, 1999 on behalf of United Healthcare, failed to comply with the requirements of §15-10A-02(i) of the Insurance Article. The Administration also determined that United Behavioral Health's Decision letter of May 12, 2000, which was issued on behalf of United Healthcare, failed to comply with the requirements of §15-10A-02(i) of the Insurance Article. In addition, the Administration determined that United Behavioral Health PRA grievance letter of December 30, 1999 that required the member to complete two (2) internal grievance processes, violated §15-10-03(a) of the Insurance Article. Based upon review of evidence, United Healthcare failed to pay benefits for medically necessary services from December 1998 through May 2000, violating §15-10A-02(i) of the Insurance Article.

The Administration ordered United Healthcare to immediately authorize payment for six additional psychotherapy sessions: July 7, 1999; July 28, 1999; August 2, 1999; November 13, 1999; November 17, 1999 and December 1, 1999. The Administration also ordered United Healthcare to immediately authorize payment for eight psychotherapy sessions for the year 2000. The Administration ordered United Healthcare to pay an administrative penalty of \$5,000 for issuing adverse decision and grievance letters which did not comply with §15-10A-03(a). In addition, the Administration has ordered United Healthcare to comply with the statutory requirements of §§15-10A-02 and 15-10A-03.

The Carrier requested a Hearing.

The Administration and United Healthcare entered into a Consent Order, **MIA v. United Healthcare of the Mid-Atlantic** - Case Nos: 573-11/00; 574-11/00; 590-12/00 and 10-1/01, whereby United Healthcare paid for all medically necessary services which were the subject of the individual Orders and agreed to comply with § 15-10A and pay a \$20,000 administrative penalty.

MIA v. CareFirst BlueCross BlueShield of the National Capital Area - Case No: 586-12/00

The Insurance Administration determined that CareFirst failed to pay for a medically necessary service in accordance with its contract and Maryland law, and therefore its actions constituted a violation of §15-10A-04(c) of the Insurance Article. The Administration ordered CareFirst to immediately authorize payment for the denied inpatient psychiatric days from August 7, 2000 to August 27, 2000 at The Renfrew Center, pursuant to §15-10A-04(c)(2).

MIA v. United Healthcare of the Mid-Atlantic - Case No: 590-12/00

The Insurance Administration determined that United Behavioral Health failed to provide a grievance decision within 24 hours of the March 2, 2000 expedited appeal request in violation of §15-10A-02(b)(2)(i). The Administration determined that United Behavioral Health's Adverse Decision letter of February 25, 2000, did not comply with the requirements of §15-10A-02(b)(2)(ii). The Administration also determined that United Behavioral Health's Adverse Decision notice dated February 25, 2000, Adverse Decision letter of March 9, 2000 and Grievance Decision letter of May 9, 2000, failed to comply with the requirements of §15-10A-02(i) of the Insurance Article. In addition, the Administration determined that United Behavioral Health's PRA adverse decision letter of February 25, 2000 which required the member complete two (2) internal grievance processes, violated §15-10A-03(a). United Healthcare failed to pay authorized benefits to the Caron Foundation within thirty (30) days of receipt of the claim and constituted a violation of §15-1005(c) of the Insurance Article. United Healthcare also failed to pay interest on two (2) claims and as a result constituted a violation of §15-1005 of the Insurance Article.

The Administration ordered United Healthcare to pay the Caron Foundation the interest due on two (2) claims, pursuant to the provisions of §15-1005(f) of the Insurance Article and COMAR 31.10.23. The Administration also ordered United Healthcare pursuant to §27-303 of the Insurance Article, that within thirty (30) days of the Order, to pay a total penalty of twelve-thousand, five hundred dollars (\$12,500); \$2,500 for failure to issue a grievance decision within 24 hours in violation of §15-10A-02(b)(2)(i); \$2,500 for violation of §15-10A-02(b)(ii), for stating that an appeal request must be received within 60 days of the date of discharge; \$2,500 for violation of §15-10A-02(i), in its February 25, 2000 Adverse Decision letter, March 9, 2000 Adverse Decision letter and May 9, 2000 Grievance Decision letter; \$2,500 for violation of §15-10A-03(a) and \$2,500 for failure to pay claims two (2) claims within 30 days of receipt in violation of §15-1005(c). In addition, United Healthcare was ordered to immediately comply with the provisions of §15-10A-02(b)(2); §15-10A-02(i); §15-10A-03(a) and § 15-1005 of the Insurance Article and COMAR 31.10.23.

The Carrier requested a hearing.

The Administration and United Healthcare entered into a Consent Order, **MIA v. United Healthcare of the Mid-Atlantic** - Case Nos: 573-11/00; 574-11/00; 590-12/00 and 10-1/01, whereby United Healthcare paid for all medically necessary services which were the subject of the individual Orders and agreed to comply with §15-10A and pay a \$20,000 administrative penalty.

MIA v. CareFirst BlueCross BlueShield - Case No: 625-12/00

The Insurance Administration determined that inpatient psychiatric treatment from March 18, 2000 to March 24, 2000 was medically necessary. The Administration ordered CareFirst to immediately authorize payment for additional inpatient psychiatric treatment beginning March 21, 2000 to March 24, 2000, pursuant to §15-10A-04(c)(2) of the Insurance Article.

The Carrier requested a hearing.

A hearing was conducted and a Final Order was issued upholding the MIA's original order.

2001 ORDERS

MIA v. PHN-HMO, Inc. - Case No: 11-1/01

The Administration determined that inpatient hospitalization from October 21, 2000 through November 9, 2000 was medically necessary. PHN's failure to pay benefits for the medically necessary service in accordance with its contract and Maryland law, constituted a violation of §15-10A-04(c) of the Insurance Article. The Administration ordered PHN to immediately authorize payment for the inpatient rehabilitation treatment from October 21, 2000 through November 9, 2000, pursuant to §15-10A-04(c) of the Insurance Article.

MIA v. CareFirst of Maryland, Inc. Case No: 18-1/01

The Administration determined that it was medically necessary for the patient to receive inpatient partial hospitalization rehabilitation. CareFirst was ordered to pay for treatment on August 18, 2000. The Administration also ordered an administrative penalty of \$2,500 be paid for violation of §15-10A-02(i)(2).

A consent order was entered into by the Carrier and the Administration. The Carrier had previously agreed to send compliant adverse decision letters. The Administration withdrew the penalty in the Consent Order.

MIA v. Capital Care, Inc. - Case No: 117-3/01

The Administration determined that it was medically necessary for the patient to be admitted to an inpatient rehabilitation treatment facility. Capital Care's failure to pay benefits for these medically necessary services in accordance with its contract and Maryland law, constituted a violation of §15-10A-04(c) of the Insurance Article.

MIA v. PHN-HMO - Case No: 120-3/01

The Administration determined that it was medically necessary for the patient to receive acute inpatient care for mental health services from February 9-14 and sub-acute inpatient treatment for mental health services from February 15 to March 5. The Carrier and the Administration entered into a consent order in which the carrier consented to pay for the medically necessary

services and an administrative penalty of \$2,500 for a violation of §15-10A-02(f) of the Insurance Article.

MIA v. Capital Care, Inc. - Case No: 148-3/01

The Administration determined that it was medically necessary for the patient to receive inpatient residential treatment at Rosehill Treatment Center. The Administration ordered Capital Care to immediately authorize payment for the dates of service from December 1, 2000 through February 26, 2001, and continuing as long as medically necessary under the terms of the health benefit plan. Capital Care also failed in its adverse decision and grievance letters to include that the member has a right to file a complaint with the Commissioner within 30 days after receipt of the carrier's grievance decision. The Administration ordered Capital Care to pay an administrative penalty of \$2,500 for violating § 15-10A-02(i)(1)(4) of the Insurance Article.

MIA v. PHN-HMO, Inc. - Case No: 184-4/01

The Administration determined that it was medically necessary for the patient to receive inpatient residential treatment at The Watershed from December 23, 2000 through December 27, 2000. PHN's failure to pay benefits for the medically necessary services in accordance with its contract and Maryland law, constituted a violation of §15-10A-04(c). The Administration ordered PHN to immediately authorize payment to The Watershed from December 23, 2000 through December 27, 2000, pursuant to §15-10A-04(c) of the Insurance Article. Also, PHN's failure in its December 27, 2000 adverse decision letter to include that the member has a right to file a complaint, violated §15-10A-02(f) of the Insurance Article. In addition, PHN's failure to include information concerning the Health Education and Advocacy Unit, as well as information concerning filing a complaint for a compelling reason, also violated §15-10A-02(f) of the Insurance Article. The Administration ordered PHN to pay an administrative penalty of \$2,500 for violation of §15-10A-02(f) of the Insurance Article.

MIA v. PHN-HMO, Inc. - Case No: 187-4/01

The Administration determined that it was medically necessary for the patient to receive inpatient residential treatment at The Watershed from October 13, 2000 through October 27, 2000. PHN's failure to pay benefits for these medically necessary services in accordance with its contract and Maryland law, constituted a violation of §15-10A-04(c) of the Insurance Article. The Administration ordered PHN to immediately authorize payment to The Watershed for dates of service from October 13, 2000 through October 27, 2000, pursuant to §15-10A-04(c) of the Insurance Article. Also, PHN's failure in its October 18, 2000 adverse decision letter to include that the member had a right to file a complaint with the Commissioner within 30 days after receipt of the carrier's grievance decision, violated §15-10A-02(f) of the Insurance Article. In addition, PHN failed to include information concerning the Health Education and Advocacy Unit, as well as information concerning filing a complaint for a compelling reason, which are also violations of §15-10A-02(f) of the Insurance Article. The Administration ordered PHN to pay an administrative penalty of \$2,500 for violation of §15-10A-02(f) of the Insurance Article.

MIA v. CareFirst of Maryland, Inc. - Case No: 218-4/01

The Administration determined that CareFirst violated §15-10A-04(c) by failing to authorize the medically necessary inpatient admission of March 20, 2001 through April 20, 2001. The Administration ordered CareFirst to immediately authorize payment for the inpatient hospitalization from March 20, 2001 through April 20, 2001 and immediately conduct a review of the patient's current medical status to determine if inpatient hospitalization continued to be medically necessary.

The carrier requested a hearing. Following the hearing, a Final Order was issued upholding the Administration's determination.

MIA v. CareFirst of Maryland, Inc. - Case No: 229-5/01

The Administration determined that partial hospitalization from March 7, 2001 through March 27, 2001, was medically necessary. The Administration ordered CareFirst to immediately authorize payment for partial hospitalization beginning March 7, 2001 with discharge on March 27, 2001, pursuant to §15-10A-04(c)(2) of the Insurance Article.

MIA v. PHN-HMO, Inc. - Case No: 272-5/01

The Administration determined that acute inpatient hospitalization from March 2, 2000 through March 9, 2000 was medically necessary. PHN's failure to pay benefits for the medically necessary services in accordance with its contract and Maryland law, constituted a violation of §15-10A-04(c) of the Insurance Article. The Administration ordered PHN to immediately authorize payment for inpatient acute care for March 2, 2000 through March 9, 2000, pursuant to §15-10A-04(c)(2) of the Insurance Article.

MIA v. Capital Care, Inc. - Case No: 362-7/01

The Administration determined that it was medically necessary for the off-label use of the prescription drug Provigil for the treatment of the patient's depression and chronic fatigue syndrome. Capital Care's failure to pay benefits for this medically necessary service in accordance with its contract and Maryland law, constituted a violation of §15-10A-04(c) of the Insurance Article. The Administration ordered Capital Care to immediately authorize payment for the off-label use of the prescription drug Provigil, pursuant to §15-10A-04 of the Insurance Article.

MIA v. CareFirst of Maryland, Inc. - Case No: 418-8/01

The Administration determined that it was medically necessary for the patient to receive partial hospitalization from November 8, 2000 through November 23, 2000 and intensive outpatient services from November 24, 2000 through February 2, 2001. CareFirst's failure to pay benefits for this medically necessary service in accordance with its contract and Maryland law, constituted a violation of §15-10A-04(c) of the Insurance Article. The Administration ordered CareFirst to immediately authorize payment for partial hospitalization from November 8, 2000

through November 23, 2000 and intensive outpatient care from November 24, 2000 through February 2, 2001, pursuant to §15-10A-04(c)(2) of the Insurance Article.

MIA v. Group Hospitalization and Medical Services, Inc. - Case No: 436-8/01

The Administration determined that it was medically necessary for the patient to receive inpatient residential treatment at The Caron Foundation from January 25, 2001 through February 23, 2001. The Administration ordered GHMSI to immediately authorize payment for inpatient residential treatment under the terms of the health benefit plan, pursuant to §15-10A-04(c) of the Insurance Article.

MIA v. Group Hospitalization Medical Services Inc. - Case No: 457-8/01

The Administration and GHMSI entered into a Consent Order regarding three separate time frames in which the carrier had denied the requested level of care for the same patient. The carrier consented to authorize payment at the inpatient detoxification level of care for November 23, 2000 through December 2, 2000, authorize payment at the partial hospitalization level of care for December 3, 2000 through December 8, 2000 and authorized payments at the intensive outpatient level of care from December 9, 2000 through December 10, 2000.

MIA v. CareFirst of Maryland, Inc. - Case No: 482-9/01

The Administration determined that inpatient hospitalization from February 6, 2001 to February 16, 2001 was medically necessary. The Administration ordered CareFirst to immediately authorize payment for inpatient hospitalization from February 6, 2001 to February 16, 2001, pursuant to §15-10A-04(c)(2) of the Insurance Article.

MIA v. Fidelity Insurance Company - Case No: 488-9/01

The Administration determined that Fidelity violated §27-303(1) of the Insurance Article by requiring that the patient obtain a second opinion, not required by the terms of the policy coverage, before considering a request for authorization of benefits. The Administration ordered Fidelity to pay the contractual amount for the patient's mental health benefits for the eight treatment sessions provided from February 9, 2001 through July 30, 2001.

MIA v. PHN-HMO, Inc. - Case No: 544-10/01

The Administration determined that PHN violated §15-10A-04(c) of the Insurance Article by failing to authorize partial hospital rehabilitation from January 13, 2001 through February 2, 2001. The Administration ordered PHN to immediately authorize coverage for the medically necessary partial hospital rehabilitation, pursuant to §15-10A-04(c) of the Insurance Article.

MIA v. PHN-HMO, Inc. - Case No: 598-11/01

The Administration determined that residential inpatient services from July 13, 2001 through July 18, 2001, were medically necessary. The Administration ordered PHN to immediately authorize payment for inpatient residential services for July 13, 2001 through July 18, 2001, pursuant to §15-10A-04(c)(2) of the Insurance Article.

MIA v. PHN-HMO - Case No: 624-11/01

The Administration determined that inpatient substance abuse services from September 7, 2001 through September 10, 2001, was medically necessary. PHN's failure to pay benefits for the medically necessary services in accordance with its contract and Maryland law, constituted a violation of §15-10A-04(c)(2) of the Insurance Article. The Administration ordered PHN to immediately authorize payment for inpatient rehabilitation services for September 7, 2001 through September 10, 2001, pursuant to § 15-10A-04(c)(2) of the Insurance Article.

MIA v. CareFirst of Maryland, Inc. - Case No: 644-11/01

The Administration determined that inpatient substance abuse services from May 3, 2001 through May 6, 2001, were medically necessary. CareFirst's failure to pay benefits for these medically necessary services in accordance with its contract and Maryland law, constituted a violation of §15-10A-04(c) of the Insurance Article. The Administration ordered CareFirst to immediately authorize payment for inpatient level of care from May 3, 2001 through May 6, 2001, pursuant to §15-10A-04(c)(2) of the Insurance Article.

2002 ORDERS

MIA v. Aetna US Healthcare, Inc. – Case No: 28-1/02

The Administration determined that it was medically necessary for the patient to receive inpatient treatment for the full 90-day program requested by her physician. Aetna's failure to pay benefits for these medically necessary services, in accordance with its contract and Maryland law, constituted a violation of §15-10A-04(c) of the Insurance Article. The Administration issued an emergency order directing the carrier to authorize payment for continued inpatient treatment until the end of the 90 day program and that, before discharge, the carrier review the patient's condition to determine if continued inpatient services continued to be medically necessary.

MIA v. PHN-HMO, Inc. - Case No: 34-1/02

The Administration determined that it was medically necessary for the patient to receive inpatient residential treatment at Marworth from August 14, 2001 through August 20, 2001. PHN's failure to pay benefits for these medically necessary services in accordance with its contract and Maryland law, constituted a violation of §15-10A-04(c) of the Insurance Article. The Administration ordered PHN to immediately authorize coverage for the medically necessary dates of service from August 14, 2001 through August 20, 2001, pursuant to §15-10A-04(c) of the Insurance Article.

MIA v. Freestate Health Plan - Case No: 44-1/02

The Administration determined that it was medically necessary for the patient to receive inpatient residential treatment at The Caron Foundation from September 2, 2001 through September 7, 2001, and intensive outpatient treatment from September 8, 2001 to September 30, 2001. Freestate's failure to pay benefits for these medically necessary services in accordance with its contract and Maryland law, constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered Freestate to immediately authorize coverage for the medically necessary inpatient residential treatment from September 2, 2001 through September 7, 2001 and intensive outpatient treatment from September 8, 2001 to September 30, 2001, pursuant to §15-10A-04(c) of the Insurance Article.

MIA v. Aetna U.S. Healthcare, Inc. - Case No: 53-1/02

The Administration determined that it was medically necessary for the patient to receive inpatient residential treatment at The Watershed from June 9, 2001 through June 21, 2001, and partial hospitalization treatment from June 22, 2001 through June 30, 2001. Aetna's failure to pay benefits for these medically necessary services, in accordance with its contract and Maryland law, constituted a violation of §15-10A-04(c) of the Insurance Article. The Administration ordered Aetna to immediately authorize payment to The Watershed for dates of service June 9, 2001 through June 30, 2001, pursuant to §15-10A-04(c) of the Insurance Article.

APPENDIX C

Market Conduct Examination

The following are summaries of Orders that resulted from market conduct examinations:

The Preferred Health Network of Maryland, Inc.

Case Number: 217-4/00

Penalty: \$75,000 (\$50,000 suspended)

A target market conduct examination of the claims handling practices of CMG Health, Inc. (“CMG”), an affiliate of Magellan Health Services, Inc. (“Magellan”), as it relates to members of The Preferred Health Network, Inc, was conducted for the period from December 1, 1999 to December 31, 1999. The examiners found various violations of the Insurance Article including the following:

- Failure to file provider contracts with the Administration 30 days before use;
- Failure to ensure timely payment of claims and appropriate interest by CMG (Magellan);
- Failure to perform proper oversight of CMG (Magellan); and
- Failure to identify behavioral health providers in provider panel directories.

The company entered into a consent agreement to take corrective action and pay an administrative penalty.

Prudential Health Care Plan, Inc.

Case Number: 221-4/00

Coventry Health Care of Delaware, Inc.

Case Number: 223-4/00

Capital Care, Inc.

Case Number: 220-4/00

Delmarva Health Plan, Inc.

Case Number: 219-4/00

Freestate Health Plan, Inc.

Case Number: 218-4/00

CIGNA HealthCare Mid-Atlantic, Inc.

Case Number: 222-4/00

A target market conduct examination found that the above carriers failed to identify behavioral health providers in provider panel lists or directories as required. Each carrier consented to take corrective action and each carrier’s administrative penalty of \$50,000 was stayed pending continuing compliance with their Consent Order.

United HealthCare of the Mid-Atlantic, Inc.

Case Number: 238-4/00

Penalty: \$400,000 (\$150,000 suspended)

A target market conduct examination of the claims handling practices of Johns Hopkins Bayview Physicians, as it relates to members of United HealthCare of the Mid-Atlantic, Inc. and a routine compliance audit found various violations of the Insurance Article including the following:

- Failure to establish a segregated fund and perform proper oversight of Johns Hopkins Bayview Physicians;
- Failure to ensure timely payment of claims and appropriate interest by Johns Hopkins Bayview Physicians; and
- Failure to identify behavioral health providers in provider panel directories.

United consented to take corrective action and pay an administrative penalty.

Aetna U.S. Healthcare, Inc., Aetna U.S. Healthcare, Inc. (DE) and Aetna Life Insurance Co.

Case Number: 240-4/00

Penalty: \$225,000 administrative penalty;

\$100,000 educational funding

A target market conduct examination of the claims-handling practices of Human Affairs International, an affiliate of Magellan Health Services, Inc., as it relates to members of Aetna U.S. Healthcare, Inc. (DE), was conducted for the period from November 1 to November 30, 1999. The examination found the following violations of the Insurance Article:

- Failure to establish a segregated fund and perform proper oversight of HAI (Magellan);
- Failure to file provider contracts with the Administration 30 days before use;
- Failure to ensure timely payment of claims and appropriate interest by HAI (Magellan); and
- Failure to identify behavioral health providers in provider panel directories.

A routine compliance audit of Aetna US Healthcare, Inc., Aetna U.S. Healthcare, Inc. (DE) and Aetna U.S. Life and Health Insurance Company found the following violations:

- Failure to identify behavioral health providers in provider panel directories;
- Failure to ensure proper payment of claims by Pioneer Eye Care;
- Failure to price and quote the Standard Comprehensive Health Benefit Plan separately from any additional benefits offered, sold or renewed to a group; and
- Failure to accurately and clearly identify the name of specific carrier in an advertisement.

The companies consented to take corrective action, pay an administrative penalty and fund efforts and/or projects designed to educate and assist Maryland health care consumers concerning their health care rights and responsibilities.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Case Number: 241-4/00

**Penalty: \$225,000 administrative penalty;
\$175,000 educational funding**

A target market conduct examination and compliance audit found various violations of the Insurance Article including the following:

- Failure to file rates and forms with the Administration prior to use;
- Failure to state the factual basis for adverse determination or reference specific criteria and standards;
- Failure to identify behavioral health providers in provider panel directories; and
- Failure to verify employee eligibility when enrolling new groups.

The company consented to take corrective action, pay an administrative penalty and fund efforts and/or projects designed to educate and assist Maryland health care consumers concerning their health care rights and responsibilities.

Magellan Behavior Health, Inc.; CMG Health, Inc.; Greenspring Health Services, Inc.; and, Merit Behavioral Health

Case Number: 242-4/00

Penalty: \$300,000 (\$150,000 suspended)

A target market conduct examinations and routine compliance audits performed on health maintenance organizations that have entered into Administrative Service Provider Contracts with Magellan Behavior Health, Inc, CMG Health, Inc, Greenspring Health Services, Inc. and Merit Behavioral Health. The examination reviewed claims processed during November and December of 1999. The examination found the following violations:

- Use of provider contracts that were not filed with the Administration and did not comply with Maryland law;
- Failure to identify behavioral health providers in provider panel directories;
- Failure to pay claims within 30 days of receipt and payment of appropriate interest;
- Failure to provide, upon request, a complete application and information that relates to consideration for participation on Magellan 's provider panel; and
- Failure to comply with licensing laws for private review agents.

The company consented to take corrective action and pay an administrative penalty.

Freestate Health Plan
Case Number: 572-11/00
Penalty: \$7,500

A target market conduct examination was conducted from March 13-April 7, 2000 of the claims handling procedure for enrollees of FreeState Health plan under an Administrative Service Provider Agreement between Free State and Green Spring Health Services, Inc., subsidiary of Magellan. The examination focused on the period between July 1, 1999 and December 21, 1999 and February 1, 2000 and February 29, 2000. The examination found the following violations:

- Failure to file its Provider Contract with the Commissioner;
- Failure to process claims within 30 days of receipt and pay applicable interest on paid claims which are not processed within 30 days;
- Failure to reference the segregated fund obligation in an administrative service provider contract;
- Failure to receive the appropriate quarterly reports; and
- Failure to monitor Magellan to ensure compliance with §15-1005 of the Insurance Article.

The company consented to take corrective action and pay an administrative penalty.

Magellan Behavioral Health
Case Number: 449-8/01
Penalty: \$150,000 administrative penalty;
\$100,000 Educational Funding

Magellan Behavioral Health agreed to a \$150,000 penalty stemming from violations of an earlier Consent Order signed April 26, 2000, which concerned a backlog of unpaid claims, among other violations of Maryland Insurance Laws. At that time, Magellan was fined \$300,000, with \$150,000 stayed pending future compliance with the terms of the Consent Order. A target market conduct examination found various violations of the Insurance Article and determined that Magellan failed to comply with the terms of the previous Consent Order. The MIA revoked the stay on the additional \$150,000 administrative penalty and Magellan agreed to pay \$100,000 in educational funding.

APPENDIX D

Case Illustrations

Examples and Illustrations of Complaints Received by the Complaint and Investigations Section.

The following complaints illustrate some of the issues that the Maryland Insurance Administration reviews regarding mental health and substance abuse. The facts described in these actual cases primarily focus on problems related to inpatient treatment.

Case 1

The mother of an 8-year-old girl who was receiving inpatient psychiatric treatment contacted the Administration. She had been admitted to the inpatient facility on November 18. Her carrier was seeking to deny care as of December 11. The complainant had appealed her case to her carrier and received an expedited review. After receiving another denial, she contacted the Administration.

The case was assigned to an investigator who spoke with both the child's regular physician and her psychiatrist. Based on information received from the providers, it was determined that this was an emergency case. The carrier was contacted. The carrier responded and upheld its denial of further inpatient treatment.

The medical records and other relevant information were collected and sent to an IRO for review. Medical records indicated that the child had contracted encephalitis at the age of three. Since that time, she had lost the ability to communicate verbally and was functioning at the level of a 9-month-old child. She exhibited self-injurious behavior in the form of head banging in excess of 300 times a day and was physically aggressive toward her family and staff at the facility. She would kick and bite and would run out into traffic or attempt to exit a moving car. The IRO determined that further inpatient care was appropriate. It found that while the criteria applied were clinically valid, it had been applied incorrectly. A conference call was held with the Administration, the carrier and the complainant to advise of the IRO's findings. The Administration issued an emergency order directing the carrier to authorize payment for continued inpatient treatment until the end of the 90-day program and, before discharge, to review the patient's condition to determine if inpatient services continued to be medically necessary.

Case 2

The complainant had been scheduled to enter an inpatient facility to treat substance abuse in Arizona. Prior to admission, the carrier denied a request for services. The complainant requested and received an expedited review. The carrier upheld the denial. The complainant received treatment from May 3 to June 4. A retrospective appeal was filed with the Administration on the complainant's behalf by the facility.

The carrier was contacted by the Administration and indicated that the denial was based on the absence of an imminent harm to self or others on the part of the complainant. The medical records and other relevant information were sent to an IRO for review. The IRO's review

resulted in a modified decision. Inpatient treatment was found to be appropriate for May 3 to May 6 and intensive outpatient treatment was found to have been the appropriate level of care for May 7 to June 4. The Administration ordered the carrier to pay for inpatient treatment from May 3 to May 6.

Case 3

The complainant filed a complaint for a retrospective denial of inpatient services for substance abuse at a Pennsylvania facility from September 2 to September 30. The Administration contacted the carrier and was informed that the denial was made because the carrier had not been provided sufficient clinical information to determine medical necessity existed for this level of care. The investigator wrote to ascertain what information was missing as the facility indicated all records had been forwarded to the carrier. The carrier asserted that it did not receive sufficient information.

The Administration forwarded the records provided by the carrier to the IRO for review. The IRO found that there was sufficient information to find the complainant's admission for inpatient treatment of substance abuse was medically necessary. The IRO found that while the carrier's criteria were clinically valid, they were incorrectly and inflexibly applied. The Administration issued an order modifying the carrier's decision to cover inpatient treatment from September 2 to September 9 and outpatient treatment from September 9 to September 30.

Case 4

Inpatient treatment for substance abuse was sought for a teenager. The carrier denied that the level of care was appropriate, concluding that the records indicated that an outpatient level of care was sufficient. Inpatient services were received from February 2 to February 16. The complainant filed with the Administration after receiving a second denial from the carrier.

The medical records and other relevant information were forwarded to an IRO for review. The IRO found that the complainant exhibited self-injurious behavior, specifically self-cutting. The IRO found that the criteria, while clinically valid, was incorrectly applied. The IRO indicated that the records showed that the complainant's symptoms had worsened and that outpatient treatment had been unsuccessfully attempted in the past. The IRO determined that all inpatient days were medically necessary.

The Administration ordered the carrier to pay for all inpatient days received.