MEDICAL NECESSITY & EMERGENCY APPEALS

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Agenda

- The Maryland Insurance Administration (MIA)
- Types of Complaints the MIA's Life & Health Unit and Appeals & Grievance Unit Can Review
- When Should a Complaint be Referred to the MIA
- What the Consumer Needs to Do to Receive Assistance From the MIA
- What a Consumer Should Expect as a Part of the Complaint Process

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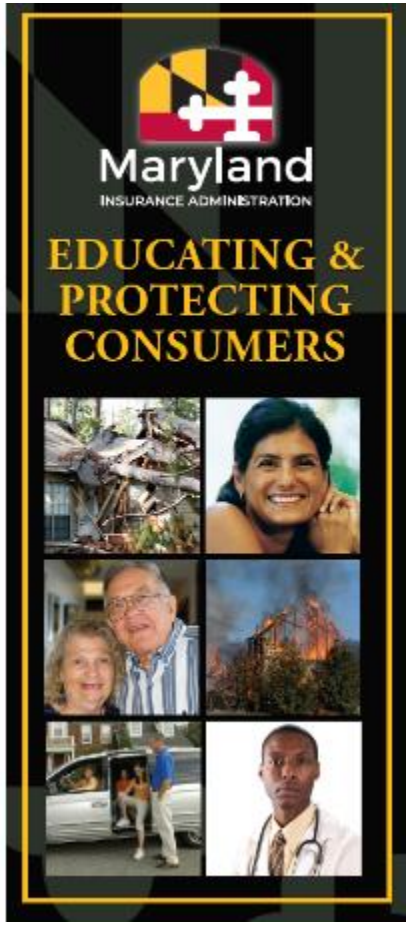
What is the Maryland Insurance Administration

The Maryland Insurance Administration (MIA) is the state agency that regulates insurance in Maryland. The MIA:

- Licenses insurers and insurance producers (agents or brokers).
- Examines the business practices of licensees to ensure compliance.
- Monitors solvency of insurers.
- Reviews/approves insurance policy forms.
- Reviews insurance rates to ensure rates are not inadequate, excessive or unfairly discriminatory.
- Investigates consumer and provider complaints and allegations of fraud.



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MIA YouTube playlist

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Background/History

- The Appeals and Grievance process begins when a carrier renders an "adverse decision," which includes a determination that a proposed or delivered healthcare service is not medically necessary, appropriate or efficient. The member, the member's representative, or the treating provider on behalf of the member has the right to protest this decision through the carrier's internal review process.

- When a protest is filed with the carrier regarding an adverse decision, this is a "grievance.“ If the carrier again determines the proposed or delivered healthcare service is not medically necessary, the member, the member's representative, or the treating provider on behalf of the member may ask the Maryland Insurance Administration to review the carrier's grievance decision by filing a "complaint."

How the Law Works

- The Appeals and Grievance Law gives the Administration the authority to contract with three Independent Review Organizations ("IROs") to review these medical necessity complaints. When the Administration sends a complaint to an IRO for review, and the IRO assigns an expert reviewer for the complaint, Maryland law requires that the reviewer be an unbiased provider in the same specialty as the area or areas appropriate to the subject of review.

- The Administration's final decision on the complaint may be based on the opinion of the IRO. If the complainant remains dissatisfied with the Administration's decision, he or she may make a written request for a hearing to challenge the Administration's decision. Carrier's do not have the right to an administrative hearing, but may file a petition for judicial review with the Circuit Court.

Types of Complaints the MIA's Life & Health Unit and Appeals & Grievance Unit Can Review

Generally, the MIA can review complaints involving health benefit plans delivered or issued in Maryland, including:

- claim denials based on medical necessity;
- denials of all or part of a claim for other reasons;
- appeals of a carrier's denial; or
- other possible violations of Maryland's insurance laws.

Denials may include:

- A claim denial. This is where your carrier or HMO has denied payment for a service or medication that was provided.
- An authorization denial. This is when a medication or treatment requires a referral or prior authorization from your provider, but this authorization has been denied by your insurance carrier or HMO.

You are entitled to a written denial unless you or your provider agrees to an alternative care plan.

Appeals

If your health care provider tells you that a certain service or medication is needed (medically necessary), but your health insurance carrier or HMO denies your claim, that is a denial based on medical necessity and you have the right to appeal that decision. Generally, you must file a grievance with the carrier first before you can file a complaint with the MIA. In some cases, though, including, for example, when you have a compelling reason, you can file a complaint with the MIA first.

In addition, you can appeal if:

- you were approved for a lower level of care than you asked for; or
- you believe the in-network or approved provider is too far away or the wait is too long; or
- you received an approval for fewer visits than your provider thinks you need.

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Types of Complaints the MIA's Life & Health Unit and Appeals & Grievance Unit Can’t Review

The MIA cannot address complaints or inquiries involving insurance contracts which are not regulated by the State of Maryland. Generally, this includes the following:

- Self-funded or self-insured employer plans
- Medical Assistance (Medicaid), except for delayed payments
- Medicare and Medicare HMOs
- Federal Employee Health Benefit Programs
- Uniformed Services Family Health Plans
- Contracts issued and delivered to the policyholder in another state.

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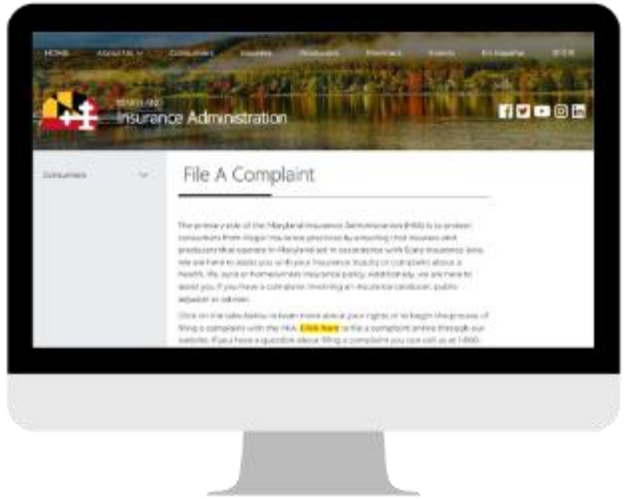
What the Consumer Needs to do to Receive Assistance from the MIA

- Complaints can be filed online, mailed in, or faxed.
- Forms to file a complaint are available on our website.
  - www.insurance.maryland.gov/Consumer/Pages/FileAComplaint.aspx
- Mail or fax your complaint to:

  Maryland Insurance Administration
  Attn: Consumer Complaint Investigation
  Life and Health/Appeals and Grievance
  200 St. Paul Place, Suite 2700
  Baltimore, MD 21202
  Fax: 410-468-2260 (Life and Health) or 410-468-2270 (Appeals and Grievance)



- Online Complaint Portal
  - https://enterprise.insurance.maryland.gov/consumer/ConsumerPortalWelcomePage.aspx
- If you have a disability and need to file a complaint by phone, you can call the MIA at 410-468-2244.
- The patient's signed consent is required for an Appeals & Grievance complaint.

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What a Consumer Should Expect as Part of the MIA's Complaint Process

- You should receive an acknowledgment of the complaint within a few days. The acknowledgment will include the contact information for the MIA's investigator.
- You can call the investigator any time you have questions.
- It usually takes approximately 3 months to investigate a complaint.
- Appeals and Grievances complaint investigations are concluded within 45 days, unless an extension of an additional 30 days is granted.

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What the Numbers Show

- In 2021, the Maryland Insurance Administration's Appeals and Grievance Unit either reversed or modified the carrier's grievance decision 70.5 percent of the time. Meaning, that if a consumer filed a medical necessity complaint with the Administration's Appeals and Grievance Unit and the unit possessed jurisdiction over the complaint, there was a better than 70 percent chance that the denial would be reversed in the complainant's favor.

- Since the enactment of the Appeals and Grievance law, the Maryland Insurance Administration's Appeals and Grievance Unit has recovered over $12 million dollars for complainants.

How the MIA is Improving Consumer Outreach

- Creation of a 24/7 Hotline marketing campaign
- Robust social media campaign promoting the 24/7 Hotline
- Consumer newsletter
- Various marketing materials, including:
  - First Aid Kits
  - Magnets
  - Flyers
- Podcast/Video production to promote 24/7 Hotline (YouTube Channel, Social Media, Website)
- Consumer education at outreach events, i.e. community events, fairs, libraries, motor vehicle administration, farmers markets

Example Questions

The following are some examples of the types of questions that the Appeals & Grievance Unit receives:

Question: Jessica and Michael are worried about their daughter Abigail, who is 15 years old. They aren't sure what the problem is, but it seems to be beyond teenage general moodiness. Abigail's grades are falling, she's gotten into a physical fight with her younger brother, and her parents think she may be drinking. Her school social worker suggested an evaluation by a psychiatrist. Abigail's parents can't afford to go out of network to get this treatment. How should they start the process to have Abigail evaluated and make sure that it will be covered?

Answer: A good place to start is with Abigail's primary care provider for recommendations of behavioral health care providers. Typically, a referral is not needed anymore, but it can't hurt to start there. Jessica and Michael can also start looking for psychiatrists through the carrier's online directory. They should check that they are searching using the right plan shown on their insurance card, because different plans may have different networks and there will probably be multiple options on the carrier's website.

Example Questions

Question: They tried the online directory, but they found that there were mistakes and it was very frustrating. What should they do at that point?

Answer: There are laws requiring carriers to keep their directories up to date, and so if there is incorrect information in the provider directory, it is helpful if you report the errors to the health plan. Maryland law requires health plans to list a way to report the incorrect information that is on their website and requires carriers to investigate and update the information. If they don't, then you can file a complaint with the MIA. Of course, in the short term, Jessica or Michael can also call the health plan for help and use the number on the back of their ID cards. There may be a separate number for behavioral health services, and some plans will provide additional help with finding a behavioral health provider if you ask.

Example Questions

Question: Jessica and Michael were able to get Abigail evaluated by a psychiatrist and she was able to start making progress with an in-network therapist. However, before her therapy sessions were over, the therapist indicated that they were no longer accepting the parents' insurance, and Jessica and Michael have been unable to find another in-network therapist with the same level of expertise to treat Abigail. What should they do at that point?

Answer: They can request a referral to keep seeing the same therapist. Maryland law requires health plans to have a process to request a referral to an outof-network provider if you need one and they don't have an in-network provider with the expertise. To find those procedures, you can look in your policy or your certificate of coverage, or you can look in the health plan's online provider directory, because health plans are required to put that information with their provider directory. The health plan is also required to provide the procedures upon request, so you can call and request them. If a referral is given, the cost sharing will be the same as for an in-network provider. However, the provider may balance bill. Balance billing means the provider can bill for the difference between the health plan's allowed amount and the provider's usual charges. The health plan may enter into a single case agreement with the provider to prevent the balance billing. However, the agreement may be limited to certain services, and claims may have to be sent to a different address than the normal P.O. box than the carrier normally uses.

Example Questions

Question: What if the request was denied because the health plan says that there are providers in-network, but Jessica and Michael don't think that the particular in-network providers have the necessary level of expertise or that it's unreasonable for them to wait because there's going to be a delay before they actually get to an appointment. They really don't want to disrupt Abigail's treatment since she's been doing well and they don't want to see any deterioration in the progress that she's been making. What would you recommend to the parents at this juncture?

Answer: Jessica and Michael have a right to challenge or appeal the health plan's decision that its in-network providers are adequate. The health plan's decision to not allow Abigail to receive treatment from an out-of-network provider is considered an adverse decision, a determination that a proposed or delivered health care service is not medically necessary, appropriate or efficient. Jessica and Michael have the right to protest this decision through the health plan's internal review process. When the health plan renders an adverse decision, they are required to provide the member with a detailed explanation in writing in the form of a letter, notice of adverse decision, or an explanation of benefits, EOB. Either document will instruct them on how to initiate the health plan's internal review process. If the health plan again determines that it's in-network provider is adequate, Jessica and Michael may ask the Maryland Insurance Administration to review the health plan's grievance decision, the health plan's decision to uphold its adverse decision, by filing a complaint. The MIA has the authority to contract with independent review organizations to review medical necessity complaints. Based on the IRO's medical opinion, the MIA reaches a decision either to uphold, modify or reverse the health plan's decision.

Example Questions

Question: The situation has gotten worse. Abigail has threatened to kill her brother and herself and it's clear that she needs emergency treatment. What can be done to make sure that she's able to obtain the treatment that she needs at this point?

Answer: In the case of mental health, emotional health disorder or substance use disorder emergencies, if a patient is in imminent danger to self or others and the determination is made by the patient's physician or psychologist and a member of the medical staff of the facility who has admitting privileges, then an insurance company cannot deny the first 24 hours of the admission based on medical necessity. It's important that Abigail or her parents notify the insurance company as soon as possible. For an emergency inpatient admission for treatment of mental illness, emotional health disorder or substance use disorder, the insurance company must make a decision on whether to preauthorize the treatment within two hours of receiving the requested documents. If the insurance company denies the request for an admission, call the Maryland Insurance Administration at 1-800-492-6116. The MIA is available 24 hours a day for complaints and emergencies when care has not yet been rendered. In an emergency, the MIA will make a decision within 24 hours. If the MIA does not regulate your health plan, your complaint will be sent to the agency that does regulate the plan.

Example Questions

Question: The parents have found and it's been recommended that Abigail go to this mental health facility that's located in Arizona that has a history of success dealing with these particular issues. What should the parents do if they would like to send her to that particular facility?

Answer: It's important to note inpatient care usually requires prior authorization. To start the process of obtaining preauthorization for an out-of-network provider, call the number on the back of the patient's health insurance ID card first. The insurance company will ask what health care services you would like to receive, and when appropriate, what facility you would like to use. The insurance company will tell you what documents it needs in order to decide if it will preauthorize the health care service. Maryland requires that insurance companies accept a provider's uniform treatment plan form if the health plan is subject to Maryland law. A uniform treatment plan form is a document used by the provider to record the information needed by the insurance company to decide whether it will preauthorize the requested service and/or facility. If the services are authorized under out-of-network benefits, there may be higher cost sharing and balance billing. Jessica and Michael can appeal the amount paid if it seems unreasonably low, and can file a complaint with the MIA if the carrier upholds its appeal. Lastly, the MIA can review whether the payment is based on their policy or certificate of coverage or violates Maryland law.

Example Questions

Question: Abigail has been authorized to receive treatment and she goes to the facility and her treating psychologist, Dr. Gomez, says that she needs two visits every week for the next 12 weeks and the plan says she can have two for only four weeks. Is there anything that the family can do at this point?

Answer: First, if Dr. Gomez agreed to accept the authorization for four weeks, it may not be a denial. However, if Dr. Gomez did not agree, then we're talking about an adverse decision. Dr. Gomez can file a grievance on behalf of Abigail and her parents. Many providers get a written consent form as part of the paperwork for a new patient. Providers often try to call for a peer-to-peer discussion and become frustrated at the time it takes. Dr. Gomez can mail, email or fax a written grievance, and the health plan will have to respond in writing. This may save time in the long run, and will satisfy the legal requirements to exhaust the internal appeals process. If the health plan still says that two visits a week for twelve weeks is not medically necessary, then Dr. Gomez or Abigail's parents may file a complaint with the MIA. The MIA can send the complaint to an independent review organization to get an opinion on whether the care is medically necessary.

Questions?

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