Carrier Reporting Instructions Guide
Maryland Insurance Article §15-10A-06

WHO NEEDS TO FILE?

Maryland law requires insurance carriers licensed to sell health insurance in this state to provide an accounting of the adverse decisions issued by their company and the disposition of any ensuing grievance filed by or on behalf of the member appealing that decision. This accounting must be submitted quarterly to the Maryland Insurance Administration on the form entitled Reporting Form for Maryland Insurance Article §15-10A-06.

A carrier that does not issue any policies that are subject to §15-10A-06 may request an exemption. Carriers who issue policies providing a "health benefit plan" as defined in §2-112.2(a) of the Insurance Article are required to comply with §15-10A-06. Generally, the types of policies that are exempt from filing are those that do not provide medical or dental benefits, or, if those benefits are provided, medical or dental necessity is not a requirement of coverage. A carrier that does not have policies in force in Maryland meeting the definition of health benefit plan may write to David Cooney, Maryland Insurance Administration, 200 St. Paul Place Suite 2700, Baltimore, MD 21202, to request an exemption.

WHEN TO FILE:

Reports are to be submitted on a quarterly basis within 15 days of the end of the following reporting periods:

1Q - First Quarter (1/1 – 3/31)
2Q - Second Quarter (4/1 – 6/30)
3Q - Third Quarter (7/1 – 9/30)
4Q - Fourth Quarter (10/1 – 12/31)

FAILURE TO TIMELY FILE YOUR REPORT may RESULT IN ADMINISTRATIVE PENALTIES. If you have any questions you are welcome to contact Mr. Louis Butler on 410-468-2271.

HOW TO FILE:

All companies have the option of filing their required report electronically. You may also report by downloading the form and mailing or faxing us a copy of your report. Mail responses should be forwarded to Louis Butler, Maryland Insurance Administration, 525 St. Paul Place, Baltimore, MD 21202. Faxed responses should be sent to Louis Butler at 410-468-2270. If you have questions regarding filing, please contact Louis Butler at (410) 468-2271 or louis.butler@maryland.gov.

HOW TO FILE ON-LINE:

All carriers that have filed reports in the past are mailed a User ID and password. If you have not received this information, please contact Louis Butler at 410-468-2271 or louis.butler@maryland.gov. Each User ID and password are unique. You may not use the User ID and password of one Company to file on behalf of another company. You should print the report for your records as well as the confirmation sheet.

HELPFUL HINTS

- **If your company has no (zero/none) grievances to report, you must still file a report unless you have received an exemption.**
- **A *request* for an exemption does not exempt your company from the filing requirements. Each carrier must obtain an individual exemption from the Administration.**
- **A request for an exemption that is still under consideration by MIA does not relieve the carrier from compliance with the reporting requirements.**
- **You will need to enter your User ID and password from the notice that was mailed to you. If you did not receive your User ID and password, please contact Louis Butler at (410) 468-2271 or louis.butler@maryland.gov.**
- **You should gather all information you need before beginning to complete this report on-line.**
- **If you fail to complete any portion of the required information for the report, i.e. contact name and address, you will not be able to submit your report on-line, and you will get an error message when you click on the "Continue" button. Use the "Back" button at the bottom of the online application page to go back to previous screens and review information; do not use the "Back" button on your Internet Explorer or Netscape browser toolbar.**
- **Before submitting your report, be sure you review all the screens to ensure that the information is correct. Use the "Back" button at the bottom of the on-line application page to review previous screens; do not use the "Back" button on your Internet Explorer or Netscape browser toolbar.**
- **If you log out of this report before submitting it, the information will not be saved and you will need to start from the beginning.**
- **Please check your calculations carefully. The system will send an error message if the total columns do not match the numbers reported for the main categories. (i.e. the number of adverse decisions reported in response to question 1 and 2 must match.) You will not be able to submit your report unless the numbers match.**
- **Please be sure to print the confirmation screen for your records. This screen will be your proof of renewal. You should also provide a copy of your report and maintain a copy for your records.**
- **If you do not receive a confirmation number, you have not submitted your report. When you first click the submit button, a gray box appears. You need to also click on the submit button in the gray box to submit your report. If you omit this step, your report will not have been submitted.**
- **Please note each company is associated with a unique USER ID/password combination. The system will not allow you to renew more than one company using the same User ID/password combination.**
- **DO NOT REPORT "PENDING" CASES – You must have a disposition to report. If the case is still pending, there is no disposition.**
- **DO NOT ADD CATEGORIES - Use ONLY those categories listed in Question #2. Do the best you can to "fit" the case into one of the 10 categories.**
- **DO NOT REPORT §15-10D COVERAGE DECISIONS**
- **DO NOT REPORT "COMPLAINTS" FILED BY MEMBERS – The data reported should only be those cases in which your company issued a medical necessity denial. If a member complains that it took 2 weeks to get an appointment with a participating provider, that case should not be counted.**
- **DO NOT OVERLOOK YOUR FILING DEADLINE – If you find that you may not be able to meet the filing deadline, *request an extension immediately.* Administrative penalties can be substantial depending on your filing history.**

- **WHEN IN DOUBT - - CALL!!!**
  We're only a phone call or an e-mail address away. Most of the calls from carriers have resulted in companies reporting *fewer* cases. Don't be afraid to ask for additional information or clarification. Contact::

Louis Butler
1-800-492-6116 ext. 2271
1-410-468-2271 (Balto Metro)
Fax: 1-410-468-2270
louis.butler@maryland.gov

DEFINITIONS/EXPLANATIONS:

I. *Adverse Decision* – **If a member requests that coverage be provided for a service/procedure that is a covered service in the members contract,** and the carrier denies that request solely based on medical necessity**, this is an adverse decision.**

ADVERSE DECISION

NOT Adverse Decision

EXAMPLES #1: Member has just completed 16 physical therapy (PT) sessions for lower back pain. Member's contract has no limitation on PT visits. Member's physician files a treatment plan for an additional 16 PT visits. PT progress notes indicate member has reached maximum improvement. A medical review of the request is conducted and the carrier denies additional PT visits **as not medically necessary**. This denial may be appealed as it was denied based on medical necessity.

- - -*This case* *will* *be reported in the carrier's quarterly report.*

EXAMPLE #2: Member has just completed 16 physical therapy (PT) sessions for lower back pain. Member's contract has a limitation of 16 annual PT visits. Member's physician files a treatment plan for an additional 16 PT visits. Carrier denies additional PT visits based on the **limitations of 16 PT visits**.

- - -*This case* *will not* *be reported in the carrier's quarterly report.*

II. *Administrative Reversals* ***– The member contacts the carrier to appeal the denial. Certain incorrect information was considered and the carrier reverses its decision due to an administrative error or other reason not requiring a utilization review. This disposition is reported in Question*** *#2A:*

(1) in the column labeled *"Total Administrative Reversals"***; and**
(2) in the column named *"Administrative Reversals***".**

III. *Grievance Filed* - **After the carrier issues the denial and the member chooses to file an appeal and grieve the decision,** this appeal is considered a grievance. This grievance and the final disposition MUST be reported by the carrier.

Using EXAMPLE #1 as a guide, the carrier's actions could be one of the following four options for reporting the disposition of the grievance:

(1) *Administrative Reversal***– The member contacts the carrier to appeal the denial. Certain incorrect information was considered and the carrier reverses its decision due to an administrative error or other reason not requiring a utilization review. This disposition is reported** ONLY **in Question** #3A:
(3) in the column labeled *"Total"***; and**
(4) in the column named *"Administrative Reversal***".**

(2) *Upheld* **– The member filed an appeal and the carrier conducted another medical review of the denial. The determination by the carrier is to uphold its original denial of the service as it is not medically necessary. This disposition is reported in:**

(1) Question #3A **in the** *"Total"* **column (as an adverse decision);**

(2) Question #3B **as it was a** *"Grievance Filed"*:

(a) in the column entitled *"Total"* **and**

(b) in the column named "*Upheld***".**

(3) *Overturned* **– The member filed an appeal and the carrier conducted another medical review of the denial. The carrier recognized that the service is medically necessary and overturns its original denial and provides the service. This disposition is reported in:**

(1) Question #3A **in the** *"Total"* **column (as an adverse decision);**

(2) **Question** #3B **as it was a** "*Grievance Filed":*

(a) in the column entitled *"Total"* **and**

(b) in the column named *"Overturned".*

(4) *Modified* **– The member filed an appeal and the carrier conducted another medical review of the denial. The carrier recognized that part of the services are medically necessary. In EXAMPLE #1, the carrier approves 8 of the requested 16 PT visits. This disposition is listed under:**

(1) Question #3A **in the** *"Total"* **column (as an adverse decision);**

(2) **Question** #3B **as it was** *"Grievance Filed":*

(a) in the column entitled *"Total"* **and**

(b) in the column named *"Modified".*

Hospital Length of Stay/ Denial of Hospital Days - Follow the instructions listed previously in Sections I & II for those **adverse decisions and grievances that involve a *Hospital Length of Stay and/or Denial of Hospital Days.***

- -Report this information in Questions #4A **and** #4B **as appropriate.**

Emergency Cases - Follow the instructions listed previously in Sections I & II for those **adverse decisions and grievances that were considered *Emergency Cases.* Please note: Emergency Cases are *NOT* cases with services provided in an emergency room. This section is for reporting cases that were of an urgent nature – regardless of the location or type of service provided.**

- -Report this information in Questions #5A **and** #5B **as appropriate.**