MARYLAND
INSURANCE ADMINISTRATION

MARYLAND'S OPIOID CRISIS AND HOW THE MARYLAND INSURANCE ADMINISTRATION CAN HELP

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Background

- In 2015, Governor Larry Hogan appointed Lieutenant Governor Boyd Rutherford to lead the Heroin and Opioid Emergency Task Force. The Task Force is made up of state and local officials, as well as experts in the treatment of addiction, law enforcement, education and prevention.

Background

- The State agencies involved include:
  - Department of Health (Chair);
  - Maryland State Police;
  - Department of Public Safety and Correctional Services;
  - Department of Juvenile Services;
  - Maryland Institute for Emergency Medical Services Systems;
  - State Department of Education;
  - Governor's Office of Crime Control and Prevention;
  - Maryland Emergency Management Agency;
  - Department of Human Services;
  - Maryland Insurance Administration; and
  - Office of the Attorney General.

Background

- A website has been established as a “one-stop shop” for all information.

BeforeItsTooLateMD.org is the one-stop shop for individuals, families, educators, and health care professionals to get the educational resources they need to prevent this epidemic from spreading.

Facebook:
facebook.com/BeforeItsTooLateMD

Twitter: @BeforeIts2Late

What is the MIA's Role in the Opioid Crisis?

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

- licenses insurance companies and producers;
- examines the business practices of licensees to ensure compliance;
- monitors solvency of insurance companies;
- reviews/approves insurance policies and rates; and
- investigates consumer and provider complaints and allegations of fraud.

What is the MIA's Role in the Opioid Crisis?

The MIA can review complaints involving Health Benefit Plans issued in Maryland, including:

- claim denials based on medical necessity;
- denials of all or part of a claim for other reasons; or
- other possible violations of Maryland insurance law.

What is the MIA's Role in the Opioid Crisis?

The MIA cannot handle complaints about:

- Health Benefit Plans that were issued in another state;
- federal programs, including Medicare, Medicaid, or the Federal Employees Health Benefits Program; or
- employee Health Benefit Plans self-funded by an employer, even if an insurer is used to administer claims.

What is the MIA's Role in the Opioid Crisis?

Outline of General Claim Denial and Complaint Process

- A claim is filed;
- A denial is issued;
- An appeal is filed with the carrier, unless it is related to an "urgent medical condition". If it is related to an urgent medical condition, the complaint gets filed with the MIA directly;
- A denial of the appeal is issued;
- A complaint may be filed with the MIA.

What is the MIA's Role in the Opioid Crisis?

Outline of General Claim Denial and Complaint Process

- A company may issue a denial for two reasons:
  - the service is not covered by the contract, for example, failure to obtain required pre-authorization; or
  - the service is not medically necessary.

What is the MIA's Role in the Opioid Crisis?

A. General Claims Process

- If the service has already been provided, or
- If the service has not been provided, but it is not an emergency, then:
- Follow the Health Benefit Plan's instructions to file an appeal. The instructions are normally on the notice of denial.
- If you authorized your provider to submit a claim on your behalf, you may also want to ask your provider if they have appealed decision or plan to. Generally only one appeal needs to be filed.

What is the MIA's Role in the Opioid Crisis?

The Pre-Authorization Process

- Pre-authorization may be requested unless it is for a prescription drug:
  - (1) to treat an opioid use disorder; and
  - (2) which contains methadone, buprenorphine, or naltrexone.

What is the MIA's Role in the Opioid Crisis?

B. Exceptions for an Urgent Medical Condition

What should you do when a request for pre-authorization is denied for a reason other than medical necessity?

- If the service has not been provided, AND
- It is for an "urgent medical condition":
  - An urgent medical condition is one where the absence of medical attention within 72 hours could result in loss of life, seriously jeopardizing the member's life or health, serious impairment to a bodily function, serious dysfunction of a bodily organ, the member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others, or would subject the member to severe pain that cannot be managed without the care or treatment that is the subject of the claim or pre-authorization request.
- THEN; call the MIA. The MIA can review the denial within 24 hours and you do not need to exhaust the appeals process.

What is the MIA's Role in the Opioid Crisis?

Medical Necessity Complaints

Medical necessity determinations include:

- a determination that a service is not medically necessary, efficient, or appropriate;
- a determination that a service is custodial;
- a determination that a service is cosmetic; or
- a determination that a service is investigational/experimental/unproven.

What is the MIA's Role in the Opioid Crisis?

Review of Medical Necessity Denials – Emergency Cases

- The MIA can review a medical necessity denial in an emergency case within 24 hours.
- *You do not need to exhaust the appeals process to file a complaint in an emergency.*
- The MIA is always available.

What is the MIA's Role in the Opioid Crisis?

Review of Medical Necessity Denials

- The MIA will send medical records and the other complaint documents to the Health Benefit Plan.
  - The Health Benefit Plan has 5 working days to respond to the complaint.
  - Sometimes the Health Benefit Plan will reverse its decision after receiving the documents.
- If the MIA does not have jurisdiction over the Health Benefit Plan, the MIA will try to refer the complaint to the correct agency.
- The MIA will send the medical records and the Health Benefit Plan's criteria to an independent review organization (IRO).
- The IRO will use a physician with the appropriate specialty to review the denial.
- If the IRO determines the service is medically necessary, the denial is overturned.

What is the MIA's Role in the Opioid Crisis?

Review of Medical Necessity Denials

- The IRO can also review the criteria used by the Health Benefit Plan.
- The MIA can require that the criteria be changed if the criteria is not: objective, clinically valid, compatible with established principles of health care, or flexible enough to allow deviations from the norms when justified on a case-by-case basis.
- If the IRO finds that the services were medically necessary, typically the Health Benefit Plan will just pay the claim. For people covered under the State employee plan, the IRO decision is binding.
- If the IRO finds that the services were not medically necessary, the MIA will usually issue a determination finding no violation.
- The MIA offers the right to a hearing when there is a finding of "no violation".

What is the MIA's Role in the Opioid Crisis?

How to File a Complaint with the MIA

- Have copies of the notice of the claim denial and the notice of appeal denial.
- Include the patient's signed authorization to release medical records. A medical release form is available on the MIA's website, www.insurance.maryland.gov.
- Use our complaint form or write a letter explaining the problem.
- File within 4 months of the appeal denial.

Information you should provide to the MIA when you file your complaint

- Your contact information
  - Name
  - Relationship to insured/patient
  - Address, City, State, Zip
  - Home phone
  - Work phone
  - Cell phone
  - Email
- Insured/Patient Information (if different than above)
  - Name of insured
  - Address, City, State, Zip
  - Home phone
  - Work phone
  - Cell phone
  - Email
  - Are you authorized to act on behalf of the insured?

Information you should provide to the MIA when you file your complaint

- Insurance Information (provide a copy of insurance card if possible)
  - Insurance Company
  - Type of Insurance
    - Health
    - HMO
    - Medicaid
    - Medicare Supplement
    - Medicare
    - Other
  - Type of Policy
    - Group
    - Individual
    - Unknown
  - If Group, name of group policyholder
  - Policy or Member #
  - Date claim began
  - How did you buy the policy
  - Producer (Agent) name (if applicable)
    - Address, City, State, Zip
    - Phone number

Information you should provide to the MIA when you file your complaint

- Does this involve group insurance through your employer?

  If so,
  - Name of Employer
  - Address, City, State, Zip

- Physician Information

  - If your complaint is about a denied claim or pre-authorization for health care, please provide the name and contact information of the doctor who is treating you:
    - Name
    - Address, City, State, Zip
    - Telephone
    - Fax number

Information you should provide to the MIA when you file your complaint

- Define your problem
  - ☐ Claim or pre-authorization denial
  - ☐ Unsatisfactory claim payment
  - ☐ Billing problem
  - ☐ Denial of medical necessity
  - ☐ Delays
  - ☐ Poor service
  - ☐ Mental health/SUD parity
  - ☐ Other _____

  - ☐ Give a brief explanation of the problem

Information you should provide to the MIA when you file your complaint

- If your complaint is about a health care claim or pre-authorization denial:
  - Have you appealed the denial?
  - Have you already received the care?
  - Is the health care urgently needed?
    - If yes, explain why.
- Resolution
  - What do you want your insurance company to do?
  - Are you sending documents? If yes, **DO NOT** send original documents, copies only please.

Information you should provide to the Insurance Company when you are requesting pre-authorization for services, claim payment for services or appealing a claim denial

- Insured Name
- Insurance ID Number
- Patient Name and Date of Birth
- Patient Relationship to You
  - Guardianship paperwork
  - Adult Patient – Authorization to Represent
- Is the patient a threat to himself / herself or others?
- Insurance Company Name
- Insurance Company Phone Number

Information you should provide to the Insurance Company when you are requesting pre-authorization for services, claim payment for services or appealing a claim denial

- Insurance Plan Name or ID Number
- Insurance Plan type:
  - Individual Plan
  - Group Plan
  - Employer Benefit Plan
  - Plan includes Out-of-Network Benefit for requested services
- Limits on benefit, if any (such as a penalty or reduced payment for Out-of-Network services)
  - Plan does not include Out-of-Network Benefit for requested services

Information you should provide to the Insurance Company when you are requesting pre-authorization for services, claim payment for services or appealing a claim denial

- Treating Provider Name and Contact Information
  - Treating Provider is In-Network
  - Treating Provider is Out-of-Network
- Primary Care Doctor Name and Contact Information (if different than Treating Provider)
- Provider Referral Letter (if required)
- Provider Letter of Medical Necessity for Requested Services
- Other Providers Involved in Treatment

Information you should provide to the Insurance Company when you are requesting pre-authorization for services, claim payment for services or appealing a claim denial

- Type of Services Requested:
  - Mental Health
  - Substance Use Disorder
  - Electro Convulsive Therapy (ECT)
  - Repetitive Transcranial Stimulation (rTMS)
  - Applied Behavior Analysis (ABA)
  - Psychological Testing
  - BioFeedback
  - Skilled Nursing
  - Traumatic Brain Injury Rehabilitation
  - Habilitative Services
    - Physical Therapy
    - Occupational Therapy
    - Speech Therapy
    - Medication
    - Medical Supplies, Equipment or Device
    - Other _____

Information you should provide to the Insurance Company when you are requesting pre-authorization for services, claim payment for services or appealing a claim denial

- Location of Requested Services:
  - Treating Provider's Office
  - Home or School
  - Outpatient
  - Intensive Outpatient Program
  - Partial Hospitalization Program
  - Acute Inpatient
  - Inpatient Rehab
  - Acute Inpatient Detox
  - Residential
  - Skilled Nursing Facility
  - Telehealth

Information you should provide to the Insurance Company when you are requesting pre-authorization for services, claim payment for services or appealing a claim denial

- Has the patient been treated for this before?
  - If yes:
    - Dates of previous treatment(s)
    - Provider(s) of previous treatment(s)
    - Location of previous treatment(s)
- Patient Share of Costs for Requested Services
  - Co-payment amount
  - Unmet Deductible
  - Co-insurance amount or percentage
  - Annual Out-of-Pocket Maximum

Helpful Tips

What should you avoid doing if a claim is denied?

- Don’t allow multiple denied claims to pile up.
- Don’t wait until the time to file an appeal has expired.

Contact Information

- For assistance in preparing an appeal or complaint: Health Education and Advocacy Unit, Office of the Attorney General, 1-877-261-8807 or 410-528-1840

- Maryland Insurance Administration:

  1-800-492-6116 or 410-468-2244

  www.insurance.maryland.gov

Additional Resources on MIA's Website

- A "Consumer Guide to Understanding Your Health Insurance Coverage for Mental Health & Substance Use Disorders", which addresses the issues in this Webinar and others in more detail.
- The MIA publishes an annual report on Appeals and Grievance (medical necessity) complaints.
- Orders issued against companies can be viewed.
- A Public Information Act request can be filed.
- Consumer publications and complaint forms can be printed.

Questions?