2017
Report

Claims - Complaints - Appeals

Mental Health
&
Substance Use Disorder Benefits

For the Period January 1, 2016 - December 31, 2016

State Corporation Commission
Bureau of Insurance

Executive Summary

House Bill 1747 of the 2015 General Assembly required, “that the State Corporation Commission's Bureau of Insurance, in consultation with health carriers providing coverage for mental health and substance use disorder benefits pursuant to § 38.2-3412.1 of the Code of Virginia, shall develop reporting requirements regarding denied claims, complaints, and appeals involving such coverage set forth in § 38.2-3412.1 of the Code of Virginia. Beginning in 2017 for the year preceding, the Bureau shall compile the information into an annual report that: (i) ensures the confidentiality of individuals whose information has been reported; (ii) is made available to the public by, among such other means as the Bureau finds appropriate, posting the reports on the Bureau's Internet website; and (iii) is written in nontechnical, readily understandable language.”

Managed Care Health Insurance Plans (“MCHIPs”) licensed in Virginia currently submit an annual report on Claims, Complaints and Appeals to the Virginia Department of Health and to the State Corporation Commission Bureau of Insurance (the “Bureau”) pursuant to §§ 32.1-137.6 C and 38.2-5804 of the Code of Virginia. However, specific information related to claims, complaints and appeals for mental health and substance use services could not be gleaned from this report. Therefore, a separate survey was developed by the Bureau, in conjunction with the Virginia Association of Health Plans (“VAHP”) and health carriers that provide the majority of fully-insured health insurance in Virginia that are not members of VAHP, along with major input from the Virginia Department of Behavioral Health and Developmental Services. The results of the survey are provided in this report.

Overview

The Bureau surveyed eighteen (18) health carriers identified as insuring greater than 5,000 lives in Virginia in the individual, small group, and large group health insurance markets during the 2016 calendar year. In total, these carriers reported more than 3 million covered lives. Carriers were requested to report information specific to three benefit categories: **Medical/Surgical Benefits, Mental Health Benefits, and Substance Use Disorder Benefits**. Further, the carriers were required to report data for the 2016 calendar year related to these specific three benefit categories for:

- Claims paid, denied and the reason for the denial;
- Complaints received and processed;
- Internal appeals processed; and
- External reviews processed.

Generally, and from year to year, the report serves to provide an overview of the surveyed data.

As required by § 38.2-3412.1 of the Code of Virginia and in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, mental health and substance use disorder benefits provided by group and individual health insurance coverage shall be in parity with the medical and surgical benefits coverage. The report provides an observation of claims, complaints and appeal denials for coverage of mental health benefits and substance use disorder benefits compared to medical/surgical benefit coverage, based on the surveyed data.

To protect the confidentiality of the individual member and health carrier the report only provides data in the aggregate. None of the data in the report pertains to any one individual or health carrier, rather it is a compilation of the total data reported by the health carriers in response to each of the surveyed questions.

Section I. Claims

Carriers surveyed reported a total of 50,317,968 claims received with 6,566,839 (13.1%) of the claims being denied. Each carrier reported whether the claim related to medical/surgical, mental health, or substance use disorder benefits. The claims reported in each of these three benefit categories were broken into five separate claims categories: Office Visit Claims, All Other Outpatient Claims, Inpatient Claims, Emergency Care Claims, and Outpatient Prescription Drug Transactions.

Table 1. Claims Overview – Medical/Surgical Benefits

Medical/ Surgical Benefits	Total Claims Received	Claims Paid	Claims Denied	% Denied to Total Claims
Office Visit Claims	10,523,644	9,957,739	565,905	5.4%
All Other Outpatient Claims	14,762,160	13,736,540	1,025,620	6.9%
Inpatient Claims	1,309,891	1,146,320	163,571	12.5%
Emergency Care Claims	1,399,828	1,284,188	115,640	8.3%
Outpatient Prescription Drug Transactions	17,692,496	13,710,572	3,981,924	22.5%
Totals:	45,669,662	39,835,359	5,834,303	12.8%

Table 2. Claims Overview – Mental Health Benefits

Mental Health Benefits	Total Claims Received	Claims Paid	Claims Denied	% Denied to Total Claims
Office Visit Claims	910,474	857,386	53,088	5.8%
All Other Outpatient Claims	219,003	189,743	29,260	13.4%
Inpatient Claims	62,326	48,115	14,211	22.8%
Emergency Care Claims	93,831	87,677	6,154	6.6%
Outpatient Prescription Drug Transactions	2,536,797	2,041,098	495,699	19.5%
Totals:	3,822,431	3,224,019	598,412	15.7%

Table 3. Claims Overview – Substance Use Disorder Benefits

Substance Use Disorder Benefits	Total Claims Received	Claims Paid	Claims Denied	% Denied to Total Claims
Office Visit Claims	449,082	418,413	30,669	6.8%
All Other Outpatient Claims	210,635	164,460	46,175	21.9%
Inpatient Claims	47,645	39,150	8,495	17.8%
Emergency Care Claims	22,422	20,125	2,297	10.2%
Outpatient Prescription Drug Transactions	96,091	49,603	46,488	48.4%
Totals:	825,875	691,751	134,124	16.2%

Denied Claim Ratios

The following charts compare the ratios of denied claims to total claims for mental health benefits, substance use disorder benefits, and medical/surgical benefits. Figure 1 shows that the denial rate for claims related to mental health benefits or substance use disorder benefits are approximately 3% greater than the 12.8% denial rate for medical/surgical benefits.

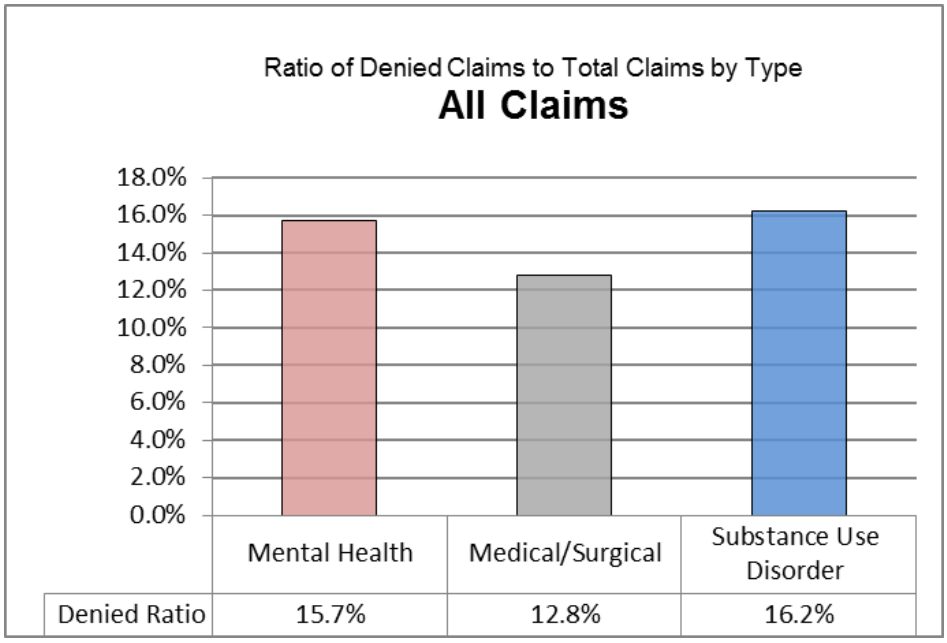

Figure 1. Denied Claims Ratio – All Claims

Claim denials were further broken down by the type of service and benefit category. Figures 2, 3 and 4 show that the denial ratio for Office Visit Claims (such as physician visits), All Other Outpatient Claims (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items), and Inpatient Claims related to mental health benefits or substance use disorder benefits exceeds claims denied for medical/surgical benefits in those categories.

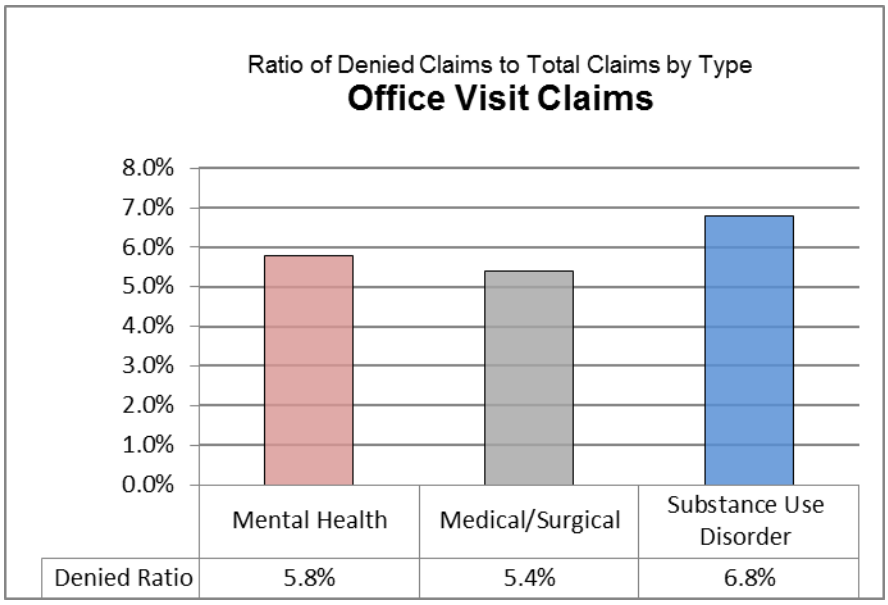

Figure 2. Denied Claims Ratio – Office Visit Claims

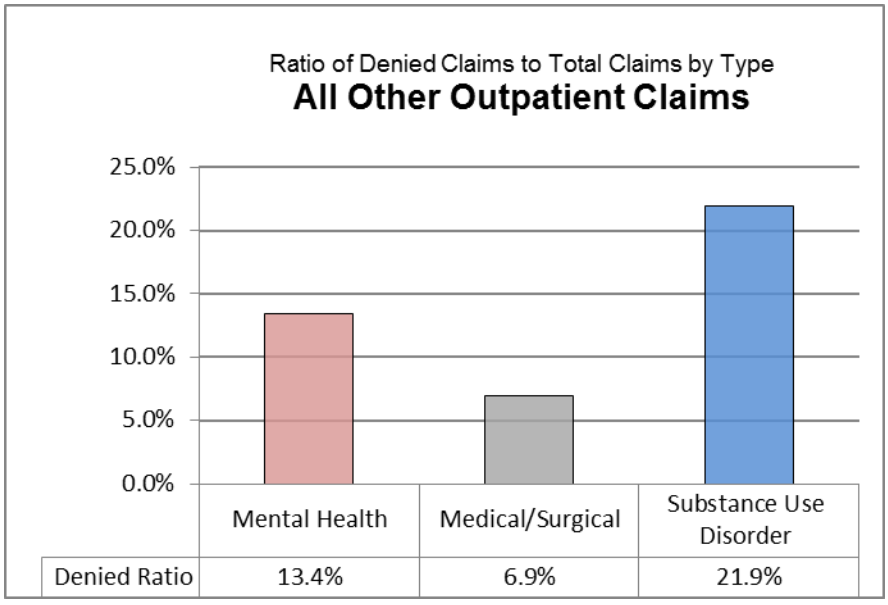

Figure 3. Denied Claims Ratio – All Other Outpatient Claims

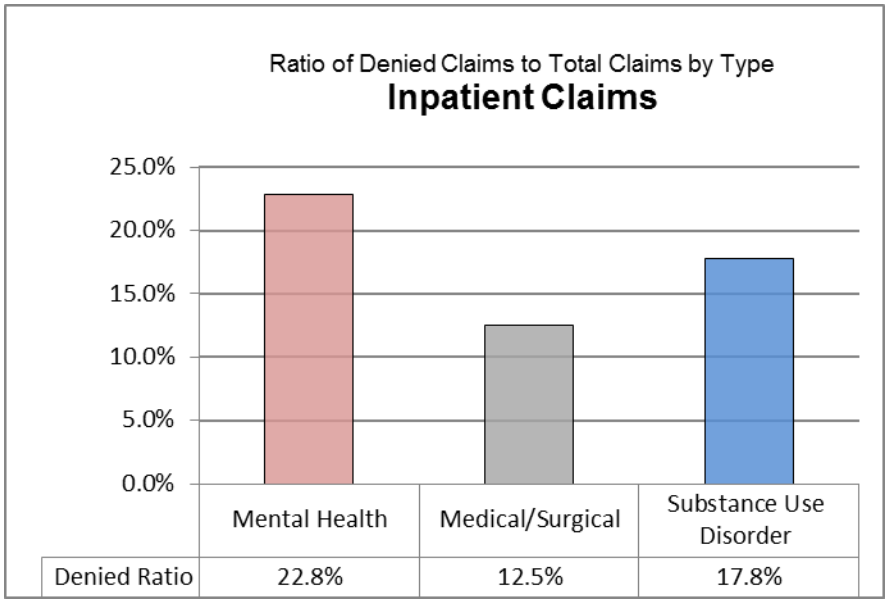

Figure 4. Denied Claims Ratio – Inpatient Claims

Figures 5 and 6 demonstrate that Emergency Care Claims and Outpatient Prescription Drug Transactions demonstrate that emergency care claims and outpatient prescription drug transactions for mental health benefits are denied less often than those for medical/surgical benefits. Claims for substance use disorders are denied at the highest rate for these categories.

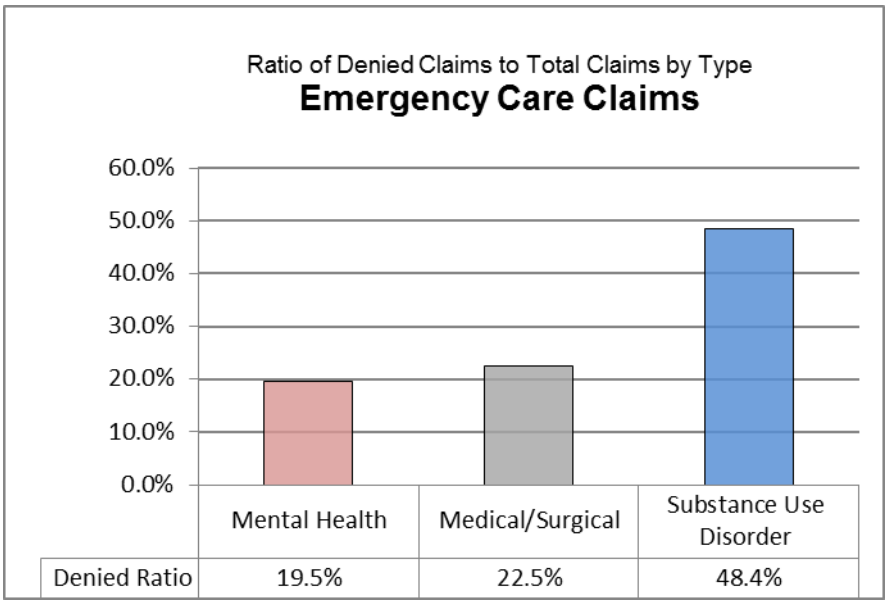

Figure 5. Denied Claims Ratio – Emergency Care Claims

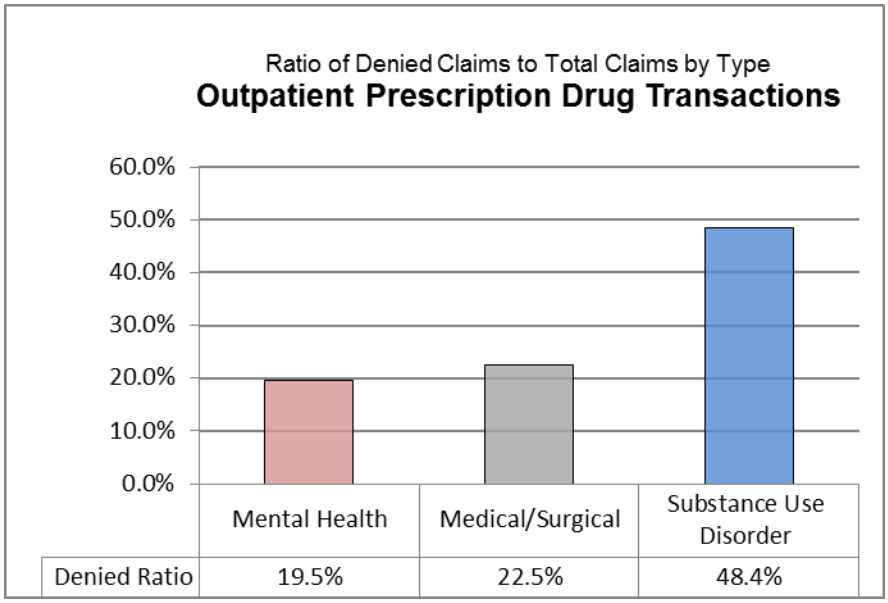

Figure 6. Denied Claims Ratio – Outpatient Prescription Drug Transactions

Attachment A of the report provides an explanation of the reasons for a denial; the top three reasons for claim denials; and the number of denied claims under six general denial categories.

Section II. Complaints

Carriers were requested to provide the number of complaints submitted to the carrier by either covered persons or the Bureau during 2016, and the number of complaints the carrier closed during 2016.

A total of 10,481 complaints were reported by the 18 carriers completing the survey. This information was broken down into five complaint areas for each of the three benefit categories: Access to Health Care Services, Utilization Management, Practitioners/Providers, Administrative/Service, and Claims Processing. These five areas are further explained in Attachment B, Complaint Areas.

Table 4 shows the number of complaints for the respective complaint area and whether the complaint was related to a medical/surgical benefit, mental health benefit, or substance use disorder benefit. Table 5 shows the ratio of the number of complaints in

each complaint area, broken down by benefit category to the total of all complaints in each complaint area and in total by benefit category.

Table 4. Total Complaints

Number of Complaints Related to:	Medical/ Surgical Benefits		Mental Health Benefits		Substance Use Disorder Benefits		All Complaints Total	
	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year
Access to Health Care Services	681	677	28	28	0	0	709	705
Utilization Management	2,012	1,990	57	56	46	46	2,115	2,092
Practitioners/ Providers	79	79	4	4	0	0	83	83
Administrative/ Service	2,616	2,591	35	35	4	4	2,655	2,630
Claims Processing	4,906	4,856	12	12	1	1	4,919	4,869
Totals	10,294	10,193	136	135	51	51	10,481	10,379

Table 5. Ratio of Complaints to Their Respective Total

Percentage of the types of complaints related to their respetive total numbers:	Medical/ Surgical Benefits		Mental Health Benefits		Substance Use Disorder Benefits		All Complaints	
	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year
Access to Health Care Services	6.6%	6.6%	20.6%	20.7%	0.0%	0.0%	6.8%	6.8%
Utilization Management	19.5%	19.5%	41.9%	41.5%	90.2%	90.2%	20.2%	20.2%
Practitioners/ Providers	0.8%	0.8%	2.9%	3.0%	0.0%	0.0%	0.8%	0.8%
Administrative/ Service	25.4%	25.4%	25.7%	25.9%	7.8%	7.8%	25.3%	25.3%
Claims Processing	47.7%	47.6%	8.8%	8.9%	2.0%	2.0%	46.9%	46.9%
Totals	10,294	10,193	136	135	51	51	10,481	10,379
Ratio to All Complaints	98.2%	98.2%	1.3%	1.3%	0.5%	0.5%	100.0%	100.0%

Complaint Ratios

The following charts demonstrate how the different areas of complaints related to mental health or substance use disorder benefits compare to those complaint areas for medical/surgical services, which comprised 98.2% of all complaints. For example, of the total complaints carriers received for medical/surgical benefits, 6.6% pertain to complaints regarding access to health care services, whereas 20.6% of the total

complaints carriers received for mental health benefits were due to access to health care services. At the same time there were no complaints regarding access to care for substance use benefits but utilization management produced the greatest percentage of complaints. The charts below are an illustration of the respective ratios.

Attachment B of the report provides examples of the complaints that fall into the five areas of complaints.

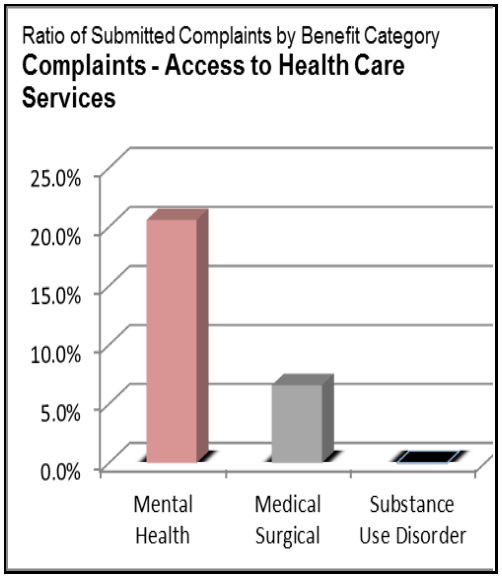

Figure 7. Access to Health Care Services Complaints

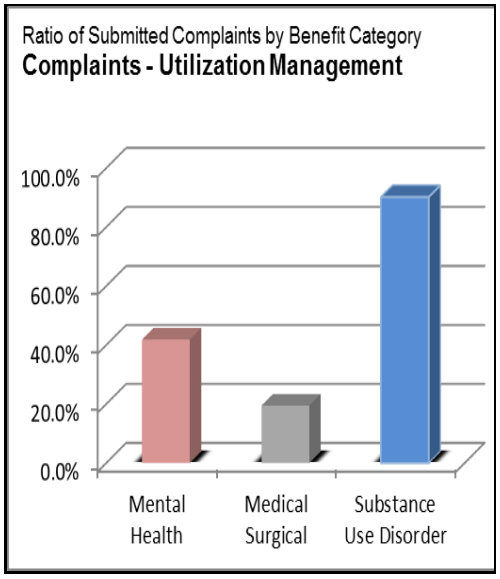

Figure 8. Utilization Management Complaints

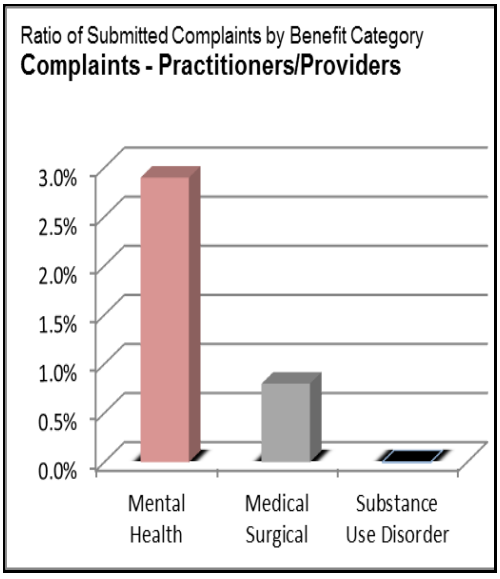

Figure 9. Complaints Regarding Practitioner/Providers

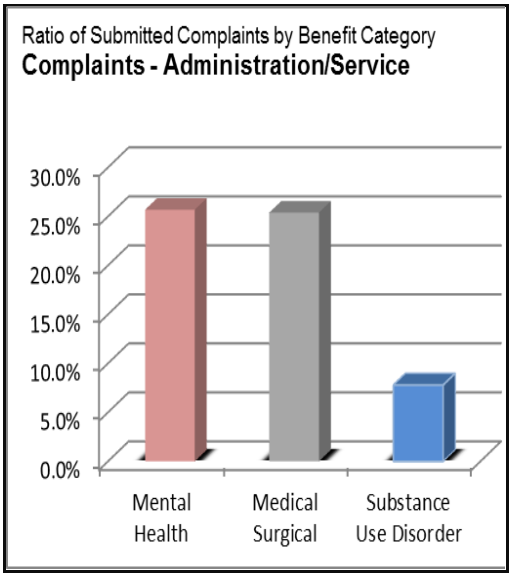

Figure 10. Administrative/Service Complaints

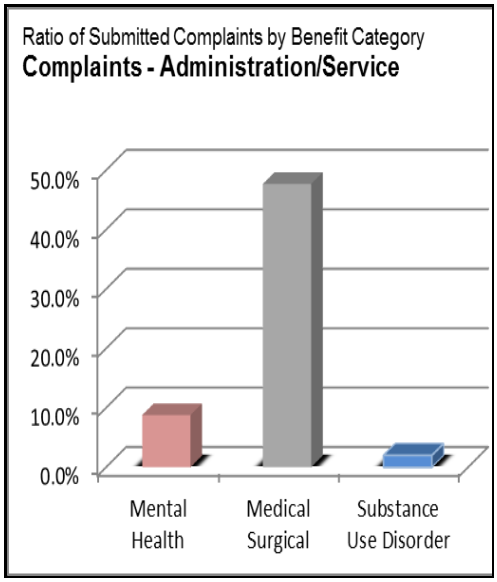

Figure 11. Claims Processing Complaints

Section III. Appeals

Internal Appeals

An internal appeal is filed by a healthcare provider or consumer to obtain approval for services an MCHIP has denied as the result of utilization review or an administrative denial. The appeal could concern a denied request for pre-authorization, which is a pre-service appeal, or the appeal could concern services that have already been provided or that do not require pre-authorization, which is a post-service appeal. The defining characteristic of the internal appeal process is that the MCHIP makes the determination. Depending upon the particular MCHIP and an individual's health plan, the person may have one or two levels of internal appeal. Pre-service appeals must be decided within 30 days, and post-service appeals must be decided within 60 days. For situations involving a serious medical condition where a quick response is required, a person or their healthcare provider can request an urgent care appeal, and the MCHIP has 72 hours to make a decision.

The health carriers responding to the survey reported that a total of 8,415 internal appeals were processed and closed in 2016. Table 6 shows the number of appeals related to the denial of benefits for medical/surgical, mental health, and substance use

disorder services and the results of those appeals. Figures 12-14 demonstrate the appeal outcome for the three benefit categories.

Table 6. Closed Internal Appeals

Closed Internal Appeals	Number Related to Medical/ Surgical Benefits	Number Related to Mental Health Benefits	Number Related to Substance Use Disorder Benefits
Internal Appeals – Denial Upheld	**5059**	**101**	**81**
Internal Appeals – Denial Partially Upheld	**242**	**4**	**5**
Internal Appeals – Denial Overturned	**2835**	**48**	**41**
Total Closed Internal Appeals	**8136**	**153**	**126**

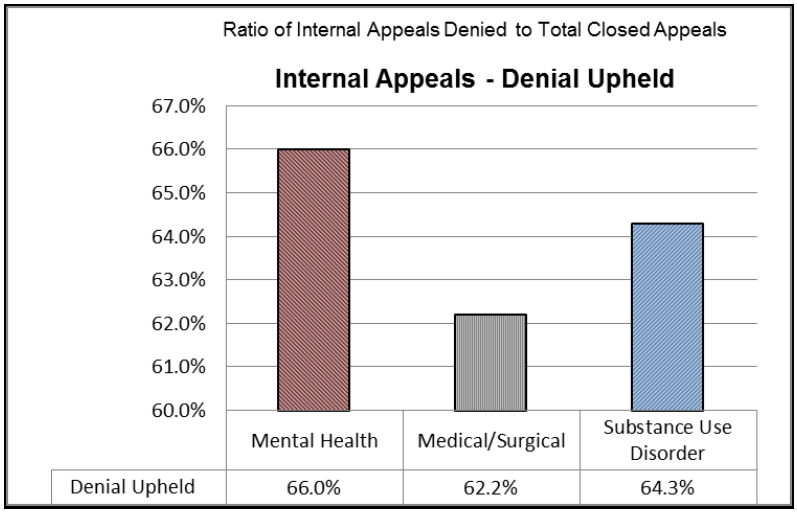

Figure 12. Closed Internal Appeals – Denial Upheld

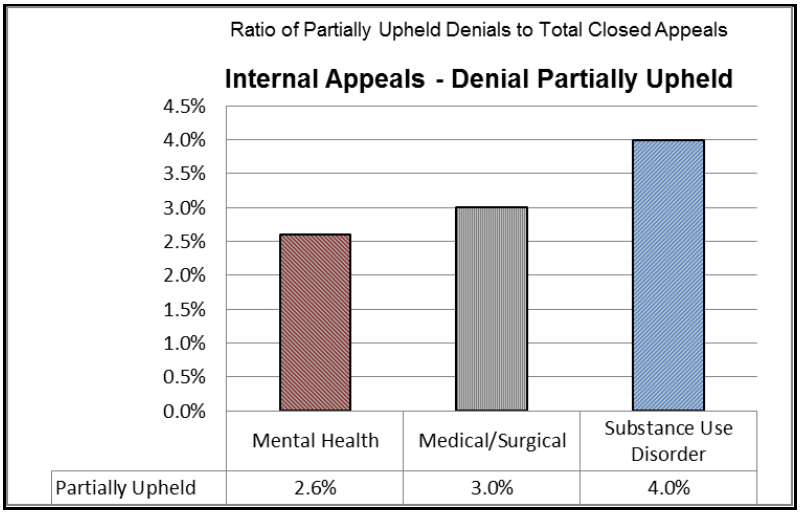

Figure 13. Closed Internal Appeals – Denial Partially Upheld

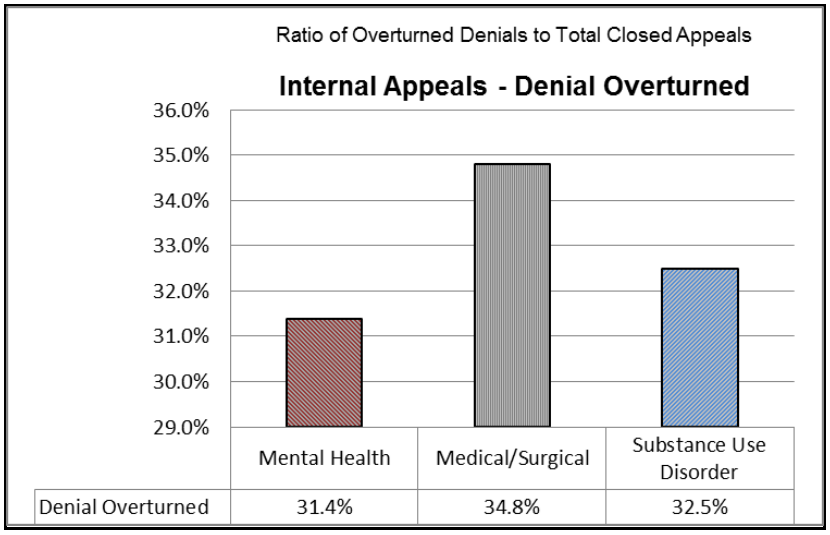

Figure 14. Closed Internal Appeals – Denial Overturned

External Review

When a consumer with a fully-insured Virginia policy receives a denial after completing the health carrier's internal appeals process (unless it is an emergency in which case completion is not required) there is an external review process available that is administered by the Bureau.

There are two kinds of denials which may be subject to an external review:

- A denial that involves a finding that services are not medically necessary; or
- A denial that involves a determination that a treatment is experimental or investigational.

The consumer or his authorized representative may file a written request for an external review within 120 days of the date the consumer receives the health carrier's final decision. The notice sent by the health carrier should provide instructions for when and how the request must be filed.

One of the Bureau's approved Independent Review Organization's ("IRO") external reviewers will be assigned the external review on a random basis, taking into account any potential conflict of interest. The IRO will issue a final decision within 45 days for a standard external review and within either 72 hours or six days for an expedited review, depending on whether or not the review relates to a treatment denied on the basis that it is experimental/investigational. The IRO will either uphold the health carrier's denial or overturn it. The health carrier is required by law to accept the external reviewer's decision.

The health carriers responding to the survey reported that 140 external reviews were performed in 2016. Table 7 shows the number of closed external reviews related to medical/surgical, mental health, or substance use disorder benefits and the results of those external reviews. Figures 15 and 16 demonstrate the frequency with which denials were upheld or overturned in external reviews for medical/surgical benefits, mental health benefits, and substance use disorder benefits.

As shown in Table 7, there were no external review decisions that resulted in a denied appeal being partially upheld during 2016.

Table 7. Closed External Reviews

Closed External Reviews	Number Related to Medical/ Surgical Benefits	Number Related to Mental Health Benefits	Number Related to Substance Use Disorder Benefits
External Reviews – Denial Upheld	**44**	**12**	**10**
External Reviews – Denial Partially Upheld	**0**	**0**	**0**
External Reviews – Denial Overturned	**66**	**2**	**6**
Total Closed External Reviews	**110**	**14**	**16**

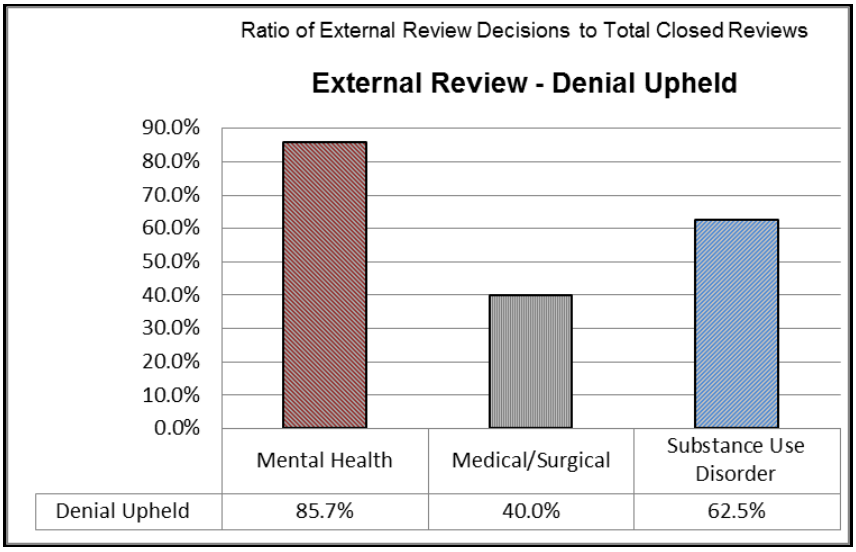

Figure 15. Closed External Reviews - Denial Upheld

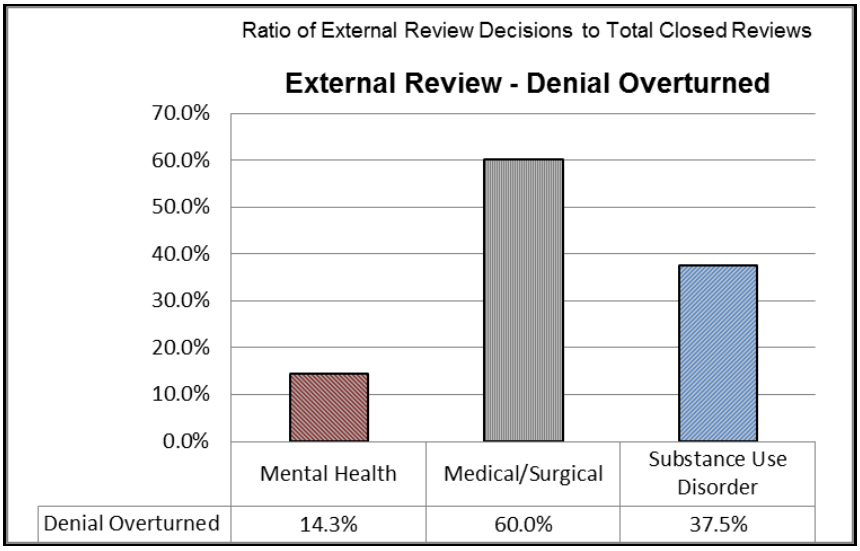

Figure 16. Closed External Reviews - Denial Overturned

Conclusion

This report provides an overview of how health carriers respond to submitted claims, complaints received, and requests regarding health benefit plan enrollees' appeals of a coverage denial as an internal appeal or external review in so far as the claim, compliant or appeal was related to a health care service for medical or surgical benefits, mental health benefits, or substance use disorder benefits.

The carriers reported that of some 6.5 million denied claims, 11% were denied for health care services relating to mental health benefits (9%) or substance use disorder benefits (2%). This appears proportionate to the 50.3 million total claims received in which slightly more than 9% of all claims received related to mental health benefits (7.6%) and substance use disorder benefits (1.6%). The report shows that depending on the type of claim (office visits, other outpatient claims, inpatient claims, emergency care claims or outpatient prescription drug transactions), claim denials for mental health or substance use disorders services were denied either less frequently or more frequently than services for medical/surgical benefits. A similar finding was presented for specific types of complaints and appeals.

The information requested and obtained was based on the carriers' data recorded for the calendar year ending December 31, 2016, and would suggest that carriers generally are complying with the statutory requirements relating to parity.

Attachment A

Claim Denial Reasons

Carriers were asked to report the total number of claims denied for which the denial would leave the member responsible for payment, and to identify the top three denial reasons in each of the three benefit categories: Medical/ Surgical ("M/S"), Mental Health ("MH") and Substance Use Disorder ("SUB").

Carriers reported that a total of 4,187,376 denials out of the 6,566,839 total claims denials reported in Section I. Claims could be attributed to each carrier's top three claim denial reasons. This means that 2,379,463 reported claim denials were for reasons other than reasons included in each carrier's top three.

Table A-1. shows the top three claim denial reasons across all carriers surveyed by the number of claim denials in each benefit category.

Table A-1. Top Three Denial Reasons by Ranking

Denial Reason by Benefit Category	Number of Denials	Rank
Medical/Surgical		
Exceeds benefit limits (contractual)	916,830	1
Not a covered benefit/service contractually excluded	670,258	2
Prescription refill too soon	653,275	3
Mental Health		
Prescription refill too soon	128,623	1
Exceeds benefit limits (contractual)	118,783	2
Not a covered benefit/service contractually excluded	54,372	3
Substance Use Disorders		
Individual ineligible/not insured when the services were provided	22,271	1
Not a covered benefit/service contractually excluded	12,673	2
Incomplete information filed	5,854	3

For purposes of the report, the Bureau consolidated the reasons reported by carriers as the top three claim denial reasons into six general categories. Table A-2. shows those denial reasons reported by carriers and organizes those reasons into general

categories. Table A-3. shows the number of all denied claims attributable to each general category, broken down by benefit category.

Table A-2. Denial Reasons by General Category

Denials related to non-covered benefits or services:
Exceeds benefit limits (contractual)
Not a covered benefit/service contractually excluded
Individual ineligible/not insured when the services were provided
Other (Explain): The plan of benefits limits coverage for cost of a private room.
Other (Explain): The dependent is not enrolled in the plan.
Other (Explain): Workers Compensation
Other (Explain): Expenses are not payable due to Employer Plan Provisions. This may be due to one or more of the following reasons: 1. Plan maximum or not covered under plan's provisions. 2. Not eligible for coverage on date(s) services rendered. . . .
Denials related to prescription drug claims:
Prescription refill too soon
Rejected - Drug Utilization Review
Filled aftr coverage terminiated
Other (Explain):Days supply greater than maximum for this plan
Other (Explain): Mail-in days supply.
Other (Explain): The procedure has been billed and allowed the maximum number of times allowed per [insurance company] payment policy.
Does not meet step therapy protocol
Denials related to preauthorization or precertification:
Services not preauthorized/Referral not obtained
Claim submitted does not match prior authorization
Other (Explain): A non-participating provider is not covered unless the services of said provider are precertified.
Other (Explain): Records indicate that the member did not comply with precertification procedures.
Other (Explain): The plan requires a referral from a PCP; records indicate a valid PCP selection has not been made.
Denials related to provider or administrative billing:
Provider billed incorrectly
Exceeds deadline for timely filing - member responsible
Incomplete information filed
Amount exceeds UCR/Allowable Charge
COB - plan is secondary
PCP not selected
The quantity of units billed exceeds the medically unlikely edit limit .
Other (Explain): Original Claim will be adjusted
Other (Explain): Health Care Professional: The submitted procedure code is disallowed because reimbursement is included in the primary service.
Other (Explain): Services and/or supplies required as a result of a work-related injury.
Other (Explain): ITS No Hold Harmless

Other (Explain): This service is not allowed because it is part of a CMS NCCI Column 1/ Column 2 edit that includes a procedure or service on a prior claim.
Other (Explain): The member's plan provides coverage for charges that are reasonable and appropriate as determined by [insurance company]. This procedure exceeds the maximum number of services allowed under [insurance company] guidelines for a single date of service.
Other (Explain): Claim Not Processed
Other (Explain):The procedure is disallowed because this service or a component of thi s service was previously billed by another health care professional.
Other (Explain):The submitted procedure code is disallowed because the primary related service was not reported on the claim or was denied for other reason.
Other (Explain): The member's plan provides benefits for covered expenses at a reasonable charge. The reasonable charge for this service is determined by Global Claim Services (GCS) for [insurance company]. . . . .
Other (Explain): The member's plan provides coverage for charges that are reasonable and appropriate as determined by [insurance company]. The charge for this service does not meet this requirement of the member's plan of benefits…..
Denials related to non-paricipating provider, out-of-network, out of service area or other such denial reason:
Provider not participating with the individual's plan
Provider/Facility not a covered provider/facility type for this service
Rendering Clinician has not been individually credentialed
Other (Explain): Claim not payable under our service area
Denials related to not medicaly necessary or inappropriate service:
Not Medically Necessary
Inappropriate level of care/inappropriate place of service/inappropriate treatment for condition or circumstance
Provider/Facility not a covered provider/facility type for this service
Experimental/Investigational

Table A-3. Number of Claims Denied by General Categories

General Catergories	All	M/S	MH	SUD
	4,187,376	**3,649,145**	**464,719**	**73,512**
Non-covered benefits or services	2,273,075	2,014,072	223,097	35,919
Prescription drug services	1,086,681	900,547	178,962	7,172
Preauthorization or precertification	410,223	355,771	42,928	10,829
Provider or administrative billing	294,118	272,068	9,646	13,086
Non-participating providers or out of network/service area	96,863	85,393	7,161	4,309
Medical necessity or inappropriate service	26,416	21,294	2,925	2,197

Attachment B

Complaint Areas

A. Access to Health Care Services	
1	Geographic access limitations to providers and practitioners
2	Availability of Primary Care Providers/Specialists/Behavioral and Mental Health Providers
3	Primary Care Provider after-hour access
4	Access to urgent care and emergency care
5	Out of network access
6	Availability and timeliness of provider appointments and provision of services
7	Availability of outpatient services with the network (to include home health agencies, hospice, labs, physical therapy, and radiation therapy)
8	Enrollee provisions to allow transfers to another Primary Care Provider
9	Patient abandonment by Primary Care Provider
10	Pharmaceuticals (based upon patient's condition, the use of generic drugs versus brand name drugs)
11	Access to preventative care (immunizations, prenatal exams, sexually transmitted diseases, alcohol, cancer screening, coronary, smoking)

B. Utilization Management	
1	Denial of medically appropriate services covered within the enrollee contract
2	Limitations on hospital length of stays for stays covered within the enrollee contract
3	Timeliness of preauthorization reviews based on urgency
4	Inappropriate setting for care, i.e. procedure done in an outpatient setting that should be performed in an inpatient setting
5	Criteria for experimental care
6	Unnecessary tests or lack of appropriate diagnostic tests
7	Denial of specialist referrals allowed within the contract
8	Denial of emergency room care allowed within the contract
9	Failure to adequately document and make available to the members reasons for denial
10	Unexplained death
11	Denial of care for serious injuries or illnesses, the natural history of which, if untreated are likely to result in death or to progress to a more severe form
12	Organ transplant criteria questioned

C. Practitioners/Providers	
1	Appropriateness of diagnosis and/or care
2	Appropriateness of credentials to treat
3	Failure to observe professional standards of care, state and/or federal regulations governing health care quality
4	Unsanitary physical environment
5	Failure to observe sterile techniques or universal precautions
6	Medical records - failure to keep accurate and legible records, to keep them confidential and to allow patient access
7	Failure to coordinate care (example - appropriate discharge planning)

D. Administrative/Health Carrier Service	
1	Inadequate, incomplete, or untimely response to concerns by health carrier staff
2	Conflict of application of health carrier policies and procedures with evidence of coverage or policy
3	Breach of confidentiality
4	Lack of access/explanation of to health carrier complaint and grievance procedures
5	Incomplete or absent health carrier enrollee notification
6	Plan documents (evidence of coverage, enrollment information, insurance card) not received
7	Enrollee did not understand available benefits
8	Enrollee claimed plan staff members were not responsive to request for assistance, or phone calls or letters were not answered
9	Marketing or other plan material was not clear
10	Complaints and appeals, formal or informal, were not responded to within required time frames, or were not adequately answered

E. Claim Processing, unrelated to utilization review	
1	Claim not paid in full, unrelated to utilization review decision
2	Claim not paid in a timely manner
3	Claim processed incorrectly, or an incorrect copayment or deductible was assessed
4	Claim was denied because of pre-existing condition
5	Enrollee held responsible contrary to “hold harmless” contractual agreement between the health plan and provider
6	Usual, Customary and Reasonable determination unreasonable