State of Maryland
OFFICE OF THE ATTORNEY GENERAL

ANNUAL REPORT ON THE HEALTH INSURANCE CARRIER APPEALS AND GRIEVANCES PROCESS

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I. Executive Summary

The Health Education and Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General (hereinafter referred to as HEAU or Unit) submits this annual report on the implementation of the Health Insurance Carrier Appeals and Grievances Law[1] (hereinafter referred to as the Appeals and Grievances Law) as required by the Maryland General Assembly.[2] HEAU is required to issue a report each November that summarizes the grievances and complaints handled by carriers, HEAU, and the Maryland Insurance Administration (MIA). HEAU is also required to evaluate the effectiveness of the internal grievance process and complaint process available to members and to propose any changes that the HEAU considers necessary to improve those processes.

As required by statute, this report will cover grievances and complaints handled during the state fiscal year 2003, beginning July 1, 2002 and concluding on June 30, 2003. The Appeals and Grievances Law is evaluated by:

- Summarizing the provisions of the law;
- Discussing implementation efforts of the health insurance carriers, MIA, and HEAU; and
- Presenting a statistical summary of grievances and complaints handled by carriers, MIA, and HEAU.

The following positive observations can be made about Maryland's Appeals and Grievances Law:

- *Maryland Health Insurance Plan regulations established under the Health Insurance Safety Net Act of 2002 allow the Health Education and Advocacy Unit to assist medically uninsurable residents appeal adverse decisions rendered by the plan administrator.*
- *The Supreme Court continues to reaffirm states' abilities to regulate the health insurance industry by limiting the ERISA preemption of state laws.*

The following are areas of concern identified by an analysis of the cases filed under the Appeals and Grievances Law:

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[1]Md. Code Ann., Insurance §15-10A-01 through §15-10A-09.

[2]Report required by Md. Code Ann., Commercial Law §13-4A-04 and Insurance § 15-10A-08.

- *Patients receiving care at a participating hospital may incur significant financial liability if some of the care is provided by hospital-based physicians not participating in their health plan.*

- *The minimum time of 180 days to file an internal grievance with an insurance carrier for a retrospective denial applies only to denials based upon medical necessity and not to coverage determinations.*

- *HEAU Annual Report data continue to show that patients seeking mental health or substance abuse services are less likely to have their denial changed during the appeals and grievances process than those seeking other services. HEAU data suggest that outcomes of mental health care cases differ sufficiently enough from the outcome of substance abuse cases to warrant health insurance carriers reporting their mental health and substance abuse cases separately.*

II. Overview of the Appeals and Grievances Process

The 1998 General Assembly enacted the Appeals and Grievances Law to provide patients a process for appealing their health insurance carriers' medical necessity "adverse decisions." In 2000 the General Assembly passed HB 405, entitled "Complaint Process of Coverage Decision,"[3] which expanded the appeals and grievances process to include contractual "coverage decisions." As a result, patients in Maryland can challenge any decision by a carrier that results in the total or partial denial of a covered health care service.

As amended, the Appeals and Grievances Law established two very similar processes for patients to dispute carrier determinations, one for carrier denials based upon medical necessity and a second process for contractual denials. For both types of denials the appeals and grievances process starts when the patient receives notice from the carrier that either an adverse or coverage decision has been rendered. An adverse decision is a finding by a health insurance carrier that proposed or delivered health care services are or were not *medically necessary*, appropriate, or efficient. A coverage decision is a determination by a carrier that results in the *contractual exclusion* of a health care service.

Under the Appeals and Grievances Law, carriers must provide patients a written notice that clearly states the basis of the carrier's adverse decision, and the Health Education and Advocacy Unit (HEAU) is available to mediate the dispute with the carrier or, if necessary, help the patient to file a grievance or appeal. The notice must also inform the patient that an external review of the decision is available through the Maryland Insurance Administration (MIA) following exhaustion of the carrier's internal process as established by the Appeals and Grievances Law.

After receiving the initial denial, the patient[4] may dispute the determination through the carrier's internal grievance or appeal process. The carrier has thirty working days to review adverse decisions involving pending care and forty-five working days for care that has already been rendered. For coverage decisions the carrier has sixty working days after the date the appeal was filed with the carrier to render a decision. At the conclusion of this internal grievance or appeal process the carrier must issue a written grievance decision or a written appeal decision to the patient.

If the carrier's final decision is unfavorable to the patient, the patient may file a complaint with MIA for an external review of the carrier's determination. Only when there is a compelling reason may patients file a complaint with MIA prior to exhausting the internal grievance process.

III. Carrier Internal Grievance Process

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[3]Md. Code Ann., Insurance §15-10D-01 through §15-10D-04.

[4]Throughout this report we refer to the rights of patients during the appeals and grievances process. The Appeals and Grievances Law also gives health care providers the right to file appeals and grievances on behalf of their patients.

All health insurance carriers regulated by the State of Maryland are required to establish a grievance process that complies with the provisions of the Appeals and Grievances Law. Health maintenance organizations, nonprofit health service plans, and dental plans are also covered by the requirements of the law.[5] The Appeals and Grievances Law establishes guidelines that carriers must follow in notifying patients of medical necessity and contractual denials, establishing grievance processes, and notifying members of grievance decisions.

The law also subjects carrier decisions to an external review by MIA. In cases of medical necessity denials, MIA can refer the case to medical experts at an Independent Review Organization (IRO) for evaluation and to provide MIA with an opinion as to the medical necessity of the care. MIA has the option of accepting or rejecting the opinion when making a final determination.

In addition, the Appeals and Grievances Law requires carriers to submit quarterly reports to MIA that describe the number and outcomes of internal grievances handled by the carriers. MIA then forwards the reports to HEAU for inclusion in this Report. While the quarterly report data submitted by carriers provides some basic insight into the carriers' internal grievance processes, its usefulness is limited by several factors, including:

- The carriers do not report data about each individual grievance. The carriers divide their data into medical service categories and report on the limited data within each category. As the categories are not standardized, reporting and categorizing may vary significantly from one carrier to another, making it difficult to compare one carrier's data to that of another.

- The diagnosis and procedure information reported is incomplete. Carriers are required to report diagnostic or treatment codes for a limited number of complaints. While the limited data provides basic evaluative information, complete reporting would provide a more valuable tool in analyzing grievance data.

- Carriers are not required to identify the grievances that involved the MIA or HEAU. Since this information is not present, it is impossible to check the cases reported by carriers against the data recorded by MIA or the HEAU to verify the consistency of data reporting.

- Carriers are not required to report membership or enrollee numbers, so an analysis of the number of adverse decisions compared to enrollee number cannot be performed.

As of January 1, 2002 the data submitted by carriers was expanded to include the number of adverse decisions issued and to identify the type of service involved in each adverse decision. This annual report

[5] Health plans offered by Medicare, Medicaid, the Federal Employee Health Benefit Plan and the federally regulated self-funded plans are not subject to the appeals and grievances requirements.

contains the first full year of adverse decision data.

Carrier Statistics FY 2003

In addition to the highlights below, charts providing statistical detail from the data submitted by the carriers appear on pages 17-23 of this report.

1. Carriers report 5,600 internal grievances were filed in FY 2003, a 44% increase from the grievances filed in FY 2002. Since carriers are not required to report membership numbers, it cannot be determined if the increase in grievances filed represents a increase in overall membership.

2. Overall, during the internal grievance process, carriers altered their original adverse decisions in a total of 61% of the grievances they received. They overturned their adverse decisions in 41% of the grievances and modified their determinations in 20% of the grievances filed. This represents a 8% increase from FY 2002, when carriers reported changing 53% of their adverse decisions.

3. Outcomes from carriers' internal grievance processes vary significantly based upon the type of service in dispute. These trends have remained fairly constant during the past three years, with adverse decisions related to pharmacy, radiology/laboratory services, and emergency room services much more likely to be reversed than adverse decisions involving mental health care and inpatient hospital services.

4. Adverse decisions involving mental health/substance abuse services continue to be significantly less likely to be overturned or modified than other types of health care services. For FY 2003 carriers reported an overturned or modified rate of 19% for mental health and substance abuse; this represents the lowest reported result since starting our annual report in FY1999. This is a 8% decrease from the FY2002 Annual Report.

IV. Maryland Insurance Administration

The Maryland Insurance Administration (MIA) has regulatory oversight of insurance products offered in the State of Maryland. The General Assembly enacted the Appeals and Grievances Law in 1998 for medical necessity denials and expanded the law in 2000 to include contractual denials. It provided MIA with the financial resources needed to handle the increased caseload and to have medical experts review the carriers' medical necessity adverse decisions. In addition to granting MIA the specific authority to order external reviews, the law also describes its responsibilities and establishes deadlines for cases involving urgently needed care.

When MIA receives a written complaint from a patient or provider, it reviews it to determine if the complaint raises issues subject to the Appeals and Grievances Law. If the Appeals and Grievances Law applies, MIA must confirm that the carrier's internal grievance process has been fully exhausted. The law requires the internal process be exhausted prior to MIA examining a carrier's adverse decision unless there is a compelling reason for review prior to exhaustion. If the carrier's internal process has been exhausted or there is a compelling reason to bypass the internal grievance process, MIA will contact the carrier in writing requesting a written response to the complaint. The carrier may respond to MIA by confirming or reversing its denial or by providing additional information related to the complaint. When MIA does not have jurisdiction or the carrier's internal process has not been exhausted, MIA refers the case to HEAU for an ombudsman to assist the patient through the grievance process.

If the carrier upholds a denial that is subject to the Appeals and Grievances Law, then MIA's investigator prepares the case for review. As part of the preparation, the investigator contacts the appropriate parties in writing, giving them a deadline for submitting additional documentation to be considered in the review. The parties, including the carrier, are notified simultaneously. Once MIA receives the proper documentation, the file is forwarded to an Independent Review Organization (IRO) for medical necessity review, or to an MIA reviewer for contractual denials. The IRO is asked to respond to specific questions set forth in a cover letter.

If the reviewer's recommendation is to overturn the carrier's denial, and the Insurance Commissioner agrees, an order is issued and forwarded in writing to the carrier, along with a notice that the carrier has the right to request a hearing challenging the order. The patient or provider who filed the complaint is notified of the outcome by telephone, if possible, and then by mail.

If the reviewer's recommendation is to uphold the carrier's denial, and the Insurance Commissioner agrees, the patient or provider is informed of the decision, by phone if possible, and that they have the right to request a hearing. The carrier is also informed of this decision by phone, and if warranted by mail.

For urgently needed care, MIA conducts an expedited external review, usually completing the above process within 24 hours. A hotline number (1-800-492-6116) is available 24 hours a day, seven days a week to respond to these emergency cases.

MIA Statistics FY 2003

In addition to the highlights listed below, charts providing statistical detail of the disposition of MIA cases appear on pages 24-28 of this report.

1. The Appeals and Grievances Unit of MIA reviewed a total of 1,305 cases that were filed between July 1, 2002 and June 30, 2003.

2. After reviewing these cases, MIA determined that 567 involved adverse decisions issued by health insurance carriers they regulated.

3. Of the 567 meeting the above criteria, MIA referred 312 to HEAU because the patient had not yet exhausted the carrier internal grievance process and there was no compelling reason to review the adverse decision prior to the exhaustion of the carrier's internal grievance process.

4. MIA initiated reviews of 255 cases in which patients challenged the grievance decision of their health insurance carrier.

5. During FY 2003, MIA issued 206 orders in cases related to carrier decisions in appeal and grievance cases.

6. Of the 206 orders issued, MIA upheld 137 or 66% of the carrier decisions, overturned 55 or 27% of the decisions, and modified 14 or 7% of the decisions.

V. The Health Education and Advocacy Unit

The Health Education and Advocacy Unit (HEAU) was established by an act of the 1986 General Assembly. The HEAU was designed to assist health care consumers in understanding health care bills and third party coverage, to identify improper billing or coverage determinations, to report billing and/or coverage problems to appropriate agencies, and to assist patients with health equipment warranty issues. To fulfill these responsibilities, HEAU built upon the established mediation program within the Consumer Protection Division of the Attorney General's Office. Based upon HEAU's successful mediation efforts, the General Assembly selected the Unit to be the first line consumer assistance agency when they passed the Appeals and Grievances Law in 1998.

The Appeals and Grievances Law requires that health insurance carriers notify patients that HEAU is available to assist them in appealing an adverse decision. With each adverse decision issued, carriers must provide patients with HEAU's contact information including HEAU's toll-free hotline (1-877-261-8807). In addition, HEAU conducts outreach programs to increase patient and provider awareness of the rights and resources granted under the Appeals and Grievances Law.

When HEAU receives a request for assistance, the Unit gathers basic information from the health insurance carriers related to the services or care denied. Specifically, HEAU asks the carrier to provide a copy of the insurance contract provisions or the utilization review criteria upon which the carrier based the denial and to identify precisely which provision or criteria the patient failed to meet. Once the carrier responds, HEAU gathers information about the patient's condition from the patient and provider. The object is to assemble all relevant information or documents necessary for the carrier to determine if the patient meets the criteria established by the health plan, or that the contractual denial is incorrect. HEAU then presents this information to the carrier for reconsideration of the denial. Many complaints are resolved during this information exchange process. If not resolved, HEAU will prepare and file a formal written grievance with the health insurance carrier on behalf of the patient.

If, at the conclusion of the grievance process, the carrier continues to deny the care, the patient or provider may request that HEAU transfer the case to MIA for external review. HEAU refers the case to MIA with a copy of all relevant medical and insurance documentation.

HEAU Statistics FY 2003

In addition to the highlights listed below, charts providing statistical detail of the disposition of HEAU cases appear on pages 29-40 of this report.

1. HEAU closed 2,497 cases during FY 2003.

2. The appeals and grievances cases fall into two categories: denials based upon medical necessity and denials based upon contractual exclusions. HEAU- mediated cases were 57% contractual denials and 43% medical necessity denials.

3. HEAU mediation resulted in 43% of the contractual denial cases being overturned or modified by the carrier; 71% of the medical necessity denial cases were overturned or modified.

4. HEAU assisted patients in obtaining more than $1.5 million in claims payments in mediated appeal and grievance cases in FY 2003, bringing the total to more than $5.75 million in claims payments related to the appeal and grievance cases since the law became effective in January 1999.

5. HEAU mediation efforts resulted in adverse decisions being changed in 60% of cases involving carriers subject to MIA regulations.

6. In cases filed against health plans not subject to review by MIA, HEAU mediation efforts resulted in carriers changing their decisions 47% of the time.

VI. Positive Developments and Areas of Concern

Based upon the HEAU's experiences in implementing the appeals and grievances process, we have identified the following points regarding both positive developments and areas of concern as follows.

Positive Developments

1. The Health Insurance Safety Net Act of 2002 provide for the HEAU Director to appoint a consumer representative to the Board of the Maryland Health Insurance Plan (MHIP). MHIP regulations allow the Health Education and Advocacy Unit to assist medically uninsurable residents appeal adverse decisions rendered by the plan administrator.

In 2002 the General Assembly passed the Health Insurance Safety Net Act and created the Maryland Health Insurance Plan (MHIP), an independent unit within Maryland Insurance Administration (MIA) responsible for providing access to affordable, comprehensive health benefits for medically uninsurable residents of the State. This program became effective July 1, 2003 and cannot deny coverage to any individual based on medical conditions.

The Health Education and Advocacy Unit has two functions under the Act. First, pursuant to the Act, the director of HEAU appoints the consumer member to the MHIP Board, which consists of five members who supervise and control MHIP. Second, MHIP regulations incorporate the Appeals and Grievances Laws allowing HEAU to assist members. MHIP complaints are addressed under the Code of Maryland Regulations 31.17.03 – Operation and Administration of the Plan. Under the Plan, members and providers have the same appeal rights regarding denials and the Plan administrator must comply with the complaint process for adverse, grievance, and coverage decisions in Insurance Article, Title 15, Subtitle 10A and 10D, Annotated Code of Maryland.

The ability of HEAU to assist and advocate for Maryland consumers is enhanced by the MHIP Board structure and the MIA regulation. In future reports, the HEAU will report on its experience in assisting these consumers.

2. The Supreme Court continues to reaffirm states' abilities to regulate the health insurance industry by limiting the ERISA preemption of state laws.

As reported in previous HEAU Annual Reports, many of our appeals and grievances cases are exempt from state regulation because they involve self-insured plans subject to the Employee Retirement Income Security Act of 1974 (ERISA).[6] ERISA establishes that the regulation of employee benefit plans is exclusively a federal concern.

In 2002, the U.S. Supreme Court rendered a decision[7] upholding the Illinois HMO Act, ruling that patients have a right to "independent review" of an HMO's refusal to pay for medical treatments and that the Act's independent review provisions were valid and not preempted by ERISA. This was an important decision for Marylanders as our appeal and grievance laws are similar to the Illinois law. In April 2003, the Court continued to limit ERISA preemption when it unanimously held that Kentucky's "any willing provider" laws requiring HMOs to make available to its members treatment by any medical provider within its geographical area that agreed to the terms and conditions of the HMO were not preempted.[8] While the Supreme Court still recognizes the overriding ERISA preemption, it has blocked the expansion of this preemption.

For FY 2003, 27% of our cases involved ERISA plans. Unfortunately history has shown that HEAU's mediation efforts are less successful for patients in ERISA plans than for patients in state (MIA) regulated plans. For FY 03, carriers' adverse decisions were overturned or modified in 47% of the cases involving ERISA plans, while plans subject to MIA regulation changed their decisions in 60% of the cases.

While the trend by the Supreme Court benefits Maryland's health care consumers, comprehensive protections expanded to patients in ERISA plans through the passage of a federal Patients Bill of Rights would allow HEAU to provide equal assistance to Marylanders in ERISA and state-regulated plans.

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[6]ERISA establishes the regulation of employee benefit plans "as exclusively a federal concern." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995). ERISA's general preemption clause, § 514(a), 29 U.S.C. § 1144(a), preempts "all state laws insofar as they . . . relate to any employee benefit plan."

[7]*Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002).

[8]Kentucky Association of Health Plans, Inc. v Miller, 538 U.S. ----- (2003), No 00-147 (April 2, 2003).

Areas of Concern

1. Patients receiving care at a participating hospital may incur significant financial liability if some of the care is provided by hospital-based physicians not participating in their health plan.

Each year HEAU receives complaints from patients who have incurred significant financial responsibility after receiving care at a participating hospital from a hospital-based physician who does not participate with their managed care health plan. Examples of hospital-based doctors include emergency room doctors, pathologists, neonatologists, radiologists, surgical assistance, and anesthesiologists.

This occurs even when the PPO or POS managed care plan pays for the covered services rendered by the nonparticipating provider at the same level they pay participating providers, because in a PPO/POS, the provider can bill the patient if the total amount is not paid by the plan. The HMO member in most instances is protected by State mandated prohibition against balance billing for covered services. In short, the PPO/POS patient is responsible for the difference between what the nonpreferred provider charged and what the plan paid. Below is an excerpt from a letter written by a consumer describing the impact of this system.

> "July 5, 2003 I was rushed to the emergency room at Fort Washington Medical Center for severe abdominal pain. This medical center is a participating provider with my plan. In going to a participating provider I assumed the attending physician would also be covered under my plan. I was surprised to find that the physician was not covered and I have received a bill for $309.00 from the physician's billing department."
>
> "As [Carrier] has a contract with the participating hospital I believe the hospital must be required by [Carrier] to have their ER physicians participating in the plans that the hospital accepts. I was given no choice over my physician, but the hospital has the choice to hire or contract only those who accept the plans they participate with. As a client of [Carrier] I expect them to protect me by not only having hospitals and ER's that participate in their plan, but the Dr's in the ER to also participate and/or be covered by the same plan."

In this case the patient still owed $207.19 after the carrier paid the amount it pays to participating providers. Under current law, the patient was required to pay the remaining portion of the bill and the provider insisted it be paid. During the mediation process the carrier informed HEAU that it has no participating physicians in the Fort Washington emergency room. Therefore, the emergency room

doctors can bill all Plan members that utilize the emergency room at the Fort Washington Medical Center, despite the fact that the Center is a participating provider in the Plan.

In addition to services provided in emergency rooms, HEAU has also received complaints about nonparticipating hospital-based providers in other situations, including non-emergency surgeries and deliveries of babies. In those instances, patients chose a local hospital and doctor in their plan to have a surgery performed or a baby delivered. After the care was rendered, patients found out that some hospital-based pathologists, neonatologists, or anesthesiologists did not participate and the patient was held responsible for paying the difference between what the nonparticipating provider charged and what the plan paid. One consumer wrote the following about her experience with this practice.

> "I am writing to appeal the recent payment made to the Howard County Neonatal providers. According to your explanation of benefits, it appears that I am being penalized for using services of a "non-participating" provider. I had no other option available when choosing these providers. They are the only neonatal providers available at Howard County General Hospital. I followed my plan rules and went to a participating hospital. These providers are contracted for their services but are not reimbursed by the hospital for them. This is out of my control."
>
> "The services in question are for Neonatal care during the birth of my son. It seems unreasonable that emergency situations would not be covered differently than a "planned"admission, particularly for newborns. At the time of delivery, the luxury of time to search for a "participating provider" was not available without compromising the health of our son."

As both these consumers point out, unless hospital-based physicians are required to participate in the health plans accepted by the hospital, there is no way that patients can avoid these unexpected and uncovered medical expenses.

2. The minimum time of 180 days to file an internal grievance with an insurance carrier for a retrospective denial applies only to denials based upon medical necessity and not to coverage determinations.

The Appeals and Grievances Law requires that carriers allow patients 180 days to file a grievance after the carrier renders a medical necessity adverse decision. However, the Appeals and Grievance Law sets no standard appeal time for contractual denials and deadlines vary from carrier to carrier. If the time periods were 180 days for all grievances, it would be less confusing for patients.

3. HEAU Annual Report data continues to show that patients seeking mental health or substance abuse services are less likely to have their denial changed during the appeals and grievances process than those seeking other services. For FY 2003 mental health/substance abuse cases as reported by carriers were much less likely than any other type of case to be overturned or modified by the carrier.

As discussed in past HEAU Annual Reports, patients challenging denials for mental health and substance abuse services are less likely to have a carrier change its original decision than patients challenging other medical service decisions. HEAU reports mental health cases separately from substance abuse cases, making it easier to review outcomes. Unfortunately, data reported by carriers combine mental health/substance abuse services, preventing a comprehensive assessment of the carriers' internal appeals and grievances process for these services. For the combined services, carriers reported only 19% of grievances were overturned or modified and 81% were upheld.

HEAU data show significant differences in outcomes of mental health and substance abuse cases. For FY 03 our combined substance abuse/mental health cases had a 51% overturned or modified rate. When the mental health cases are separated from substance abuse cases we see that carriers overturned or modified adverse decisions in 42% of the substance abuse cases, compared with 61% of the mental health cases. The variability in outcomes argues for carriers reporting mental health and substance abuse data separately to allow a complete assessment of the appeals and grievances process by service.

VII. Conclusion

Maryland's Appeals and Grievances Law continues to provide significant assistance to patients challenging health insurance adverse decisions. In past years enhancements to the 1999 Appeals and Grievance Law improved patient access to HEAU and MIA assistance by requiring better notices to patients, lengthening patient deadlines, and broadening the scope of the types of denials covered. In 2002, the General Assembly passed the Health Insurance Safety Net Act and created the Maryland Health Insurance Plan (MHIP). MHIP regulations continued to insure HEAU's ability to assist Maryland consumers by requiring plan administrators to comply with the Appeals and Grievances Law.

Still, there are areas of concern; we must be aware of possible barriers to the appeal and grievance processes. Until the Appeals and Grievance Law sets a standardized appeal time frame for contractual denials, the possibility for varying times by the carriers could contribute to consumer confusion and lost opportunities for appeal. Additionally, mental health and substance abuse cases are some of the most difficult to get overturned by the carrier. To allow meaningful assessment of the appeals and grievance process in these cases, carriers should be required to report mental health adverse decisions, grievances, and appeals separately from substance abuse decisions, grievance and appeals.

Additionally, consumers need the ability to predetermine their financial liability when they seek care from a hospital participating in their health plan. Care from a nonparticipating hospital-based physician can severely impact consumers' financial liability and they need the ability to assess this prior to care being rendered.

Finally, though ERISA plans continue to be exempt from state regulation, recent Supreme Court decisions have not expanded ERISA preemptions. Ideally a federal Patients Bill of Rights will be enacted to provide comprehensive protections to patients in ERISA plans and HEAU will be able to provide equal assistance to Marylanders in ERISA and state-regulated plans.

VIII. Appendix

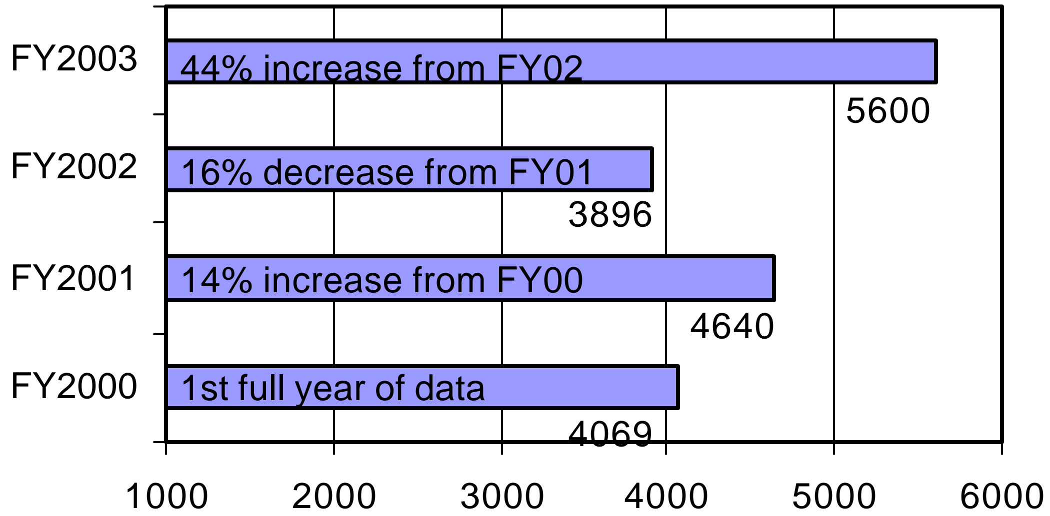
Carrier Data

Reported by Carriers

Fiscal Year 2003

	Adverse Decisions		Grievances Filed		
Carrier	Total	Admin. Reversal	Total	Upheld	Overturned/ Modified
Aetna Dental Inc.	7	2	19	63%	37%
Aetna U.S. Healthcare - Largo, MD	4565	342	378	37%	63%
Allianz Life Insurance Co. of North America	7	2	12	67%	33%
Ameritas Life Insurance Corporation	9	0	0	0%	0%
CareFirst BlueChoice, Inc.	4139	1	362	62%	38%
CareFirst of Maryland Inc.	10528	31	768	67%	33%
Celtic Insurance Company	0	0	19	63%	37%
CIGNA Dental Health of Maryland, Inc.	355	0	24	29%	71%
CIGNA Healthcare Mid-Atlantic, Inc.	433	0	212	34%	66%
Companion Life Insurance Company	34	0	16	13%	88%
Connecticut General Life Insurance Co.	208	1	157	32%	68%
Continental Assurance Company	4	1	5	80%	20%
Continental General Insurance Company	1	1	0	0%	0%
Coventry Health Care of Delaware	529	0	130	17%	83%
Delmarva Health Plan, Inc.	27	0	12	42%	58%
Dental Benefit Providers of MD, Inc.	747	0	72	46%	54%
Fidelity Insurance Company	60	4	73	36%	64%
Fortis Benefits Insurance Company	11	4	6	0%	100%
Fortis Health	9	0	4	75%	25%
Freestate Health Plan, Inc.	911	1	10	60%	40%
GE Group Life Assurance Company	8	0	2	100%	0%
Golden Rule Insurance Company	2	1	2	100%	0%

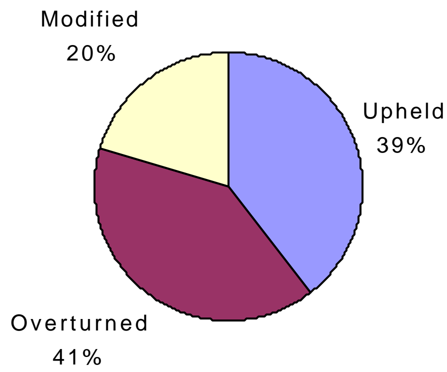
Carrier	Adverse Decisions Total	Adverse Decisions Admin. Reversal	Grievances Filed Total	Grievances Filed Upheld	Grievances Filed Overturned/ Modified
Group Dental Service of Maryland, Inc.	4679	0	1740	16%	84%
Group Hospitalization & Medical Services, Inc. T/A Carefirst Blue Cross Blue Shield	1831	3	131	53%	47%
Guardian Life Insurance Company of America	532	2	110	27%	73%
Humana Dental Insurance Company	8	0	1	100%	0%
Humana Dental Insurance Company	1	0	1	100%	0%
Jefferson Pilot Financial Insurance Co.	26	1	2	100%	0%
Kaiser Permanente Insurance Company	314	1	96	15%	85%
MAMSI Life and Health Insurance Co.	3387	8	363	48%	52%
MD-Individual Practice Association, Inc.	1019	0	136	54%	46%
Mutual of Omaha Insurance Company	1	1	1	0%	100%
Nationwide Life Insurance Company	2	0	6	67%	33%
Optimum Choice, Inc.	7735	0	581	57%	43%
Philadelphia American Life Ins. Co.	0	0	1	0%	100%
Preferred Health Network - HMO, Inc.	302	0	68	56%	44%
Reliance Standard Life	1	0	0	0%	0%
The Mega Life and Health Insurance Co.	3	0	12	67%	33%
Trustmark Insurance Company	5	0	5	20%	80%
UNICARE Life and Health Insurance Co.	44	0	15	80%	20%
Unimerica Insurance Company	8	0	0	0%	0%
United HealthCare Insurance Company	2	0	20	55%	45%
United Healthcare of the Mid-Atlantic, Inc.	34	0	9	22%	78%
United of Omaha Life Insurance Company	12	0	12	42%	58%
United Wisconsin Life Insurance Company	165	129	7	0%	100%
Total	**42705**	**536**	**5600**	**39%**	**61%**



This chart shows the history of carrier grievances under the A&G Law since the first full year of data.

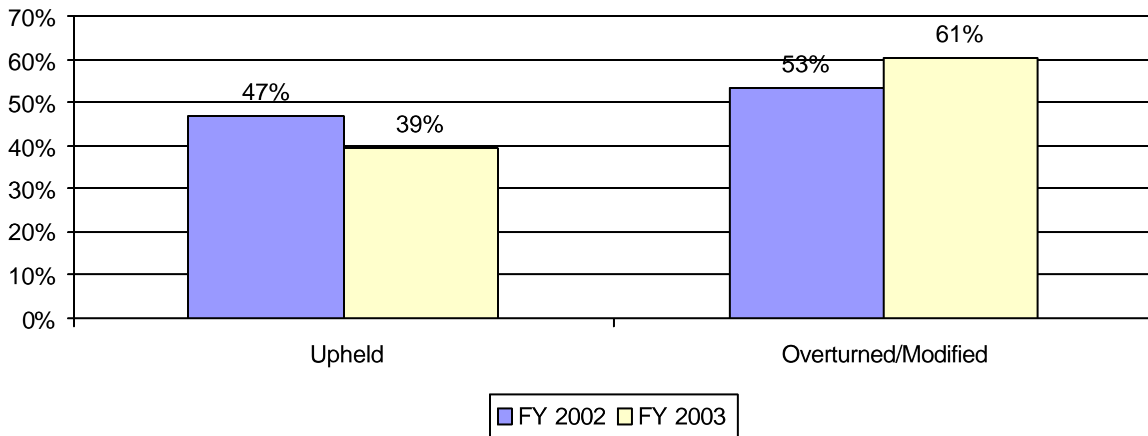
Carrier Grievance Data

Outcomes of Grievances Filed
FY 2003



This chart describes the outcomes of the 5,600 internal grievances reported by carriers during FY 2003.

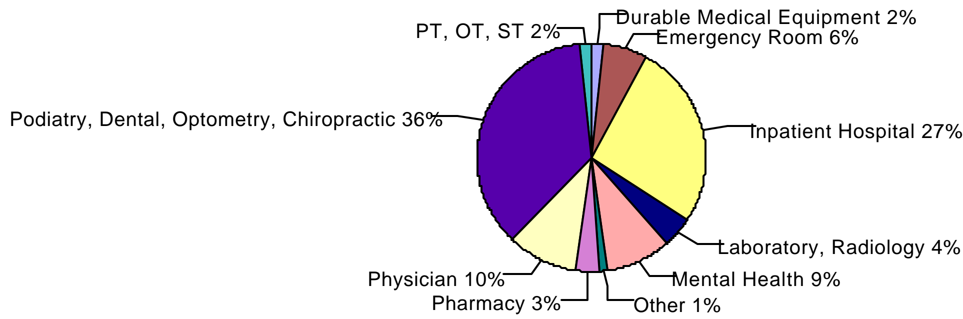
Outcomes of Grievances Filed
Two Year Comparison



This chart compares the year-to-year outcomes of grievances filed with carriers.

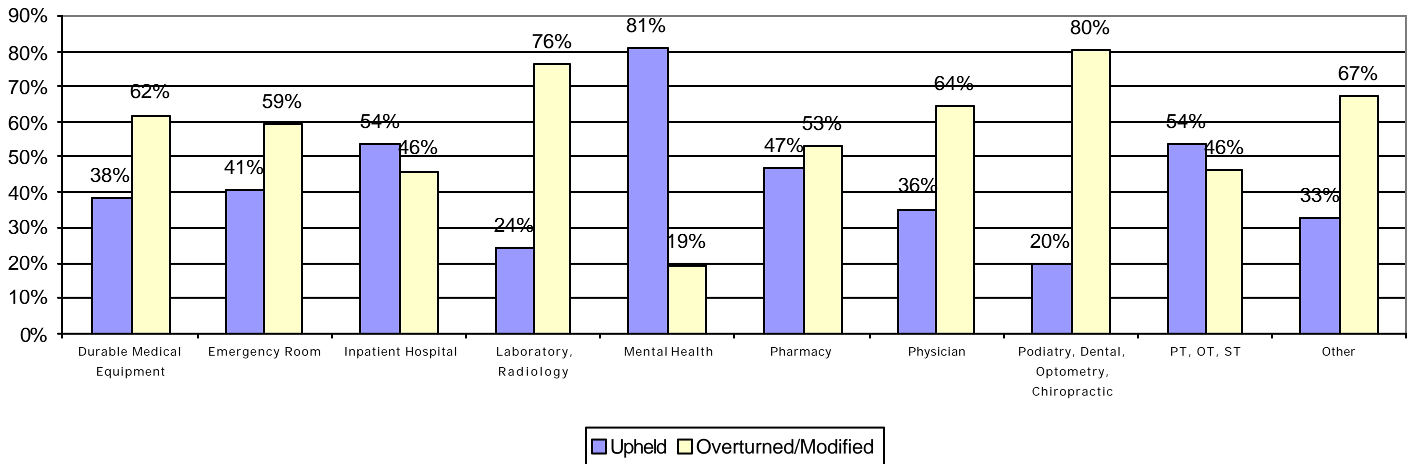
Carrier Grievance Data

Type of Service Involved in Grievances Filed
FY 2003



Carriers are required to report the type of service involved in the internal grievances they receive. The above chart details the types of services involved in internal grievances as reported by carriers in FY 2003.

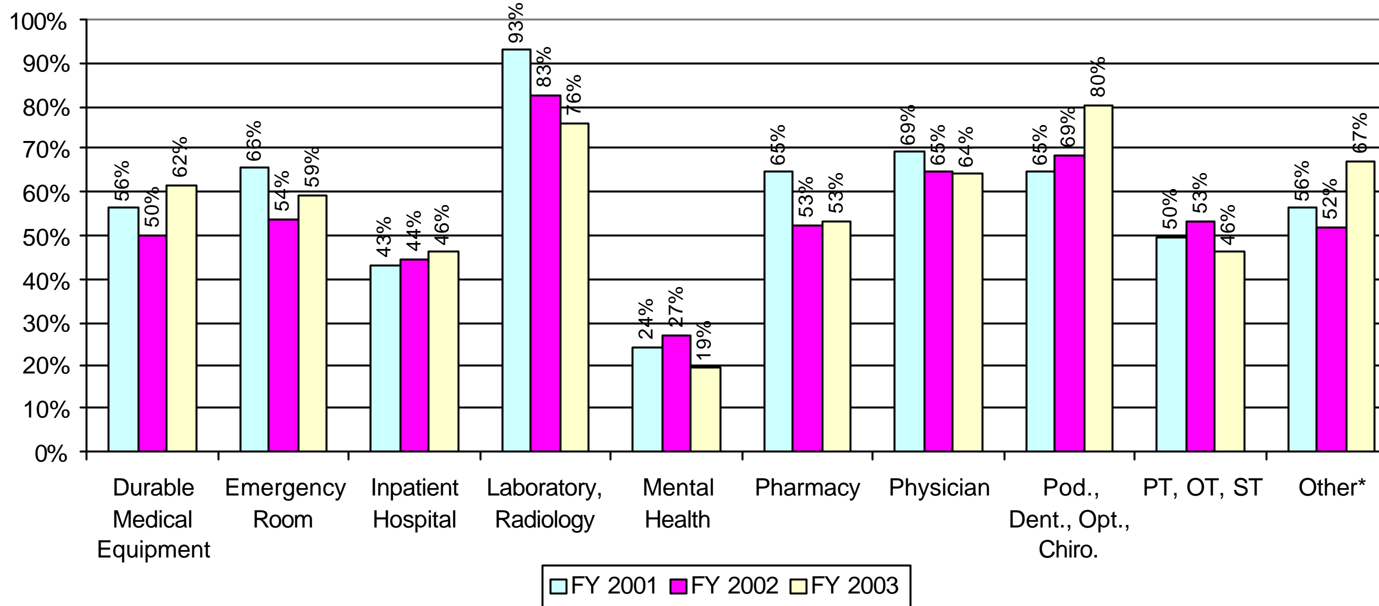
Outcomes of Grievances by Type of Service
FY 2003



Carriers are required to identify the type of service involved in the internal grievances they receive as well as the outcomes of those grievances. This chart compares the variance in the outcome of grievances based upon the type of service being disputed in the grievance. This chart is based upon carrier reported data. The cases reported as overturned or modified have been combined to more clearly present the data. The carriers report Mental Health and Substance Abuse together.

Carrier Grievance Data

Percentage of Grievances Overturned or Modified
Three Year Comparison

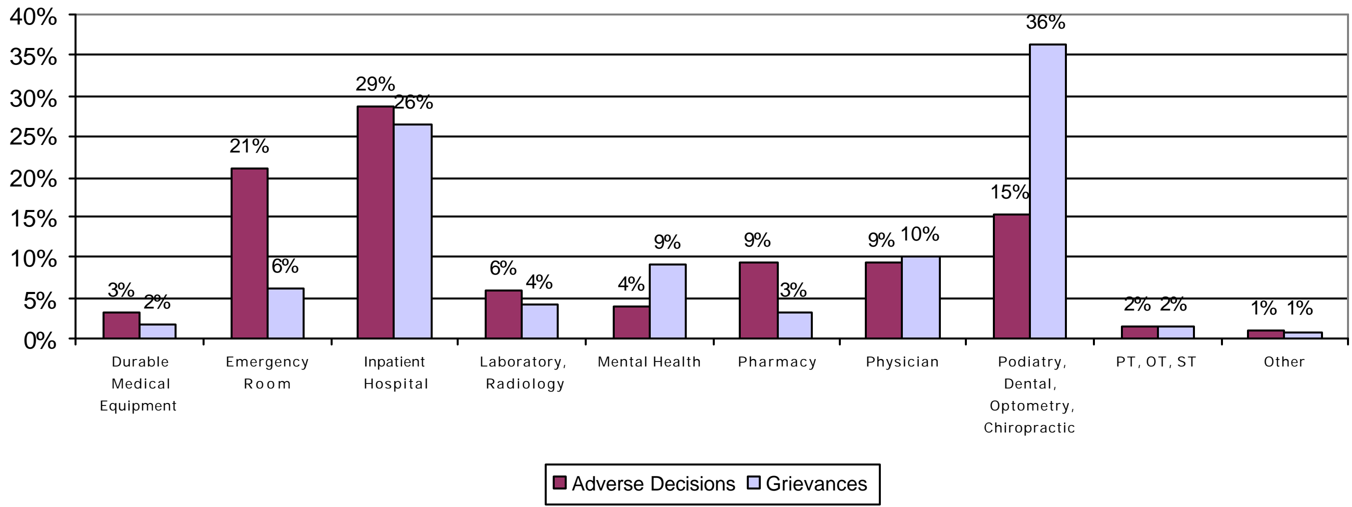


This chart compares the percentage of cases reported as overturned or modified, comparing FY 2001, FY 2002, and FY 2003 outcomes as reported by the carriers.

Carrier Data

Adverse Decisions Issued vs. Grievances Filed

FY 2003



MIA Appeals and Grievances Complaints

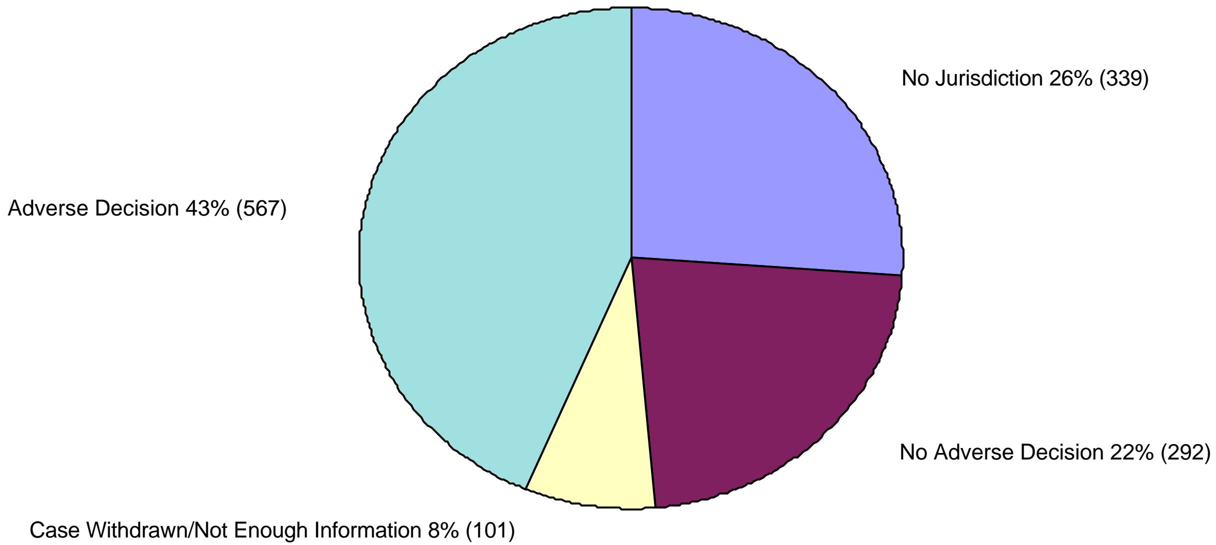
Complaints Listed by Carrier

Carrier	Total	Carrier Upheld by MIA		Carrier Overturned by MIA		Carrier Modified by MIA		Carrier Reversed Itself During Investigation	
Aetna	22	11	50%	2	9%	0	0%	9	41%
BCBS of Maryland	158	87	55%	19	12%	8	5%	44	28%
CIGNA	11	4	36%	2	18%	0	0%	5	45%
Conseco Life Insurance Company	1	0	0%	0	0%	0	0%	1	100%
Coventry	10	0	0%	4	40%	1	10%	5	50%
Delmarva	1	1	100%	0	0%	0	0%	0	0%
Dental Benefit Providers	1	0	0%	1	100%	0	0%	0	0%
Fortis Benefits Ins. Co.	1	0	0%	0	0%	0	0%	1	100%
Fidelity Ins Co	9	4	44%	1	11%	0	0%	4	44%
Guardian	2	0	0%	0	0%	0	0%	2	100%
Kaiser Permanente	22	13	59%	2	9%	0	0%	7	32%
MAMSI	83	55	66%	12	14%	3	4%	13	16%
MD IPA	11	4	36%	3	27%	0	0%	4	36%
Metropolitan Life Ins. Co.	1	0	0%	0	0%	0	0%	1	100%
Mega Life & Health	1	1	100%	0	0%	0	0%	0	0%
Optimum Choice	41	19	46%	7	17%	1	2%	14	34%
PHN HMO	9	6	67%	2	22%	1	11%	0	0%
United Concordia	4	2	50%	0	0%	0	0%	2	50%
United HealthCare	8	5	63%	0	0%	0	0%	3	38%
TOTAL	**396**	**212**	**54%**	**55**	**14%**	**14**	**4%**	**115**	**29%**

FY 2003

MIA Complaints FY 2003

Complaints Reviewed by Appeals and Grievances Unit



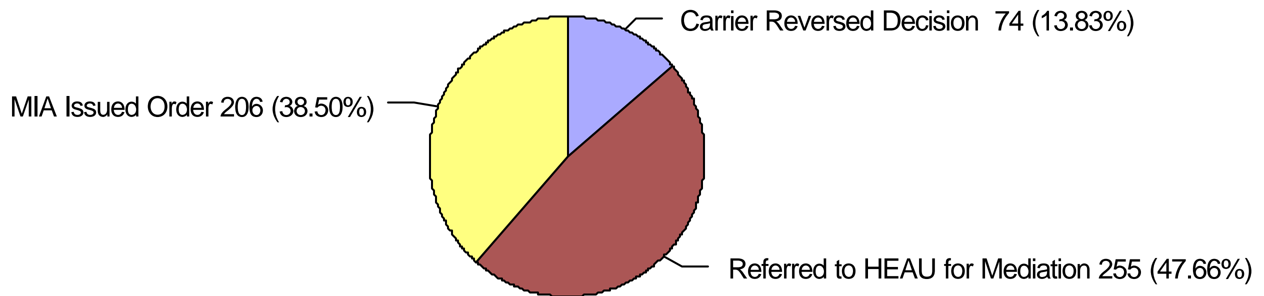
When the MIA Appeals and Grievances Unit receives a written complaint, it reviews it to determine:

- Is the carrier subject to state jurisdiction?
- Does the complaint include a dispute of an adverse decision?

Some cases are withdrawn or there is not enough information to complete the review. This chart details the outcomes of MIA's review of cases during FY 2003.

MIA Appeals and Grievances Complaints

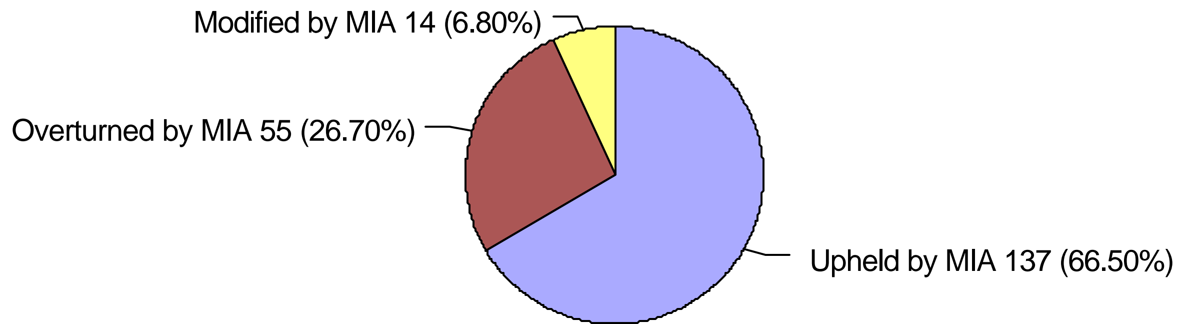
Disposition of Complaints FY 2003



During FY 2003, MIA determined that 567 complaints challenged adverse decisions made by carriers that were subject to state jurisdiction. Cases in which the patient had not exhausted the carrier's internal grievance process were referred to HEAU. The remaining cases were either resolved by carriers during the review process or resulted in an MIA order.

MIA Appeals and Grievances Complaints

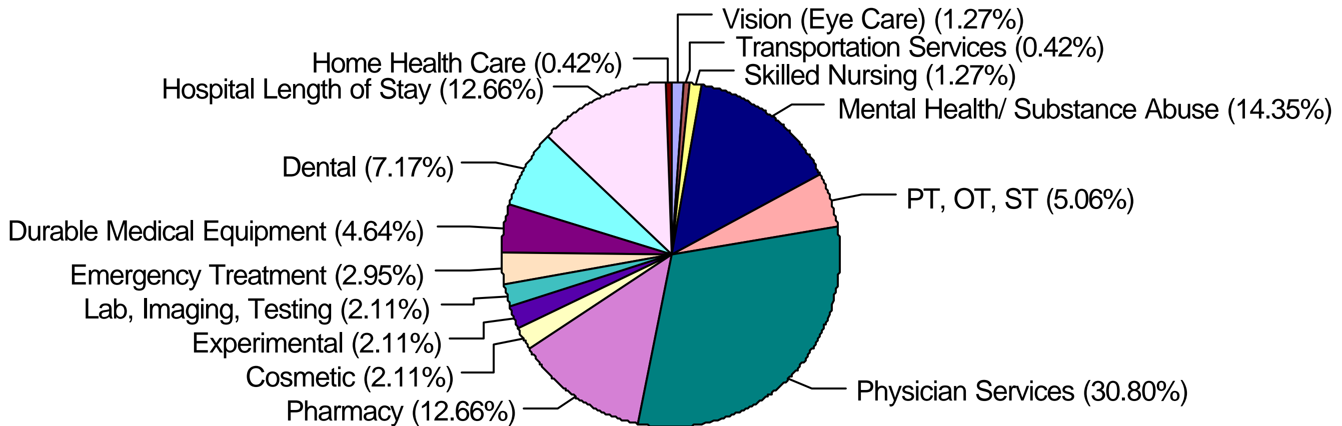
Results of MIA Orders FY 2003



MIA issued 206 orders related to Appeals and Grievances Complaints during FY 2003. This chart describes the outcomes of those orders.

MIA Appeals and Grievances Complaints

Type of Service Involved in Complaints
FY 2003



The above chart identifies the types of services involved in Appeals and Grievances Complaints handled by MIA during FY 2003.

* Includes Acupuncture, Assisted Living, Breast Reduction, Claim Payment, Experimen tal, Hospital Length of Stay, In-Patient Rehabilitation, Skilled Nursing and Transportation Services.

Outcomes of Complaints by Type of Service

FY 2003

Type of Procedure	Total	Carrier Upheld by MIA		Carrier Overturned by MIA		Carrier Modified by MIA		Carrier Reversed Itself During Investigation	
Cosmetic	5	5	100%		0%		0%		0%
Dental	17	8	47%	1	6%	1	6%	7	41%
Durable Medical Equipment	11	3	27%	4	36%	0	0%	4	36%
Emergency Services	7	1	14%	2	29%	0	0%	4	57%
Experimental	5	3	60%	0	0%	2	40%	0	0%
Hospital Length of Stay	30	12	40%	11	37%	2	7%	5	17%
Home Health Care	1	1	100%	0	0%	0	0%	0	0%
Lab, Imaging, Testing	5	4	80%	0	0%	1	20%	0	0%
Mental Health/Substance Abuse Service	34	13	38%	7	21%	4	12%	10	29%
Pharmacy	30	14	47%	3	10%	0	0%	13	43%
Physician Services	73	58	79%	0	0%	0	0%	15	21%
PT, OT, ST	12	5	42%	2	17%	2	17%	3	25%
Skilled Nursing	3	3	100%	0	0%	0	0%	0	0%
Transportation Services	1	1	100%	0	0%	0	0%	0	0%
Vision (Eye Care)	3	2	66%	0	0%	0	0%	1	33%
TOTAL	**237**	**131**	**55%**	**30**	**13%**	**12**	**5%**	**61**	**26%**

This chart shows the outcomes of Appeals and Grievances Complaints handled by MIA during FY 2003. It shows how the outcome varies based upon the types of services involved in the complaints.

HEAU Appeals and Grievances Cases

Cases Listed by Carrier

FY 2003

HEAU Appeals & Grievances Cases by Carrier		Total	Upheld		Overturned/Modified	
Aetna US Healthcare	Not State Regulated	28	13	46%	15	54%
	State Regulated	22	8	36%	14	64%
	Total HEAU Complaints	**50**	**21**	**42%**	**29**	**58%**
Alliance	Not State Regulated	0	0	0%	0	0%
	State Regulated	2	0	0%	2	100%
	Total HEAU Complaints	**2**	**0**	**0%**	**2**	**100%**
American Republic Insurance Company	Not State Regulated	0	0	0%	0	0%
	State Regulated	1	1	100%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
Amerigroup	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
Blue Cross Blue Shield Of Delaware	Not State Regulated	1	1	100%	0	0%
	State Regulated	1	0	0%	1	100%
	Total HEAU Complaints	**2**	**1**	**50%**	**1**	**50%**
Blue Cross Blue Shield Of Maryland	Not State Regulated	17	7	41%	10	59%
	State Regulated	22	9	41%	13	59%
	Total HEAU Complaints	**39**	**16**	**41%**	**23**	**59%**
Blue Cross Blue Shield Of Michigan	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
Blue Cross Blue Shield Of MN	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
Blue Cross Blue Shield Of the National Capital Area	Not State Regulated	1	1	100%	0	0%
	State Regulated	2	1	50%	1	50%
	Total HEAU Complaints	**3**	**2**	**67%**	**1**	**33%**
Blue Cross Ble Shield Of the Rochester Area	Not State Regulated	1	0	0%	1	100%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
Bureau of Wholesale Sales Representatives	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
Capital Care	Not State Regulated	2	2	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**2**	**2**	**100%**	**0**	**0%**

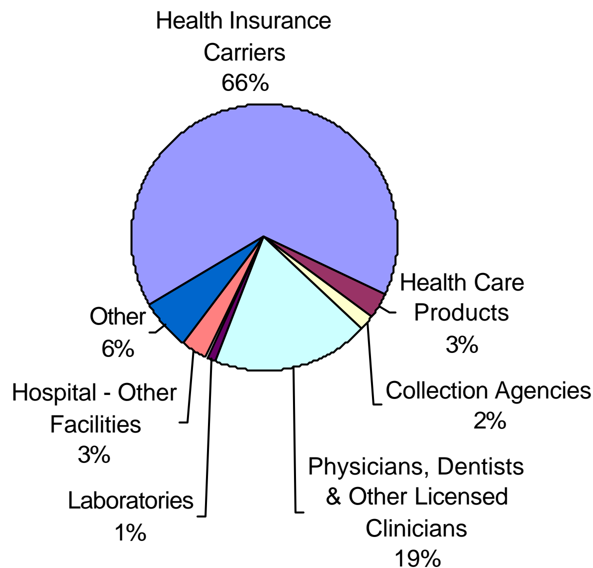
HEAU Appeals & Grievances Cases by Carrier		Total	Upheld		Overturned/Modified	
Carday	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
CareFirst	Not State Regulated	62	30	48%	32	52%
	State Regulated	117	46	39%	71	61%
	Total HEAU Complaints	**179**	**76**	**42%**	**103**	**58%**
CareFirst Administrators	Not State Regulated	1	0	0%	1	100%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
CHC Industries Inc.	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
CIGNA	Not State Regulated	21	9	43%	12	57%
	State Regulated	15	4	27%	11	73%
	Total HEAU Complaints	**36**	**13**	**36%**	**23**	**64%**
CIGNA Dental	Not State Regulated	1	1	100%	0	0%
	State Regulated	2	1	50%	1	50%
	Total HEAU Complaints	**3**	**2**	**67%**	**1**	**33%**
COBRAsource, Inc.	Not State Regulated	1	0	0%	1	100%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
Connecticut General Life Insurance Company	Not State Regulated	2	2	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**2**	**2**	**100%**	**0**	**0%**
Coventry Health Care	Not State Regulated	1	1	100%	0	0%
	State Regulated	2	0	0%	2	100%
	Total HEAU Complaints	**3**	**1**	**33%**	**2**	**67%**
Delmarva Health Plan	Not State Regulated	0	0	0%	0	0%
	State Regulated	1	0	0%	1	100%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
Electrical Welfare Trust Fund	Not State Regulated	1	0	0%	1	100%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
Empire Blue Cross Blue Shield	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
Fidelity Insurance	Not State Regulated	2	1	50%	1	50%
	State Regulated	2	0	0%	2	100%
	Total HEAU Complaints	**4**	**1**	**25%**	**3**	**75%**

HEAU Appeals & Grievances Cases by Carrier		Total	Upheld		Overturned/Modified	
	Not State Regulated	2	2	100%	0	0%
Fortis Benefits	State Regulated	1	0	0%	1	100%
	Total HEAU Complaints	**3**	**2**	**67%**	**1**	**33%**
	Not State Regulated	2	0	0%	2	100%
FreeState Health Plan	State Regulated	8	3	38%	5	63%
	Total HEAU Complaints	**10**	**3**	**30%**	**7**	**70%**
	Not State Regulated	1	0	0%	1	100%
GE Group Administrators	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
	Not State Regulated	1	0	0%	1	100%
GIC Indemnity Plan	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
	Not State Regulated	1	1	100%	0	0%
Golden Rule Insurance	State Regulated	2	1	50%	1	50%
	Total HEAU Complaints	**3**	**2**	**67%**	**1**	**33%**
	Not State Regulated	2	0	0%	2	100%
Government Employees Hospital	State Regulated	0	0	0%	0	0%
Association (GEHA)	**Total HEAU Complaints**	**2**	**0**	**0%**	**2**	**100%**
	Not State Regulated	1	0	0%	1	100%
Group Benefit Services, Inc.	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
	Not State Regulated	1	1	100%	0	0%
Guardian Insurance Company	State Regulated	3	0	0%	3	100%
	Total HEAU Complaints	**4**	**1**	**25%**	**3**	**75%**
	Not State Regulated	0	0	0%	0	0%
Guardian Life Insurance Co.	State Regulated	1	0	0%	1	100%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
	Not State Regulated	1	0	0%	1	100%
Guardian Life Insurance	State Regulated	0	0	0%	0	0%
Company of America	**Total HEAU Complaints**	**1**	**0**	**0%**	**1**	**100%**
	Not State Regulated	2	2	100%	0	0%
InforMed	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**2**	**2**	**100%**	**0**	**0%**
	Not State Regulated	8	3	38%	5	63%
Kaiser Permanente	State Regulated	26	7	27%	19	73%
	Total HEAU Complaints	**34**	**10**	**29%**	**24**	**71%**
	Not State Regulated	0	0	0%	0	0%
Mail Handlers Benefit Plan	State Regulated	1	1	100%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**

HEAU Appeals & Grievances Cases by Carrier		Total	Upheld		Overturned/Modified	
	Not State Regulated	11	8	73%	3	27%
MAMSI Life & Health Insurance	State Regulated	46	28	61%	18	39%
Company	**Total HEAU Complaints**	**57**	**36**	**63%**	**21**	**37%**
	Not State Regulated	11	9	82%	2	18%
MDIPA	State Regulated	7	5	71%	2	29%
	Total HEAU Complaints	**18**	**14**	**78%**	**4**	**22%**
	Not State Regulated	2	0	0%	2	100%
Medicare	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**2**	**0**	**0%**	**2**	**100%**
	Not State Regulated	3	1	33%	2	67%
Medicare Part B Trailblazers	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**3**	**1**	**33%**	**2**	**67%**
	Not State Regulated	0	0	0%	0	0%
MediChoice Maryland, Elder	State Regulated	1	0	0%	1	100%
Health Maryland, HMO, Inc.	**Total HEAU Complaints**	**1**	**0**	**0%**	**1**	**100%**
	Not State Regulated	0	0	0%	0	0%
MEGA Life & Health Insurance	State Regulated	1	0	0%	1	100%
Company	**Total HEAU Complaints**	**1**	**0**	**0%**	**1**	**100%**
	Not State Regulated	1	1	100%	0	0%
Metlife	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
	Not State Regulated	1	1	100%	0	0%
NCAS	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
	Not State Regulated	3	1	33%	2	67%
One Health Plan	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**3**	**1**	**33%**	**2**	**67%**
	Not State Regulated	13	11	85%	2	15%
Optimum Choice	State Regulated	42	20	48%	22	52%
	Total HEAU Complaints	**55**	**31**	**56%**	**24**	**44%**
	Not State Regulated	1	0	0%	1	100%
Performax	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
	Not State Regulated	4	0	0%	4	100%
Preferred Health Network	State Regulated	6	5	83%	1	17%
	Total HEAU Complaints	**10**	**5**	**50%**	**5**	**50%**
	Not State Regulated	0	0	0%	0	0%
Private Healthcare Systems	State Regulated	1	0	0%	1	100%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**

HEAU Appeals & Grievances Cases by Carrier		Total	Upheld		Overturned/Modified	
St. John's College Health Care Benefit Plan	Not State Regulated	1	0	0%	1	100%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
TennCare Appeals Unit	Not State Regulated	1	0	0%	1	100%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
Tricare	Not State Regulated	2	1	50%	1	50%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**2**	**1**	**50%**	**1**	**50%**
UNICARE	Not State Regulated	2	2	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**2**	**2**	**100%**	**0**	**0%**
Uniformed Services Family Health Plan	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
United Concordia Companies, Inc.	Not State Regulated	3	2	67%	1	33%
	State Regulated	1	0	0%	1	100%
	Total HEAU Complaints	**4**	**2**	**50%**	**2**	**50%**
United Food and Commercial Workers Union	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
United Healthcare	Not State Regulated	10	5	50%	5	50%
	State Regulated	27	6	22%	21	78%
	Total HEAU Complaints	**37**	**11**	**30%**	**26**	**70%**
United Healthcare of the Mid-Atlantic	Not State Regulated	2	2	100%	0	0%
	State Regulated	7	1	14%	6	86%
	Total HEAU Complaints	**9**	**3**	**33%**	**6**	**67%**
Value Options Health	Not State Regulated	1	0	0%	1	100%
	State Regulated	1	0	0%	1	100%
	Total HEAU Complaints	**2**	**0**	**0%**	**2**	**100%**
Vision Service Plan	Not State Regulated	1	0	0%	1	100%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
Total	**Not State Regulated**	**246**	**130**	**53%**	**116**	**47%**
	State Regulated	**371**	**147**	**40%**	**224**	**60%**
	Total HEAU Complaints	**617**	**277**	**45%**	**340**	**55%**

HEAU Cases
Who Are Cases Filed Against?
FY 2003

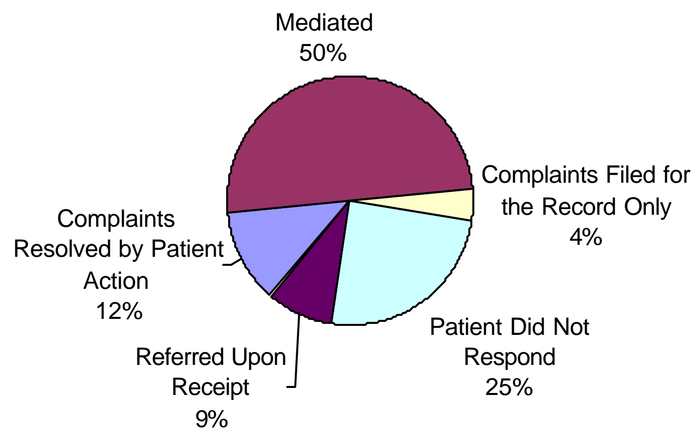


The HEAU mediates several types of patient disputes with health care providers and health insurance carriers. Most complaints involve provider billing or insurance coverage issues, but HEAU cases also involve helping patients obtain copies of their medical records, mediating disputes related to sales and service problems with health care products and assisting patients with various other problems encountered in the healthcare marketplace. This chart shows the types of industries against which complaints were filed with HEAU during FY 2003.

HEAU Appeals and Grievances Cases

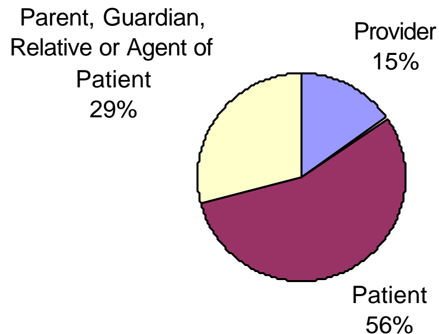
Disposition of Cases

FY 2003



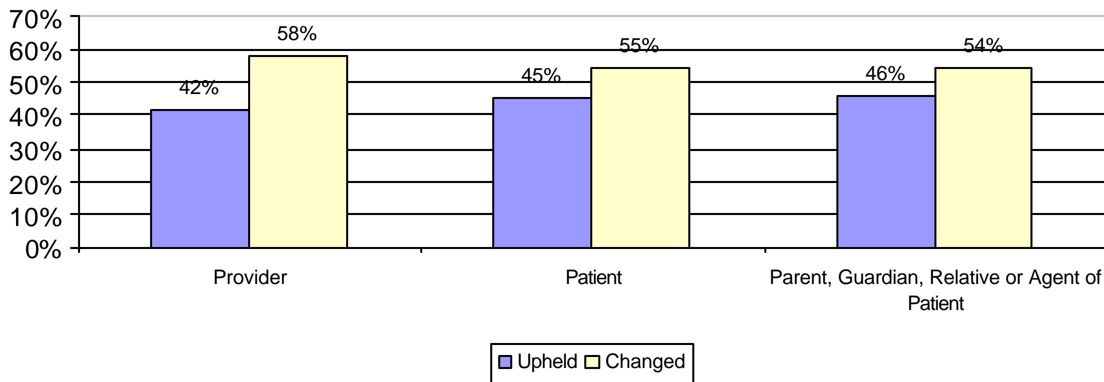
The HEAU closed 1,233 cases related to patients who disputed carrier adverse decisions. However, not all of these cases were mediated by HEAU. While the majority of these cases were mediated, some were filed for the record only and others were resolved by patients without direct HEAU assistance. 25% of the cases were withdrawn or there was not enough information to proceed. This chart shows the disposition of all Appeals and Grievances cases closed by HEAU during FY 2003.

HEAU Appeals and Grievances Cases
Who Filed Case?
FY 2003

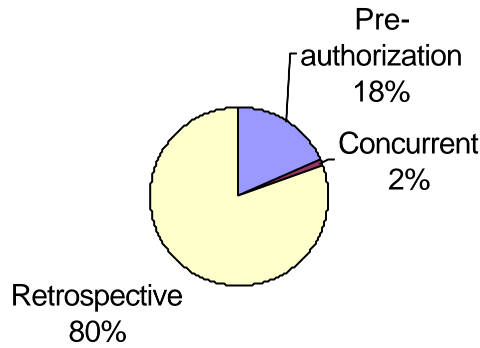


Cases may be filed on behalf of patients by providers, parents, relatives or other agents of patients. The above chart indicates who filed cases with HEAU.

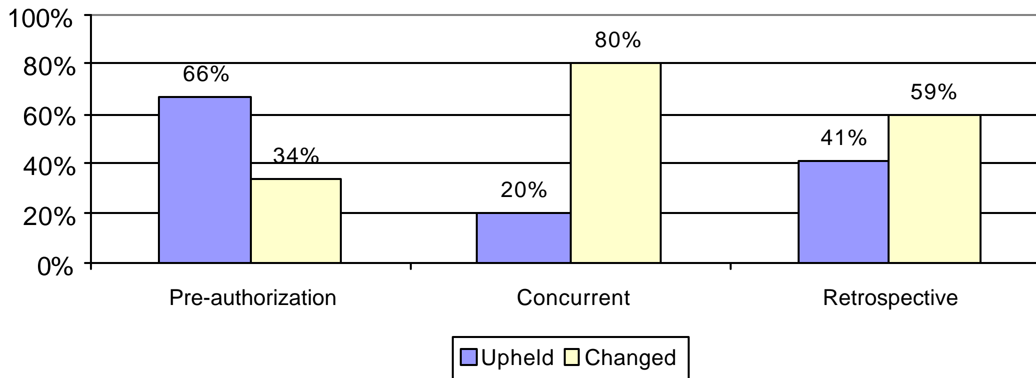
Outcomes Based Upon Who Filed Case
FY 2003



This chart shows the outcome of Appeals and Grievances Cases mediated by HEAU during FY 2003. Cases resulting in carriers overturning or modifying adverse decisions have been combined for this chart.

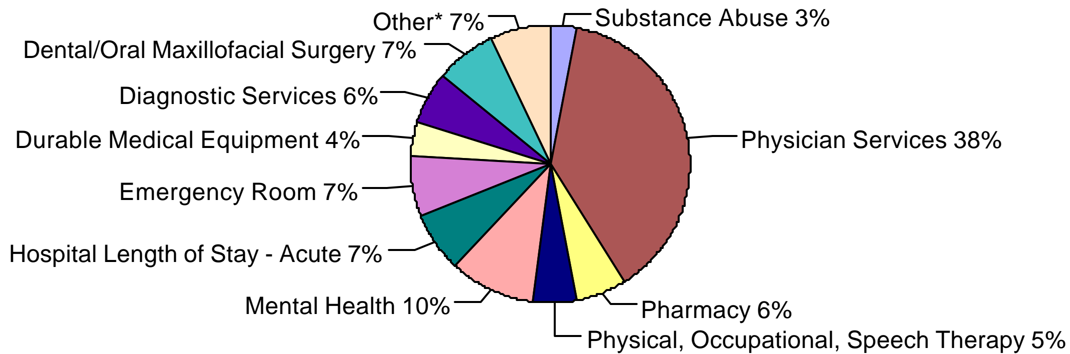


Carriers may issue adverse decisions before (pre-authorization), during (concurrent) or after (retrospective) treatment. This chart indicates when the adverse decisions were issued in Appeals and Grievances Cases mediated by HEAU during FY 2003.



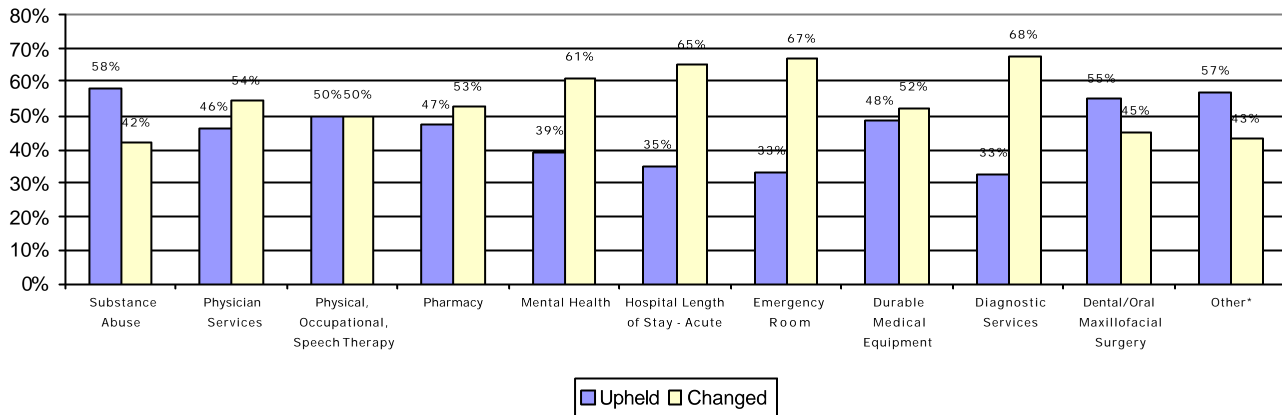
This chart shows the outcomes of Appeals and Grievances Cases mediated by HEAU during FY 2003.

HEAU Appeals and Grievances Cases
Type of Service Involved in Cases
FY 2003



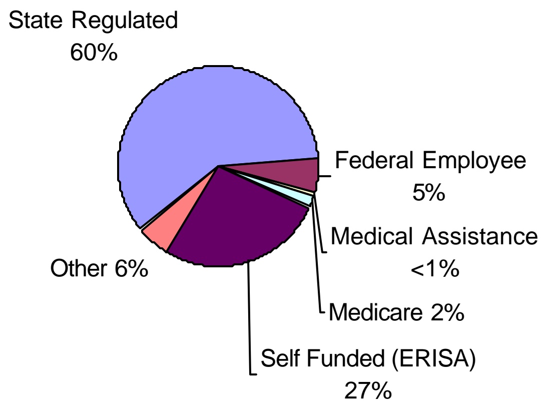
The above chart identifies the types of services involved in Appeals and Grievances cases mediated by HEAU during FY 2003.

Outcomes of Cases by Type of Service
FY 2003

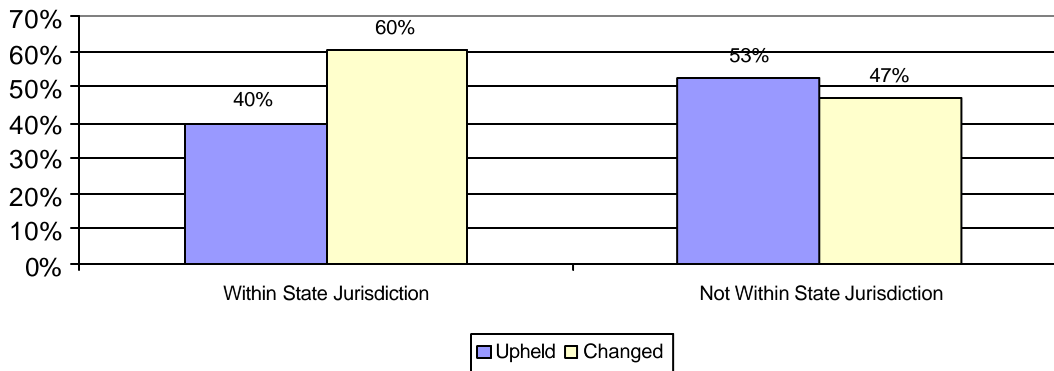


This chart shows the outcomes of Appeals and Grievances cases mediated by HEAU during FY 2003. It shows how the outcome varies based upon the types of services involved in the cases. Cases resulting in carriers overturning or modifying adverse decisions have been combined for this chart.

* In both of the above charts, Other includes: Acupuncture, Chiropractic, Habilitative Services, Home Health, Optometry, Products and Supplements, Skilled Nursing Facility, Transport and Other cases where the Type of Service did not fit an existing category.



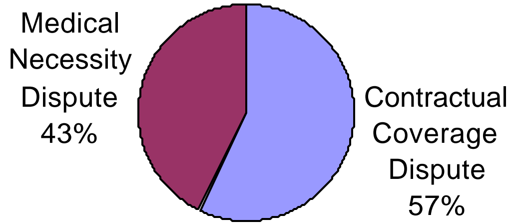
The above chart identifies the types of carriers involved in the Appeals and Grievances cases mediated by HEAU during FY 2003.



This chart shows the outcomes of Appeals and Grievances cases mediated by HEAU during FY 2003. It shows how the outcome varies based upon whether the carrier is within state jurisdiction*.

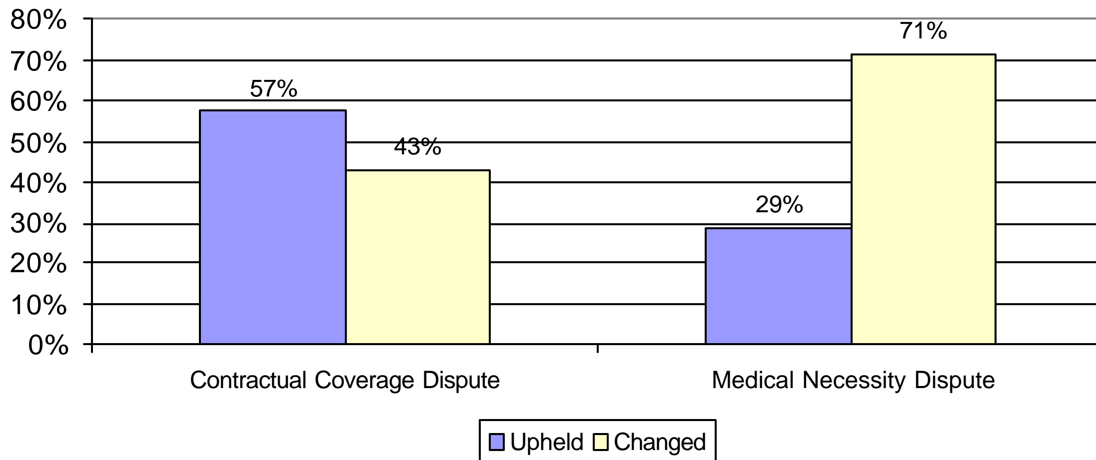
* Carriers not within state jurisdiction include Self-insured, Federal Employee, Medical Assistance, Medicare, Military and Out-of-State plans.

HEAU Appeals and Grievances Cases
Cases by Type of Decision
FY 2003



The above chart identifies the percentage of medical necessity and contractual coverage disputes for the Appeals and Grievances cases mediated by HEAU during FY 2003.

Outcomes of Cases by Type of Decision
FY 2003



This chart compares the outcomes of medical necessity and contractual coverage disputes.