2022 Report on Independent Dispute Resolution (IDR), In-Network Providers and Denied Claims

Prepared by the Maine Bureau of Insurance
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The 129th Legislature enacted P.L. 2019, chapter 668, "An Act to Protect Consumers From Surprise Emergency Bills." The law established a process for healthcare providers, persons covered by self-insured/ERISA plans, and certain uninsured patients to request resolution of disputes that involve bills for covered emergency services rendered by out-of-network providers. The Bureau of Insurance contracted with Maximus Federal Services to facilitate the independent dispute resolution (IDR) process under 24-A M.R.S. § 4303-E(1) and Bureau of Insurance Rule Chapter 365.

Under 24-A M.R.S. § 4303-E(4), the Superintendent of Insurance must annually report to the Legislature regarding the IDR process and related topics (see Appendix A). For this report, we requested that all health carriers with more than 1,000 covered lives -- as reported to the Bureau under Rule 940 and 945 -- submit the required information. Specifically, we requested the following information:

- Total Annual Amount Spent on Emergency Out-of-Network Costs
- Number of Claims Submitted
- Number of Claims Denied
- Number of Claim Denials by Reason:
    - Coding Error
    - Duplicate Claim
    - Medical Necessity/Experimental
    - More Information Needed to Complete Claim
    - No Prior Authorization
    - Out-of-Network Provider
    - Patient Covered by Medicare/Other Health Plan
    - Services Before/After Coverage in Effect
    - Services Not Covered
    - Time for Claim Filing Expired
    - Other (specified)
- Number of Downcoded Claims by Reason:
    - Diagnostic Information Does Not Meet Claim Billed
    - Errors in Transcription
    - Incorrect Codes Used
    - Services Bundled
    - Other (Specified)
- Number of In-Network Facilities
- Number of In-Network Providers in the following Specialties:
    - Behavioral Health
    - Gynecology/Obstetrics
    - Cardiology
    - Dermatology
    - Ophthalmology
    - Orthopedic Surgery
    - Gastroenterology

For the report, we defined "downcoding" as "the alteration by plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower Qualifying Payment Amount (QPA) than the service

code or modifier billed by the provider or facility,"[1] and "facility" as "any public or private hospital, clinic, center, medical school, medical training institute, health care facility, physician's office, infirmary, dispensary, ambulatory surgical center, or other institution or location where medical or mental health care is provided to any person."

Maximus provided the information in item number one, shown below. For cases in 2022, providers often bundled claims on the IDR portal. Some bundled claims involved claims from both self-insured and fully funded plans, which had to be separated. As of March 2023, we adjusted the portal to allow only one patient per case and to prohibit bundling.

The Bureau developed an online form for carriers to complete; the form and instructions are provided as Appendix B. The information for items two through six below are the carriers' responses to that form. Items seven and eight are based on the Bureau's information.

The information provided in this report is for the period of January 1, 2022 through December 31, 2022.

We received responses from: Aetna Life Insurance Company, Anthem of Maine, Community Health Options, Harvard Pilgrim Health Care, HPHC Insurance Company Inc., and United Health Care. Although Cigna Health Care administers self-insured plans that may participate in IDR pursuant to 24-A M.R.S. § 4303-E(2), only insurers that meet the definition of "carrier" in 24-A M.R.S. § 4301-A(3)[2] are required to report information to the Bureau. We requested that carriers provide responses in the aggregate for their Maine business and not at the plan specific level.

These are the responses to the information requested in 24-A M.R.S. § 4303-E(4):

1) The number of independent dispute resolutions in 2022:

There were twenty (20) requests for Independent Dispute Resolution. One (1) request was withdrawn. Six (6) requests were dismissed because they involved self-funded plans. Two (2) cases involving a combination of self-funded and fully-insured claims were partially dismissed. Seven (7) cases were dismissed because the plan/patient was not sitused in Maine.

Of the eligible cases, two decisions were made in favor of the respondent health plan and two in favor of the provider applicant. The decided cases involved neonatology, general surgery and orthopedics. The following chart shows the amounts of initial final offers from the provider, the insurer's final offer, and the amount awarded to the provider through IDR:

[1] 45 CFR § 149.140 (a)(18).

[2] "Carrier" is defined as: "A. An insurance company licensed in accordance with this Title to provide health insurance; B. A health maintenance organization licensed pursuant to chapter 56; C. A preferred provider arrangement administrator registered pursuant to chapter 32; D. A fraternal benefit society, as defined by section 4101; E. A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24; F. A multiple-employer welfare arrangement licensed pursuant to chapter 81; G. A self-insured employer subject to state regulation as described in section 2848-A; or H. Notwithstanding any other provision of this Title, an entity offering coverage in this State that is subject to the requirements of the federal Affordable Care Act.

Case [3]	Initiating Final Offer	Responding Final Offer	Case Decision Amount
4259	$147,108.62	$52,101.08	$46, 787.23
4410	$17,055.00	No response from health plan	$17,055.00
4452	$18, 471.60	No response from health plan	$18, 471.60
4458	$45,907.00	$1,115.60	$1,115.60

2) The total annual amount of spending on out-of-network emergency costs:

Carrier	Amount
A	$2,661,702
B	$1,166,060
C	$36,726
D	$24, 141
E	$211,062
F	$20,765
G	$2,074,064

3) The aggregate number of in-network high-volume specialists practicing in Maine, per carrier:

	Facilities	Behavioral Health	OB/ GYN	Cardiology	Dermatology	Ophthalmology	Orthopedic Surgery	Gastroenterology
A	4,062	3,216	246	177	68	92	182	87
B	6,988	2,546	170	148	45	82	137	64
C	3,815	3,749	180	55	61	87	155	67
D	183	2,002	173	180	50	79	126	79
E	183	2,002	173	180	50	79	126	79
F	2,193	2,405	238	185	67	91	210	96
G	3,216	441	296	187	43	117	207	88

4) Total number of provider-submitted claims and total number of denials, by carrier:

	Total Provider Claims	Total Denied Provider Claims
A	1,645,366	143,864
B	683,828	31,334
C	641	88
D	2,381	2,164
E	2,595	2,179
F	286,341	52,804
G	3, 206,155	12,848

[3] In addition to those discussed in the narrative, some of these cases represent bundled claims with a combination of fully-funded and self-funded plans.

5) The number of provider-submitted claims that were denied and the applicable reason, by carrier:

	Coding	Dupe	Experi-mental/ Not Medically Necessary	More Info Needed	No Prior Auth	Out of Network Provider	Other Plan	Before/After Effective Date	Services Not Covered	Time Expired	Other
A	5,378	27,495	498	10,773	1,196	1,227	3,830	18,529	7,935	7,704	59,299[4]
B	5,889	2,398	0	1,800	4,103	841	1,007	8,106	4,341	2,463	386[5]
C	9	42	2	4	0	0	0	11	19	1	0
D	770	37	10	67	39	797	0	1	21	7	415[6]
E	775	36	10	67	39	797	0	1	26	13	415[7]
F	8,915	9,468	665	16,398	1,644	1,319	2,560	4,145	3,472	1	4,217[8]
G	14	480	3,554	2,430	1,798	968	183	889	444	1,115	973[9]

6) The number of provider-submitted claims that were downcoded and the applicable reason:

	Diagnosis info doesn't meet claim billed	Errors in Transcription	Inadequate Documentation	Wrong Code	Bundled	Other	Total
A	47	0	0	0	0	0	**47**
B	22	0	0	4	132	0	**168**
C	0	0	15	0	0	0	**15**
D	0	0	0	0	0	0	**0**
E	0	0	0	10	0	0	**0**
F	31	8	14	10	0	22[10]	**85**
G	0	0	0	244	121	81[11]	**446**

7) The number of written complaints the Consumer Health Care Division received in 2022 relating to out-of-network health care charges: *10*

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[4] Most common reasons for "Other" response: adjustment made to original submission: 29, 999; System generated RAC (Reject Action Code) EOB detail checked: 19,020; Unknown: 2,579; Denied due to bundling: 1,722; Claim in Second/Third month of Grace Period: 1,242; Resubmit Claim to Related Company: 929; Original claim processed incorrectly: 870; Other reasons: 68.

[5] Most common reasons for "Other" response: benefit maximum reached: 386

[6] Most common reasons for "Other" response: Service Fee Less Than Charges: 263; Pay Zero, Included In Other Line: 169; Reduced Allowable: 96; Deny All Claim Lines: 32 ; Required Info Not Received (within 45 days): 11; Increased Allowable: 5; Out of Pocket Maximum Reached: 3; Pro Fee Can Not Be Processed w/out Facility Claim: 3; Rendering Clinician Not Credentialed: 3.

[7] Most common reasons for "Other" response: Service Fee Less Than Charges: 263; Pay Zero, Included In Other Line: 169; Reduced Allowable: 96; Deny All Claim Lines: 32; Required Info Not Received (within 45 days): 11; Increased Allowable: 5; Out of Pocket Maximum Reached: 3; Pro Fee Can Not Be Processed w/out Facility Claim; 3; Rendering Clinician Not Credentialed: 3.

[8] Most common reasons for "Other" response: Dependent Not Covered under Plan: 239, Benefits exceeded plan limits: 3978

[9] Most common reasons for "Other" response: Member not effective: 294; Provider Billed Incorrectly: 679

[10] Unbundled claims

[11] Drug testing code exceeds limit of seven drug classes per date of service: 81

8) An analysis of the impact of IDR, with respect to both emergency services and other health care services, on premium affordability and the breadth of provider networks:

IDR is only available for out-of-network emergency services. Thus, IDR would not directly impact the cost of other out-of-network services. During 2022, the IDR process was not used sufficiently to have impact on premium affordability or provider networks.

Summary

Some providers are using the independent dispute resolution process to resolve out-of-network emergency bills. During 2022, 20 cases were initiated but the majority were dismissed as ineligible. We are unsure whether this means that providers are satisfied with the amount carriers are paying for out-of-network emergency services or whether the IDR process is still too new and out-of-network providers are charging patients what the carrier does not pay.

Appendix A

§4303-E. Dispute resolution process for surprise bills and bills for out-of-network emergency services

1. Independent dispute resolution process. The superintendent shall establish an independent dispute resolution process by which a dispute for a surprise bill for emergency services or a bill for covered emergency services rendered by an out-of-network provider in accordance with section 4303-C, subsection 2 may be resolved as provided in this subsection beginning no later than October 1, 2020.

A. The superintendent may select an independent dispute resolution entity to conduct the dispute resolution process. The superintendent shall adopt rules to implement a dispute resolution process that uses a standard arbitration form and includes the selection of an arbitrator from a list of qualified arbitrators developed pursuant to the rules. A qualified arbitrator must be independent; may not be affiliated with a carrier, health care facility or provider or any professional association of carriers, health care facilities or providers; may not have a personal, professional or financial conflict with any parties to the arbitration; and must have experience in health care billing and reimbursement rates. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

B. An independent dispute resolution entity shall make a decision within 30 days of receipt of the dispute for review.

C. In determining a reasonable fee for the health care services rendered, an independent dispute resolution entity shall select either the carrier's payment or the out-of-network provider's fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in this paragraph. In determining the reasonable fee for a health care service, an independent dispute resolution entity shall consider all relevant factors, including:

(1) The out-of-network provider's level of training, education, specialization, quality and experience and, in the case of a hospital, the teaching staff, scope of services and case mix;

(2) The out-of-network provider's previously contracted rate with the carrier, if the provider had a contract with the carrier that was terminated or expired within one year prior to the dispute; and

(3) The median network rate for the particular health care service performed by a provider in the same or similar specialty, as determined by the all-payer claims database maintained by the Maine Health Data Organization or, if Maine Health Data Organization claims data is insufficient or otherwise inapplicable, another independent medical claims database. If authorized by rule, the superintendent may enter into an agreement to obtain data from an independent medical claims database to carry out the functions of this subparagraph.

D. If an independent dispute resolution entity determines, based on the carrier's payment and the out-of-network provider's fee, that a settlement between the carrier and out-of-network provider is reasonably likely, or that both the carrier's payment and the out-of-network provider's fee represent unreasonable extremes, the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The carrier and out-of-network provider may be granted up to 10 business days for this negotiation, which runs concurrently with the 30-day period for dispute resolution.

E. The determination of an independent dispute resolution entity is binding on the carrier, out-of-network provider and enrollee and is admissible in any court proceeding between the carrier, out-of-network provider and enrollee or in any administrative proceeding between this State and the provider.

F. When an independent dispute resolution entity determines the carrier's payment is reasonable, payment for the dispute resolution process is the responsibility of the out-of-network provider. When the independent dispute resolution entity determines the out-of-network provider's fee is reasonable, payment for the dispute resolution process is the responsibility of the carrier. When a good faith negotiation directed by the independent dispute resolution entity results in a settlement between the carrier and the out-of-network provider, the carrier and the out-of-network provider shall evenly divide and share the prorated cost for dispute resolution.

G.

H. The superintendent shall enforce the determination of an independent dispute resolution entity pursuant to this subsection or any agreement made by a carrier and an out-of-network provider after the conclusion of the independent dispute resolution process pursuant to this subsection. The superintendent may use any powers provided to the superintendent under this Title.

I. Following a determination by an independent dispute resolution entity of a reasonable fee for a particular health care service, an out-of-network provider may not initiate the dispute resolution process under this subsection for that same health care service for a period of 90 days.

2. Self-insured health benefit plans. An entity providing or administering a self-insured health benefit plan exempted from the applicability of this section under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) may elect to be subject to the provisions of this section to resolve disputes with respect to a surprise bill for emergency services or a bill for covered emergency services from an out-of-network provider. In the event an entity providing or administering a self-insured health benefit plan elects to be subject to the provisions of this section, the provisions of this section apply to a self-insured health benefit plan and its members in the same manner as the provisions of this section apply to a carrier and its enrollees. To elect to be subject to the provisions of this section, the entity shall provide notice, on an annual basis, to the superintendent, on a form and in a manner prescribed by the superintendent, attesting to the entity's participation and agreeing to be bound by the provisions of this section. The entity shall amend the health benefit plan, coverage policies, contracts and any other plan documents to reflect that the provisions of this section apply to the plan's members.

3. Information required from carriers. As part of the carrier's annual public regulatory filings made to the superintendent, a carrier shall submit in a form and manner determined by the superintendent information related to:

A. The use of out-of-network providers by enrollees and the impact on premium affordability and benefit design; and [PL 2019, c. 668, §3 (NEW).]

B. The number of claims submitted by a provider to the carrier that are denied or down coded by the carrier and the reason for the denial or down coding determination.

4. Report from superintendent. On or before January 31st annually, beginning January 1, 2022, the superintendent shall report the following information received from all carriers in the aggregate:

A. The number of requests for independent dispute resolution filed pursuant to this section between January 1st and December 31st of the previous calendar year, including the percentage of all claims that were subject to dispute. For each independent dispute resolution determination, the carrier shall provide aggregate information that does not identify any provider, carrier, enrollee or uninsured patient involved in each determination about:

(1) Whether the determination was in favor of the carrier, out-of-network provider or uninsured patient;

(2) The payment amount offered by each side of the independent dispute resolution process and the award amount from the independent dispute resolution determination;

(3) The category and practice specialty of each out-of-network provider involved, as applicable; and

(4) A description of the health care service that was subject to dispute;

B. The percentage of facilities and hospital-based professionals, by specialty, that are in network for each carrier in this State as reported in access plans submitted to the superintendent;

C. The number of complaints the superintendent receives relating to out-of-network health care charges;

D. Annual trends on health benefit plan premium rates, the total annual amount of spending on inadvertent and emergency out-of-network costs by carriers and medical loss ratios in the State to the extent that the information is available;

E. The number of physician specialists practicing in the State in a particular specialty and whether they are in network or out of network with respect to the carriers that administer the state employee group health plan under Title 5, section 285, the Maine Education Association benefits trust health plan, the qualified health plans offered pursuant to the federal Affordable Care Act and other health benefit plans offered in the State;

F. A summary of the information submitted to the superintendent pursuant to subsection 3 concerning the number of claims submitted by health care providers to carriers that are denied or down coded by the carrier and the reasons for the denials or down coding determinations;

G. An analysis of the impact of this section, with respect to both emergency services and other health care services, on premium affordability and the breadth of provider networks; and

H. Any other benchmarks or information that the superintendent considers appropriate to make publicly available to further the goals of this section.

The superintendent shall submit the report to the joint standing committee of the Legislature having jurisdiction over health insurance matters and shall post the report on the bureau's publicly accessible website.