# AMCNO Meets with Ohio Department of Insurance Regarding Prompt Pay and External Review Issues

## Assists in Development of Toolkit for Consumers and Providers

The Ohio Department of Insurance (ODI) has continued to work with provider organizations on prompt pay and external review issues. The most recent meeting in January 2009 concerned transparency matters, specifically, the reporting of data collected by ODI to the public.

**Consumer Complaints**
The Consumer Services Division outlined how consumers could file a complaint with ODI noting that just over 42% of their total consumer complaints are healthcare-related — the others are for personal auto carrier complaints, home carrier complaints and life and annuity carrier complaints. The most common reasons for healthcare claim complaints by consumers were claim denials, claim settlement unsatisfactory offer, claim settlement payment delay, premium and rating, coverage questions, premium refunds due and other health reasons. ODI is currently in the process of updating their data collection system in their consumer services division and asked for input on what type of consumer complaint data would be most helpful for reporting purposes.

**Physician Complaints**
In addition, the ODI staff that handles provider complaints discussed upcoming changes to the OCHAMP provider complaint filing system which will allow ODI to capture complaint information in more detail. For example, the comments section on the complaint form filled out by providers is somewhat limited so the ODI is planning to expand that section for additional comments as well as building an alert into the provider complaint form so that providers know how much time they have to complete the form before they "time out" on the ODI Web site. In addition, a case number will appear on the ODI site once the complaint has been accepted and a copy of the email sent by ODI to the insurer will be sent to providers once the complaint has been filed and sent.

ODI staff also noted that although they do not have the ability on their Web site to accept mass complaints about an insurer, providers can use the comments section to drill down on issues. So for example, a physician could file one complaint against an insurer and then indicate in the comments section that this complaint is only one of a large number of similar complaints the physician has against the company. A physician could also outline in the comments section if there are outstanding claim payments owed by a company which would add some additional information to each complaint filing.

**Market Conduct Review**
ODI staff from the market conduct division discussed changes to their upcoming prompt pay data call. This "prompt pay data call" had previously been conducted by ODI in the third quarter of each year. During this data call, ODI collected claims information for every single claim that a health insurance provider processed in that quarter and ODI conducted a review looking for violations of the Ohio prompt pay law. Some of the items reviewed by ODI were whether the claims were paid in 30 days, denied in 30 days, whether claims were paid beyond 30 days, if the claims were paid within 45 days, the limit of time for payment, whether there was any interest due on claims, etc.

In 2009, ODI plans to expand the prompt pay data call to give them more insight into these issues and they plan to ask the health insurance companies to provide their information by line of business — such as individual coverage or group coverage — to give ODI the opportunity to see if there is a trend on a specific line of business. The individual insurance information will not be made available to the public but if someone wanted the industry averages that can be provided. They do not collect data on self-insureds or Medicare Advantage plans.

**External Review**
ODI staff also provided information on the independent review process. The ODI staff stated that they are considering making de-identified outcome information available on their Web site that would include the results of the external reviews and could provide an analysis of a review decision inclusive of providing the clinical information used to make the decision on the claim, and the sources used to conduct the review and make a clinical decision. The group was of the opinion that this would be helpful and ODI staff indicated they would continue to review this concept along with the HIPAA issues and public record issues to determine how to proceed with this concept.

**Toolkit Launched**
One key point of interest mentioned at the meeting was the launch of an ODI toolkit to help Ohioans understand the process in which they can appeal a health coverage claim denial made by their insurer. The ODI is providing a link to the toolkit on their Web site. In addition, the AMCNO is also providing additional information to our members through our publications and email alerts.

The toolkit initiative — which includes helpful information for medical providers — was one of several topics to come from ongoing stakeholder meetings with representatives from the Department, insurance companies and associations, businesses, medical providers and consumer advocates. **The AMCNO has been an active participant in this process, inclusive of sending in changes to the toolkit prior to its publication and we are named as a contributor on the final publication.** The stakeholder group continues its work to improve the prompt pay process in which doctors are reimbursed by insurers and how consumers can more easily appeal certain health coverage claims denials, and in particular, through independent review organizations (IROs). To view the entire toolkit go to www.ohioinsurance.gov. ■