



DEPARTMENT OF

**Professional &  
Financial Regulation**

STATE OF MAINE

- OFFICE OF SECURITIES
- BUREAU OF INSURANCE
- CONSUMER CREDIT PROTECTION
- BUREAU OF FINANCIAL INSTITUTIONS
- OFFICE OF PROF. AND OCC. REGULATION

# **NEW CLAIMS PAYMENT PRACTICES**

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## **UNDER RULES 420 AND 425**

Maine Bureau of Insurance

Long-Term Care Insurance Forum  
May 9, 2016

# 24-A M.R.S. § 5083

- **New law - Payment of Claims**
  - (2013 Public Law Chapter 278) - Emergency legislation.
- **Establishes:**
  - notice requirements
  - time periods for claims payments
  - documentation
  - interest on overdue claims payments
- **Provides for:**
  - Appeals/external review
- **Burden on insurer:**
  - to obtain information not specified in statute reasonably necessary to pay claim.
- **Bureau amended LTC rules 420 and 425** effective 3/30/15.

# Payment of Claims

- **Documentation Required of Insured:**
  - ✓ Statement describing the claim
  - ✓ HIPAA release
  - ✓ Physician statement
  - ✓ LTC provider statement (including bill, license, nurse notes)
  - ✓ Power of Attorney
  - ✓ Other information reasonably necessary to evaluate claim.
- **Burden on Insurer:**
  - burden on insurer to obtain information (other than above) reasonably necessary to pay or continue paying claim (except for information solely in possession of insured).

# Insurer must pay claim within 30 days, or issue notice of denial

- **Notice must explain specific reason(s) for denial.**
- **Can Not delay payment beyond 30 days from receipt of information for “*technical issue*”:**
  - Defined as a procedural matter, not integral to determination of benefits.
  - Examples: forms that duplicate information, provider license number etc.
- **Can extend beyond 30 days for “*substantive issue*”:**
  - Defined as a matter integral to the determination of whether insured is eligible for benefits and that is essential for the insurer to decide claim.
  - Examples: documentation listed above, information unavailable to insurer from provider, or in sole possession of insured/representative.
- **Insurer may not delay resolution any longer than is reasonably necessary and must act expeditiously to obtain information.**

# Appeals – 1<sup>st</sup> Level

**Insured has right to both levels of internal appeal of any denied claim.**

- **Standard appeal (1<sup>st</sup> level):**
  - written request to insurer within 120 days of denial receipt.
- **Appeal panel:**
  - one or more qualified individuals designated by insurer who did not make original claim denial determination.
- **Timeline:** generally 30 days
- **Decision must be in writing and must contain:**
  - credentials of person(s)
  - statement of reviewer(s)' understanding of reason(s) for the appeal request
  - policy provisions at issue
  - reasoning in clear and detailed terms
  - reference to evidence and/or guideline used as decision basis
  - notice of subsequent appeal rights
  - right to contact Maine Bureau of Insurance

# Appeals – 2<sup>nd</sup> Level

- **Written request must be made to insurer within 120 days of receipt of standard appeal decision.**
- **Majority of decision panel must not be previously involved.**
- **Insured may request to appear before insurer via conference call, video conferencing or other appropriate technology.**
  - Meeting must be held within 45 days.
  - Insurer must notify insured at least 15 days in advance of date.
  - Insured has right to present case to panel, submit material, ask questions.
- **Timeline for decision:**
  - Generally 30 days after receipt of all information if no meeting requested.
  - If review meeting is requested, panel must issue decision within 5 working days of meeting.
- **Decision letter must include same type of information as decision for 1<sup>st</sup> level appeal.**

# External Review

## “Claim denial eligible for external review”

### 1) “Adverse benefit trigger determination”

Determination that the insured has not satisfied a required clinical standard for eligibility including:

- the existence/degree of cognitive impairment, chronic illness, or inability to perform one or more specified ADLs.

### 2) Claims denial that requires the exercise of professional judgement within the scope of practice of a health care professional in one of the following areas:

- Preexisting condition/disease;
- Mental/nervous disorders;
- Alcoholism/drug addiction;
- Illness/conditions arising from:
  - War, Participation in Felony/Riot, Service in Armed Forces, Suicide/Attempted suicide/Self-inflicted injury, Aviation

# External Review

- **Insured can request external review of a “claim denial eligible for external review”**
  - After completing both internal review levels.
  - By submitting written request to the Bureau of Insurance within 120 days after receipt of insurer’s final appeal decision.
  - Insured may participate by teleconference (or other reasonable means), submit material supporting claim, ask insurer questions.
  - Insurer bears cost of external review.
- **The Bureau oversees the external review process**
  - The Bureau contracts with independent external review organizations
  - Person conducting review must be a licensed health care professional qualified to determine an insured’s functional or cognitive impairment.
  - Can’t be employee of insurer, related to insured, or have provided care to insured.

# External Review

- **In rendering a decision the independent external review organization must consider:**
  - all relevant clinical information relating to insured's physical and mental condition;
  - relevant clinical standards and guidelines
- **Decision is issued within 30 days**
- **Decision is binding upon insurer only**