2024
Report

Claims - Complaints - Appeals
Mental Health, Substance Use Disorder
Benefits, Network Adequacy and
Comparative Analyses

Summary of 2023 Insurance Carrier Data

Submitted to the Senate Committee on Commerce and Labor and the House of Delegates Committee on Labor and Commerce,
pursuant to § 38.2-3412.1 G of the Code of Virginia

State Corporation Commission
Bureau of Insurance

November 1, 2024

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November 1, 2024

Transmitted via Email

The Honorable R. Creigh Deeds
Chair, Commerce and Labor Committee
Senate of Virginia

The Honorable Jeion A. Ward
Chair, Labor and Commerce Committee
Virginia House of Delegates

Members of the Senate Commerce and Labor Committee

Members of the House Labor and Commerce Committee

Dear Senator Deeds and Delegate Ward:

Pursuant to the requirements of § 38.2-3412.1 G of the Code of Virginia, the Bureau of Insurance submits this report containing aggregate health carrier data concerning denied claims, complaints, appeals, and network adequacy for mental health and substance use disorder benefits for the reporting period January 1, 2023 through December 31, 2023.

This report also includes a summary of all comparative analyses of Non-Quantitative Treatment Limitations prepared by health carriers pursuant to 42 U.S.C. § 300gg-26(a)(8) and requested by the Bureau of Insurance for the reporting period.

Sincerely,

Scott A. White
Commissioner of Insurance

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Executive Summary

As required by § 38.2-3412.1 B 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 must be in parity with medical and surgical benefits coverage.

The Bureau of Insurance has developed health carrier reporting requirements for mental health and substance use disorder benefits that include denied claims, complaints, appeals, and network adequacy, and compiled the information received into this report pursuant to § 38.2-3412.1 G of the Code of Virginia. In addition, this report includes a summary of all comparative analyses of Non-Quantitative Treatment Limitations prepared by health carriers pursuant to 42 U.S.C. § 300gg-26(a)(8) and requested by the Bureau of Insurance.

To gather the necessary information, the Bureau of Insurance conducted a data call of 16 health carriers insuring more than 2.48 million lives in the individual, small group, and large group health insurance markets in Virginia during 2023. Key takeaways include:

- In total, while the difference was small, carriers denied claims more often for substance use disorder benefits than for medical/surgical benefits and less often for mental health benefits. Carriers generally denied claims in fewer service categories (1 of 5) for mental health benefits and in more service categories (5 of 5) for substance use disorder benefits than claims for medical/surgical benefits.

- Denied claims involving mental health benefits were upheld by carriers in 55% of closed internal appeals and 44% of closed external reviews, compared to 61% and 51% for medical/surgical, and 77% and 67% for substance use disorder, respectively.

- The largest share of complaints differed across each benefit category. For medical/surgical benefits, claims processing accounted for 44.2% of the complaints; for mental health, administrative/service accounted for 40.9%; and for substance use disorders, utilization management accounted for 52.6%.

- Based on the data submitted by the health carriers and the existence of different standards for network adequacy, the Bureau of Insurance could not determine whether there is parity in network adequacy or compare access to network providers for mental health, substance use disorder, or medical/surgical benefits.

- The Bureau of Insurance is currently reviewing 320 comparative analyses of Non-Quantitative Treatment Limitations for this reporting period as part of the market conduct examination process. Therefore, no compliance determination has yet been made.

1. Introduction

As required by § 38.2-3412.1 B of the Code of Virginia (Code) and in accordance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, mental health and substance use disorder benefits provided by group and individual health insurance coverage must be in parity with medical and surgical benefits coverage. If a particular analysis of information presented in this report were to indicate a significantly higher rate of occurrence for a mental health or substance use disorder benefit than for a medical/surgical benefit, then the Bureau of Insurance (Bureau) might consider the carrier to be in noncompliance with the parity provisions as to that category of benefits.

In accordance with § 38.2-3412.1 G of the Code, the Bureau has developed carrier reporting requirements for mental health and substance use disorder benefits that include denied claims, complaints, appeals, and network adequacy, and compiled the information into this report. This report provides only aggregate data to protect the confidentiality of individual members since the legislation does not require carriers to be identified. In addition, as provided in the reporting requirement, this report also includes a summary of all comparative analyses of Non-Quantitative Treatment Limitations (NQTL) prepared by health insurance carriers pursuant to 42 U.S.C. § 300gg-26(a)(8) and requested by the Bureau during the reporting period. The Bureau must submit this report to the designated legislative committees annually by November 1, and post it on Commission's website.

To gather the necessary information, the Bureau conducted a data call of 16 health carriers insuring more than 2.48 million lives in the individual, small group, and large group health insurance markets in Virginia during 2023.

2. Claims

Carriers surveyed for this 2024 report received a total of 72,730,407 claims, with 16,233,560 (22.3%) of those denied. This was a significantly higher denial rate than reported in each of the previous two reports: 19.7% in 2023 and 13.6% in 2022.

Each carrier reported the total number of denied claims related to medical/surgical, mental health, and substance use disorder benefits. These claims were then separated into five service types: office visit claims, all other outpatient claims, inpatient claims, emergency care claims, and outpatient prescription (Rx) drug transactions. See Tables 1, 2, and 3.

Table 1. Claims Overview – Medical/Surgical Benefits (2023)

Claim Category: Medical/ Surgical Benefits	Total Claims Received	Claims Paid	Claims Denied	% Total Claims Denied
Office Visit Claims	10,591,528	9,911,975	679,553	6.4%
All Other Outpatient Claims	11,632,390	10,848,236	784,154	6.7%
Inpatient Claims	1,467,848	1,303,960	163,888	11.2%
Emergency Care Claims	1,184,425	1,088,767	95,658	8.1%
Outpatient Rx Transactions	37,649,569	25,278,889	12,370,680	32.9%
Totals:	62,525,760	48,431,827	14,093,933	22.5%

Table 2. Claims Overview – Mental Health Benefits (2023)

Claim Category: Mental Health Benefits	Total Claims Received	Claims Paid	Claims Denied	% Total Claims Denied
Office Visit Claims	1,056,921	977,746	79,175	7.5%
All Other Outpatient Claims	762,259	703,554	58,705	7.7%
Inpatient Claims	72,130	62,389	9,741	13.5%
Emergency Care Claims	16,088	14,004	2,084	13.0%
Outpatient Rx Transactions	7,762,390	5,905,477	1,856,913	23.9%
Totals:	9,669,788	7,663,170	2,006,618	20.8%

Table 3. Claims Overview – Substance Use Disorder Benefits (2023)

Claim Category: SUD Benefits	Total Claims Received	Claims Paid	Claims Denied	% Total Claims Denied
Office Visit Claims	101,563	77,210	24,353	24.0%
All Other Outpatient Claims	173,658	144,889	28,769	16.6%
Inpatient Claims	46,485	39,260	7,225	15.5%
Emergency Care Claims	14,955	11,742	3,213	21.5%
Outpatient Rx Transactions	198,198	128,749	69,449	35.0%
Totals:	534,859	401,850	133,009	24.9%

Overall, substance use disorder (24.9%) had a somewhat higher rate of denied claims than medical/surgical (22.5%) which had a somewhat higher rate than mental health (20.8%). Were the differences considered significant, carriers in the aggregate could be in compliance with parity requirements with respect to mental health benefits (a difference of 1.7 percentage points) but not in compliance in the case of substance use disorder benefits (a difference of 2.4 percentage points) based on this indicator. The highest rate of claims denied across the three benefit types were for outpatient Rx services.

Figures 1 through 6 compare the rate of denied claims to total claims for each service type within the three benefit categories for 2023.

Fig. 1. Denied Claims – All Claims (2023)

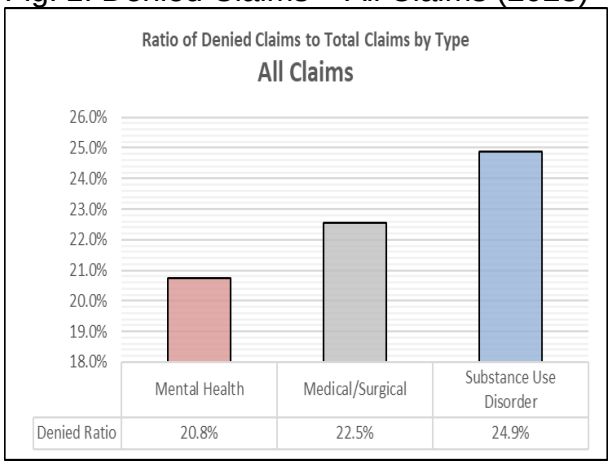


Fig. 2. Denied Claims – Office Visits (2023)

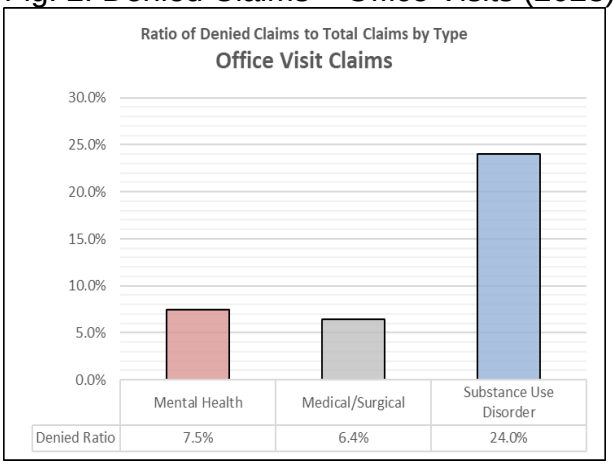


Fig. 3. Denied Claims –
All Other Outpatient Claims (2023)

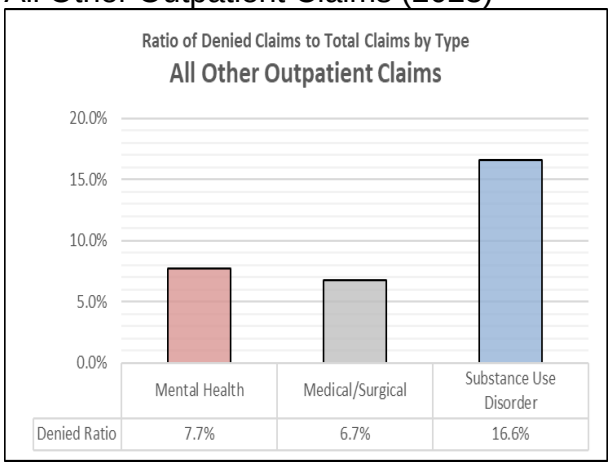


Fig. 4 Denied Claims
Inpatient Claims (2023)

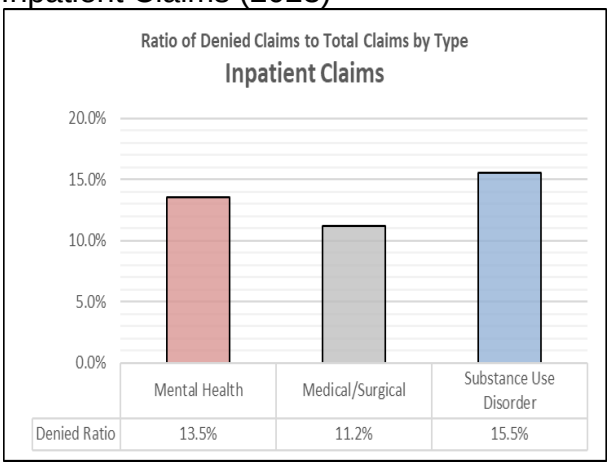


Fig. 5. Denied Claims –
Emergency Care Claims (2023)

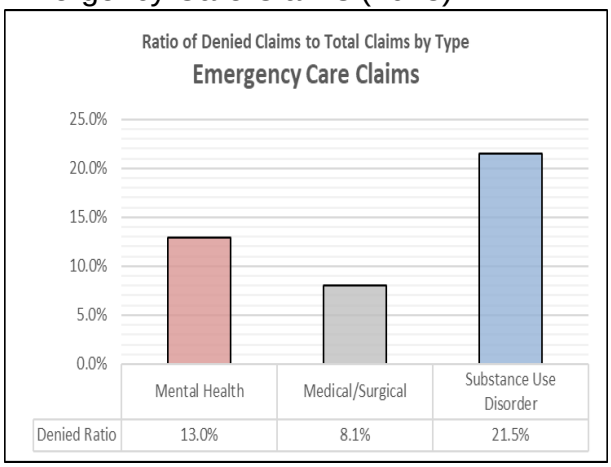
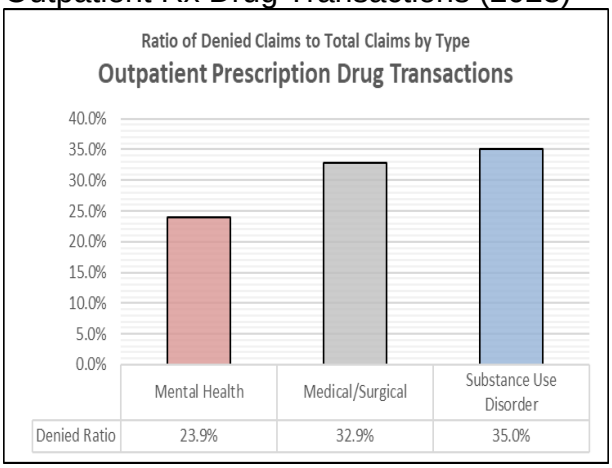


Fig. 6. Denied Claims –
Outpatient Rx Drug Transactions (2023)



Reasons for Claim Denial

For the 16,233,560 claims denied, carriers identified the top three reasons they were denied by benefit category. While the top three reasons remained unchanged from the previous year's report for medical/surgical benefits, they did change for mental health and substance use disorder. New for mental health was "rejected drug utilization review" and new for substance use disorder were "provider billed incorrectly" and "services not preauthorized/referral not obtained." In total, 38%, or 5,795,738, claims were denied for one of the top three reasons, while 62%, or 10,437,822, were denied for some other reason. The results are reflected in Table 4.

Table 4. Top Three Reasons for Claim Denials by Benefit Category (2023)

Reason for Claim Denial by Benefit Category	Number of Denials	Rank	Percent of Total
Medical/Surgical			
Prescription refill too soon	1,870,315	1	27.6%
Not a covered benefit/service contractually excluded	1,602,075	2	23.6%
Exceeds benefit limits (contractual)	1,465,672	3	21.6%
Mental Health			
Exceeds benefit limits (contractual)	450,112	1	26.3%
Rejected – Drug Utilization Review	434,092	2	25.3%
Prescription refill too soon	355,839	3	20.8%
Substance Use Disorders			
Services not preauthorized/Referral not obtained	26,825	1	30.4%
Provider billed incorrectly	14,814	2	16.8%
Provider not participating with individual's plan	9,652	3	11.0%

Across all benefit categories, the Bureau consolidated the top three reasons carriers denied claims into six general subcategories. Table 5 shows the aggregate number of all denied claims attributable to each subcategory by benefit category.

Table 5. Number of Claims Denied by General Subcategories (2023)

General Subcategories	Medical/ Surgical	Mental Health	Substance Use Disorder	All Claims Denied
Non-covered benefits or services	3,342,979	843,648	23,389	4,210,016
Prescription drug services	2,270,942	789,931	6,636	3,067,509
*NPP/OON or service area	156,428	11,045	12,157	179,630
Preauthorization or precertification	224,629	12,005	26,825	263,459
Provider or administrative billing	406,646	54,261	17,890	478,797
Medical necessity/inappropriate service	378,928	3,303	1,232	383,463
Totals:	6,780,552	1,714,193	88,129	8,582,874

*Non-participating provider/out-of-network

3. Complaints

For 2023, carriers reported receiving 9,417 complaints from either covered persons or the Bureau, with 97.6% being closed. This was up from 8,705 complaints reported for 2022, but less than the 10,182 complaints reported for 2021. Complaints were assigned to one of five complaint areas for each of the three benefit categories: access to health care services, utilization management, practitioners/providers, administrative/service, and claims processing. Table 6 shows the number of complaints for each complaint area and whether the complaint was related to a medical/surgical benefit, mental health benefit, or substance use disorder benefit.

Table 6. Number of Complaints Submitted (S) and Closed (C) (2023)

Complaint Area	Medical/ Surgical		Mental Health		Substance Use Disorder		All Complaints	
	S	C	S	C	S	C	S	C
Access to Health Care Services	915	893	67	64	1	1	983	958
Utilization Management	1,415	1,391	67	67	10	10	1,492	1,468
Practitioners/Providers	77	75	1	1	0	0	76	76
Administrative/ Service	2,674	2,566	121	120	3	3	2,798	2,689
Claims Processing	4,021	3,954	40	39	5	5	4,066	3,998
Totals	**9,102**	**8,879**	**296**	**291**	**19**	**19**	**9,417**	**9,189**

Table 7 shows the ratio of complaints in each complaint area by benefit category, to the total of all complaints in each complaint area and in total by benefit category.

Table 7. Ratio of Complaints by Area Relative to their Respective Totals (2023)

Complaint Area	Medical/ Surgical		Mental Health		Substance Use Disorder		All Complaints	
	S	C	S	C	S	C	S	C
Access to Health Care Services	10.1%	10.1%	22.6%	22.0%	5.3%	5.3%	10.4%	10.4%
Utilization Management	15.5%	15.7%	22.6%	23.0%	52.6%	52.6%	15.8%	16.0%
Practitioners/ Providers	0.8%	0.8%	0.3%	0.3%	0.0%	0.0%	0.8%	0.8%
Administrative/ Service	29.4%	28.9%	40.9%	41.2%	15.8%	15.8%	29.7%	29.3%
Claims Processing	44.2%	44.5%	13.5%	13.4%	26.3%	26.3%	43.2%	43.5%
Totals	**9,102**	**8,879**	**296**	**291**	**19**	**19**	**9,417**	**9,189**
Ratio to All Complaints	**96.7%**	**96.6%**	**3.1%**	**3.2%**	**0.2%**	**0.8%**	**100.0%**	**100.0%**

Figures 7 through 11 show differences in the ratio of submitted complaints by complaint area for each benefit category. As Table 7 shows, medical/surgical services comprised 96.7% of all complaints; of these, 10.1% pertained to access to health care services, whereas of the 3.1% share of total complaints carriers received for mental health benefits, 22.6% pertained to access to health care services. Utilization management generated the largest percentage of complaints in the substance use disorder category at 52.6%.

Fig. 7. Access to Health Care Services (2023)

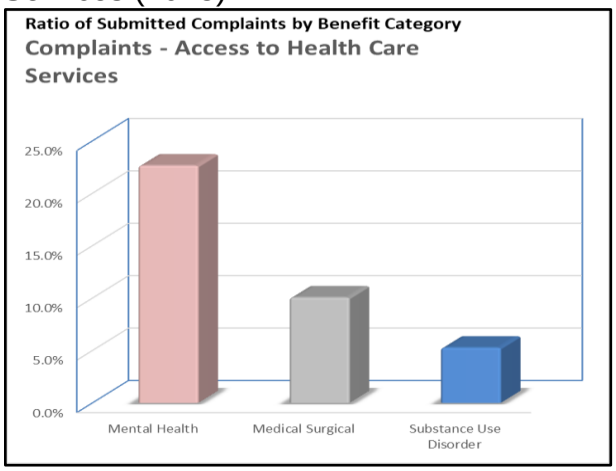


Fig. 8. Utilization Management (2023)

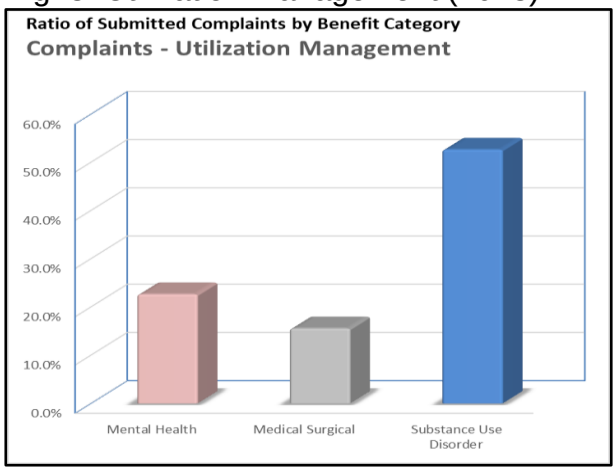


Fig. 9. Practitioners/Providers (2023)

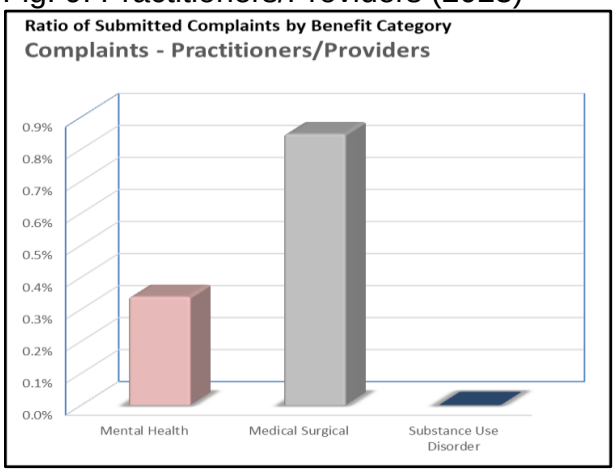


Fig. 10. Administrative/Service (2023)

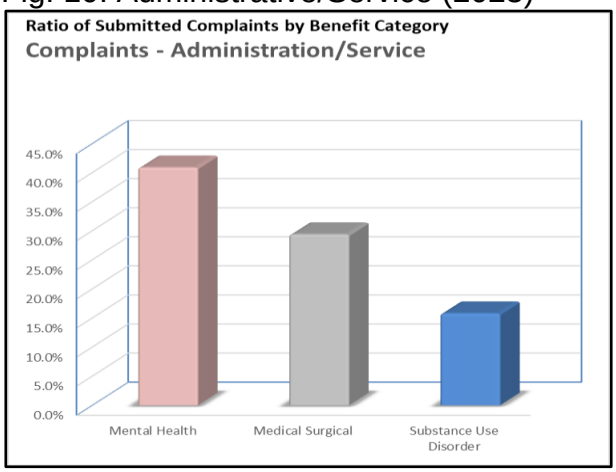
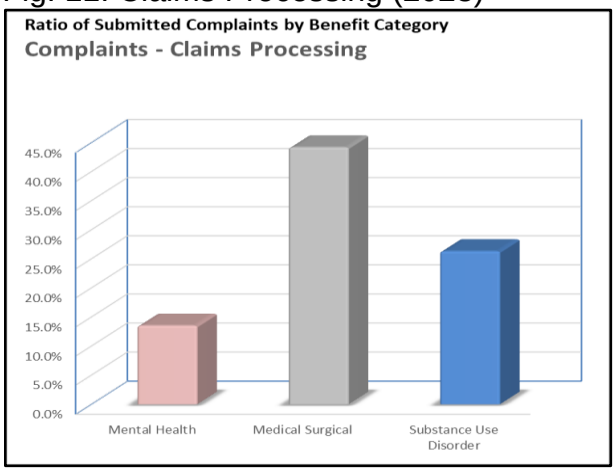


Fig. 11. Claims Processing (2023)



4. Appeals

Overview

An internal appeal is filed to obtain approval for services denied by a managed care health insurance plan as the result of utilization review or an administrative denial. The defining characteristic of the internal appeal process is that the health carrier makes the determination. The consumer may have one or two levels of internal appeal.

When a consumer with a fully insured Virginia policy receives a denial after completing or "exhausting" the health carrier's internal appeals process, an external review facilitated by the Bureau may be available. If the request is eligible, the Bureau will assign the external review to an approved Independent Review Organization to either uphold the health carrier's denial or overturn it.

Internal Appeals

As shown in Table 8, survey respondents processed and closed a total of 9,429 internal appeals across the three benefit categories in 2023, an increase from 6,571 in 2022.

Table 8. Outcomes of Closed Internal Appeals (2023)

Outcomes of Closed Internal Appeals	Number Related to Medical/ Surgical	Number Related to Mental Health	Number Related to Substance Use
Denial Upheld	5,459	180	95
Denial Partially Upheld	121	5	4
Denial Overturned	3,398	142	25
Total	8,978	327	124

Figures 12 through 14 compare the outcome of internal appeals for each of the three benefit categories.

Fig. 12. Closed Internal Appeals – Denial Upheld (2023)

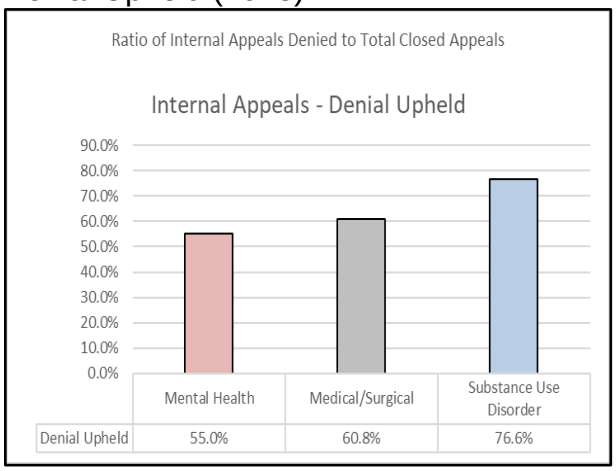


Fig. 13. Closed Internal Appeals – Denial Partially Upheld (2023)

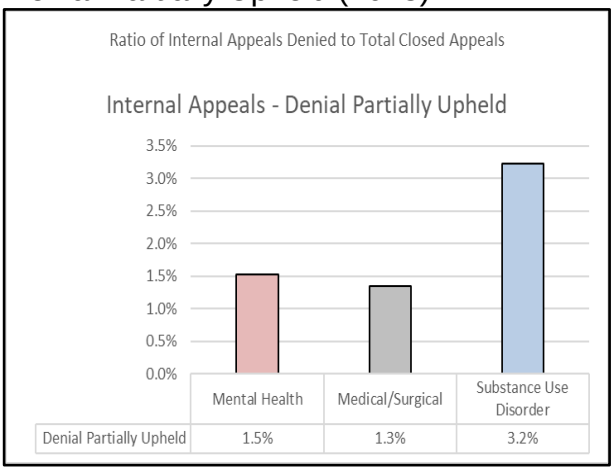
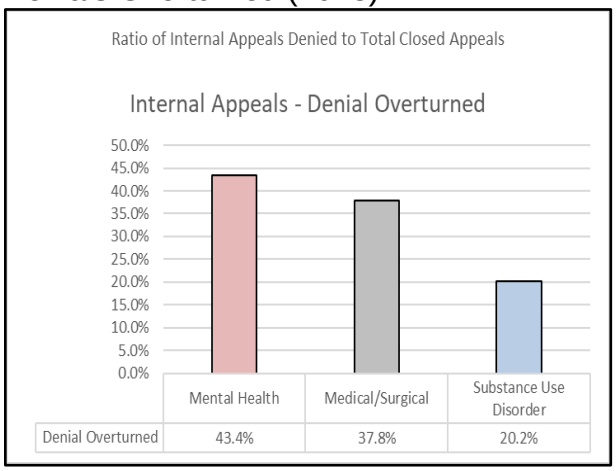


Fig. 14. Closed Internal Appeals – Denials Overturned (2023)



External Review

According to survey respondents, 217 external reviews were performed in 2023. Table 9 shows the number and results of closed external reviews for each benefit category.

Table 9. Outcomes of Closed External Reviews (2023)

Outcomes of Closed External Reviews	Number Related to Medical/ Surgical	Number Related to Mental Health	Number Related to Substance Use
Denial Upheld	104	4	2
Denial Partially Upheld	1	0	0
Denial Overturned	100	5	1
Total	205	9	3

Figures 15 and 16 demonstrate the frequency with which denials were upheld or overturned for each benefit category.

Fig. 15. Closed External Reviews – Denial Upheld (2023)

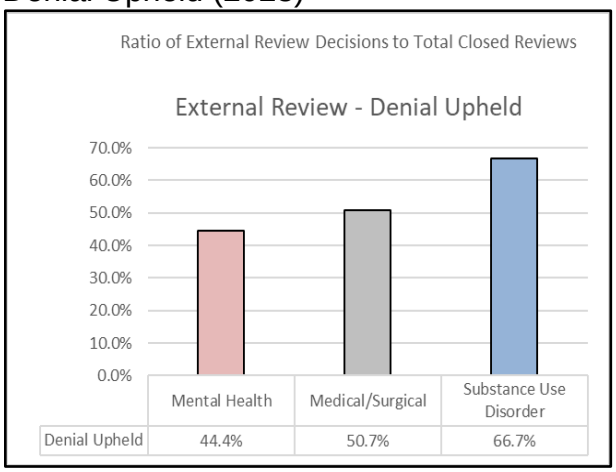
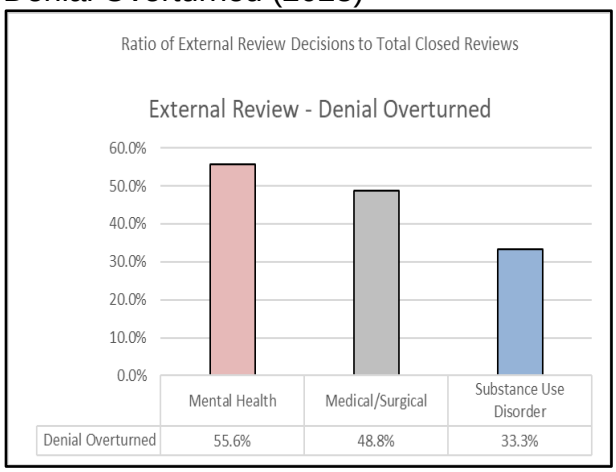


Fig. 16. Closed External Reviews – Denial Overturned (2023)



5. Network Adequacy

Overview

Network adequacy refers to a health plan's ability to deliver the benefits promised by providing reasonable access to enough in-network primary care and specialty physicians, and all other health care services included under the terms of the contract. Determining network adequacy can be challenging for several reasons, including:

- The absence of a national standard and the significant variation in standards that do exist across states and types of coverage.

- Reliance on plan provider directory data which may be inaccurate or out of date in evaluating health plan networks.

- The absence of a national standard for ensuring the accuracy of information in health plan provider network directories.

- The absence of a standard measure of network size or breadth, or any way for consumers or regulators to discern differences in network size easily.

Under 45 CFR § 156.230, federal regulations provide network adequacy standards, including those for accessing mental health and substance use disorder services. The federal Centers for Medicare and Medical Services (CMS) has been conducting meetings for the purpose of establishing a standard for enforcing network adequacy. In Virginia, the Virginia Department of Health is required to determine standards for accessing provider networks pursuant to § 32.1-137.2 G of the Code. Additionally, in 12 VAC-408-260, the department requires carriers to establish network adequacy regarding access to providers. Other states similarly have various statutes and rules concerning network adequacy.

Unresolved are provisions to assess parity between medical/surgical, mental health, and substance use disorder network services.

Network Adequacy Parity Analysis

Despite challenges, the Bureau previously analyzed the parity of network adequacy among the three benefit categories by comparing complaint ratios. Assuming enough complaints for results to be credible, this approach could suggest possible disparities in network adequacy for mental health or substance use disorder benefits if the complaint ratio were significantly higher for these categories than for medical**/**surgical benefits.

Table 10 shows that medical/surgical claimants submit far more complaints than mental health or substance use disorder claimants, based on the ratio of complaints to total claims. While the numbers do not suggest differences in treatment, the number of complaints for mental health and substance use disorders remains very low.

Table 10. Comparison of Total Complaints to Total Claims (2023)

Benefit Category	Claims Presented	Percent of Claims Presented	Complaints	Complaints to Claims Ratio
Medical/Surgical	62,525,760	86.0%	9,102	1 in 6,869
Mental Health	9,669,788	13.3%	296	1 in 32,668
Substance Use Disorder	534,859	0.7%	19	1 in 28,150
Totals:	72,730,407	100%	9,238	1 in 7,876

Table 11 shows the percentage and number of complaints involving access to health care services for each benefit category. This complaint subcategory includes out-of-network service provision, availability and timeliness of appointments, and availability of providers, all of which can provide insight into network utilization and adequacy. The mental health complaint ratio for access to health care services is more than twice the medical/surgical ratio, down from 3.3 times in the 2023 report and 5.0 times in the 2022 report.

Table 11. Complaint Ratios – Access to Health Care Services by Benefit Category (2023)

Complaint Type	Mental Health	Medical/Surgical	Substance Use Disorder
Access to Health Care Services	22.6% (67 of 296)	10.1% (915 of 9,102)	5.3% (1 of 19)

The relative number of complaints involving access to health care services in the mental health category compared to those in the medical/surgical category could indicate a lack of parity in network adequacy if deemed a significant difference. However, one of the primary challenges in assessing the adequacy of carrier networks is that many mental health professionals also provide substance use disorder services, which could result in double counting of mental health or substance use providers.

Network adequacy measurements also can be skewed if only a fraction of providers listed as in-network providers are treating patients. Table 12 shows how this factor may be measured. The Bureau compared the total number of in-network providers and out-of-network providers actually paid for services in 2023 to 2022 end-of-year data.

Table 12. Network Adequacy Measurements (2023)

A		B	C	D	E
Percent of in-network providers receiving payment (active participants)		Percent of out-of-network providers paid	Percent of providers denied payment because out-of-network	Number of members per month to number of in-network providers	Percent of total claims
Medical/Surgical	49.2%	11.8%	6.6%	66	86.0%
Mental Health	40.6%	30.5%	3.5%	262	13.3%
Substance Use Disorder	68.3%	12.0%	9.8%	609	0.7%

Since the previous year's report, the data in Table 12 shows:

- (Column A) Active in-network provider participation decreased across all categories, with substance use disorder seeing the largest drop.
- (Column B) The frequency of out-of-network provider payments increased significantly for mental health services. This could suggest that it is significantly more difficult for a consumer to find their desired mental health provider in-network than for either of the other two categories.
- (Column C) Payment denials for out-of-network providers increased modestly across all categories, with substance use disorder experiencing the largest increase. This could point to problems if more people were forced to go out-of-network for services, and the denial rates due to being out of network are high. While substance use disorder showed a three-fold increase, it is difficult to draw conclusions due to limitations inherent t in existing network adequacy standards.
- (Column D) The number of members per in-network provider increased for medical/surgical and mental health but decreased for substance use disorder. This measure could suggest potential access issues in the form of longer wait times or difficulty getting appointments. Although substance use disorder had a significant decrease, the ratio of available providers indicates finding or receiving services for this benefit may be problematic. However, it can be difficult to compare availability across these categories when one needs to factor in provider availability for various specialties. What is evident is that, in general, in-network provider availability became scarcer in 2023 than in 2022 for mental health and medical/surgical, whereas availability increased from 2022 for substance use disorder services.
- (Column E) The distribution of claims remained relatively stable, with a slight increase in mental health claims.

6. Comparative Analyses

Overview

The Bureau is also required to include in this report a summary of all NQTL[1] comparative analyses it requested of health carriers during the reporting period for the design and application of NQTL pursuant to 42 U.S.C. § 300gg-26(a)(8). The summary must include the Bureau's explanation of whether the analyses were accepted as compliant, rejected

[1] See The Mental Health Parity and Addiction Equity Act (MHPAEA) | CMS. According to the CMS, under the 2013 MHPAEA regulations, "(q)uantitative treatment limitations are numerical, such as visit limits and day limits. Nonquantitative treatment limitations include but are not limited to medical management, step therapy and pre-authorization. There is an illustrative list of nonquantitative treatment limitations in the regulation." According to CMS, the 2024 MHP regulations "(r)einforce that health plans and issuers cannot use NQTLs applicable to MH/SUD benefits that are more restrictive than the predominant NQTLs applied to substantially all medical/surgical benefits in the same classification. Examples of NQTLs include prior authorization requirements and other medical management techniques, standards related to network composition, and methodologies to determine out-of-network reimbursement rates."

as noncompliant, or under review. The report must include the corrective actions the Bureau required health carriers to take to bring noncompliant analyses into compliance.

A comparative analysis is a narrative with supporting documentation prepared by a health carrier that must demonstrate that any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health/substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the same classification.

The comparative analyses should be sufficiently specific, detailed, and reasoned.

For illustrative purposes, the National Association of Insurance Commissioners' Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group provided an example of a comparative analysis qualifying as sufficient for the NQTL Concurrent Review.

The Bureau conducts this review as part of the market conduct examination process. All market conduct examination reports must be kept confidential under § 38.2-1320.5 of the Code until the examinations are finalized.

Summary for Prior Reporting Period

In the 2023 report, the Bureau reviewed 416 comparative analyses under 12 insurance products from four carriers as part of the market conduct examination process. These included the following NQTL: Medical Necessity, Prior Authorization, Concurrent Review, Retrospective Review, Post-Payment Retrospective Review, Blanket Policy Exclusions, and Experimental/Investigational/Unproven. The Bureau completed the review of all of these comparative analyses during this reporting period and found that all were insufficient and not in compliance with the federal Mental Health Parity and Addiction Equity Act, 42 U.S.C. 300gg-26(a)(8), and § 38.2-3412.1 B of the Code. As a result, the Bureau has directed the carriers to take corrective actions by developing a comparative analysis demonstrating compliance, or it will require the carriers to remove the NQTL in question from mental health or substance use disorder benefits in the classifications reviewed. However, the carriers will have an opportunity to respond to the Bureau's draft reports issued at the end of each examination. All market conduct examination reports are in process.

Summary for Current Reporting Period

During the current reporting period, the Bureau requested and reviewed comparative analyses of NQTL associated with a sampling of 10 insurance products from two carriers. These included the same NQTL from the prior reporting period except that Provider Reimbursement was included instead of Blanket Policy Exclusions.

While the selected products account for 38,662 covered lives, it is also important to note that comparative analyses generally represent a carrier's entire fully insured book of business in Virginia rather than just the selected products. When accounting for the

number of applicable classifications (such as "Inpatient, In-Network," "Outpatient, Out-of-Network, All Other"), the Bureau's review accounted for 320 comparative analyses during the reporting period. The comparative analyses were reviewed for compliance with the federal Mental Health Parity and Addiction Equity Act, 42 U.S.C. 300gg-26(a)(8), and § 38.2-3412.1 B of the Code of Virginia.

The requested comparative analyses are currently under review as part of the market conduct examination process and therefore no compliance determination has yet been made. The working papers and other specific details are required to be kept confidential under § 38.2-1320.5 of the Code. However, the market conduct reports including more specific information will be made public upon the conclusion of the examinations**.**

7. Conclusion

This is the fifth data collection effort by the Bureau and health carriers to assist in determining if parity exists between medical/surgical benefits and mental health and substance use disorder benefits. With regard to determining if parity in network adequacy exists among the three benefit categories, that remains unclear, in part because of the lack of certain standards and inaccurate network provider directories. The Bureau continues to participate in CMS discussions concerning enforcement of network adequacy standards and is monitoring ways to incorporate network adequacy measurements for use in future determinations of mental health and substance use disorder parity. The Bureau continues to review NQTL comparative analyses required of health carriers under federal law and is in various stages in the process of determining compliance with and the need for or response to any required corrective actions.

Appendix A. Reasons for Denial of Claims 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): Workers Compensation
Denials related to prescription drug claims:
Prescription refill too soon
Rejected - Drug Utilization Review
Filled after coverage terminated
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
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): The # of units reported exceeds the typical frequency per day.
Other (Explain): Submitted procedure disallowed because it is incidental to code billed on same date of service.
Other (Explain): ITS No Hold Harmless Allowable Override
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): The member's plan provides coverage for charges that are reasonable and appropriate. The charge for this service does not meet this requirement of the member's plan of benefits because this service is considered mutually exclusive to another procedure performed on the same date of service.
Other (Explain): The procedure is disallowed because this service or a component of this service was previously billed by another health care professional.
Other (Explain): Submitted procedure code is disallowed because the primary related service was not reported on the claim or was denied for other reason.
Other (Explain): Claim Paid at 0 for 60 Day Grace Period
Other (Explain): No charges are eligible for payment due to Medicare provider's obligation or Medicare has paid full charges.
Other (Explain): Claim line denied by external bundling/fraud detection system
Other (Explain): Not covered overutilizes services
Other (Explain): Duplicate charges
Other (Explain): Facility's daily rate includes charges.
Other (Explain): Benefits for this service are included in the payment.
Denials related to no-participating 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 is not payable under our service area; must be filed to the Payer/Plan in the service area received.
Denials related to not medically 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

Appendix 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 materials 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