Understanding the Health Care Provider Complaint Process

Revised June 2009

Claim Filing Procedures

The first step to achieving prompt processing of claims is filing claims correctly. Claim forms must be filled out completely and accurately. Make sure you send the claim to the correct address and if possible, file the claim electronically. Claims will be rejected if they contain incomplete, invalid, or incorrect member identification numbers. If a claim is returned to you because of mistakes, correct them immediately and resubmit to the payor to meet any filing deadline specified in your contract or in the patient's plan document.

Always keep documentation of when the claim was submitted. File the claim using a method that will document when the claim was received by the payor. Keep records of your telephone conversations and all written correspondence between you and the payor regarding the status of the claim. Post the claim payment to the account as soon as it is received.

What Types of Provider Complaints Does the Department of Insurance Handle?

Many providers seek assistance from the Department of Insurance when health claims are delayed, denied or unsatisfactorily settled by insurance companies and HMOs. The Department is able to assist providers with these problems to the extent of our authority under the law.

Note: While the Department encourages provider complaints as an avenue to assist health care providers and consumers and as a method to track market conduct of insurers and HMOs, complaints submitted by collection agencies who have bought the claims are not accepted.

Prompt Pay

State law requires HMOs, insurance companies, IPAs and PHOs to pay health care claims promptly. Failure to pay the claims within the period required by the law entitles the health care provider to interest on the claim. See our Fact Sheet entitled, *The Prompt Pay Law*, for more information.

Claim Denial

If you believe a claim has been unjustly denied, our Department will review your complaint to ensure the company is abiding by Illinois insurance laws and the policy language. If the denial involves a determination of medical necessity, we can ask the company to review it. However, our authority is limited. See our Fact Sheet entitled, *Medical Necessity*, for more information.

Unsatisfactory Claim Payment

The most common complaints regarding unsatisfactory claim payments involve CPT coding disputes and usual and customary fee reductions. The Department has limited authority over these issues. While we are willing to ask a payor to review a situation that you believe has been handled inappropriately, we are not equipped to handle volumes of complaints regarding disputed claim payments. Please complete the provider complaint form and provide all documentation to support your position, including medical records and information regarding any special services provided to the patient that justify a higher fee or use of a different CPT code. See our Fact Sheet entitled, *Usual and Customary Fees in Health Insurance Claims*, for more information.

Provider Contract Disputes

A provider contract with an HMO, IPA, PHO or PPA, is a legal document entered into between two parties. Generally, our Department does not become involved in provider contract disputes. We suggest you look to the terms of the contract for remedies of disputes. If the contract dispute involves balance billing, assignment, recoupments or the prompt payment of claims, the Department may be able to assist.

Utilization Review

Although the Department of Insurance has limited jurisdiction over claim denials for medical necessity, we can ensure the payor or its delegated Utilization Review Firm handled the review process in accordance with the law. If you are having problems obtaining a utilization review decision or if you believe the review or appeal was not handled appropriately, please contact our Department.

The Department of Insurance Does Not Have Jurisdiction over the Following Plans:

1. **Self-insured employers and health & welfare benefit plans –** Many large employers provide health benefits for their employees through self-insured plans. Although self-insured plans are frequently administered by an insurance company, it is the employer and not the insurance company that bears the risk for paying claims. State laws, including the Prompt Pay Law, do not apply to self-insured employers and health & welfare benefit plans. Your patients should follow the complaints and appeals procedures contained in their benefit booklets. Many times, these plans have deadlines for filing of complaints and appeals that the patient must meet. The U.S. Department of Labor has some oversight of these plans.
2. **Federal Employees' health and life insurance**
3. **Medicare HMOs**
4. **Military Insurance**
5. **Policies purchased in another state** (HMO policies may be the exception. Call our Division for assistance if your patient is covered by an HMO)
6. **Medicare**

7. **Medicaid**
8. **KidCare**
9. **Illinois Comprehensive Health Insurance Plan**
10. **State of Illinois Employee Quality Care Plan**
11. **Workers' Compensation**

For information on how to file complaints regarding the above plans, see our Fact Sheet entitled, *Contact the Proper Agency - Where To File Medicare, Medicaid and Other Health Plan Complaints* or call our Consumer Assistance Hotline toll-free number (866) 445-5364.

Before Filing a Complaint

1. Contact the insurance company, HMO or administrator about your problem. Document your phone calls by noting the name of the person you speak to, the date of the call and a brief summary of the conversation. Keep copies of all written communications.
2. If you are not satisfied with the results you receive, contact the Department of Insurance for assistance. Insurance analysts are available to answer general questions by phone at our toll-free Consumer Assistance Hotline (866) 445-5364. **However, complaints must be submitted in writing.**

How to File a Complaint

Complaints may be submitted electronically or by mail using either the on-line or hard copy *Health Care Provider Complaint Form*. A separate complaint form must be completed for each patient. Please mail your complaint and all attachments to:

Illinois Department of Insurance
320 West Washington Street
Springfield, Illinois 62767-0001
Fax: (217) 558-2083
Consumer_complaints@ins.state.il.us

Do not complete a complaint form using your patient's name as the complainant's name. Filing a complaint in another individual's name may constitute fraud and may be subject to criminal or civil action. Patients who wish to file complaints should use the *Consumer Complaint Form*.

All complaints must include the following information:

1. A copy of the patient's health insurance ID card;
2. A copy of the uniform bill such as the HCFA 1500, UB-92 or standard dental form;
3. Documentation of your attempts to resolve the problem prior to contacting the Department of Insurance, including the following:

    1. Copies of correspondence mailed to the payor;
    2. Documentation of phone conversations made to the payor;
    3. Copies of responses you have received from the payor.
4. In addition to the above information, **Prompt Pay complaints** must also include evidence of the date of claim submission such as:
    1. Electronic transmission confirmation;
    2. Certified mail return receipt;
    3. Provider mail log;
    4. Courier delivery information.

When the Department receives your complaint, it will be reviewed to determine if all required information has been provided. If so, a copy of the complaint will be sent to the insurance company, HMO or payor involved. When a response is received from the company, an analyst will review it and take one of the following actions:

- If the complaint is resolved, the complaint will be closed and you will be sent a letter.
- If an insurance law or rule has been violated, the Department will request corrective action.
- If the company is not abiding by the policy, the Department will request corrective action.
- If no violation of Illinois insurance law or rules is found, a letter will be sent to you with an explanation of the finding and notice that the investigation is being closed.

In each instance, you will receive a written response from the Department explaining the results of the investigation.

For More Information

Call our Consumer Services Section at (312) 814-2420 or our Office of Consumer Health Insurance toll free at (877) 527-9431 or visit us on our website at http://insurance.illinois.gov/