



North Carolina Department of Insurance Wayne Goodwin, Commissioner

COMPLAINTS AGAINST HEALTH PLANS: GUIDANCE FOR PROVIDERS

Where should a complaint against a health plan be filed?

Complaints from healthcare providers and facilities can be filed directly with the Department's Consumer Services Division, at the following address:

North Carolina Department of Insurance
Consumer Services Division (attn: Provider Complaints)
1201 Mail Service Center
Raleigh, NC 27699-1201

A standardized Provider Complaint Form and other materials of interest to providers (Prompt Pay Law, Uniform Credentialing, etc.) are available on the "Healthcare Professionals and Facilities" page of the NCDOI website (<http://www.ncdoi.com>).

Complaints from consumers (patients/insureds) can be filed directly with the Department's Consumer Services Division, at the following address:

NC Department of Insurance
Consumer Services Division
1201 Mail Service Center
Raleigh, NC 27699-1201

An Internet-based consumer complaint form is available via the "Consumer" page of the NCDOI website (<http://www.ncdoi.com>). The Consumer Services Division can be reached by calling 1-800-546-5664 or (919) 807-6750, but a written complaint will be required before a complaint can be pursued with an insurer.

In the event that a complaint is reviewed and determined to have been sent to the wrong division, it will be promptly forwarded to the appropriate division for handling.

Not sure about filing a provider complaint?

Providers and facilities may discuss concerns with the Consumer Services Division in advance of filing a written complaint, by calling 1-800-546-5664 or (919) 807-6750. However, a written complaint will be required in order for the Division to initiate a formal review and (when appropriate) inquiry. We are glad to talk with you, help you determine whether filing a complaint is an appropriate course of action, and (when appropriate) help you identify alternative courses of action.

What information is needed when a provider complaint is filed?

Including as much relevant information as possible with your complaint can help speed the Department's review. The following information may be needed:

- The name of the insurance company involved.
- A written statement outlining your complaint and summarizing the facts. Provide copies of correspondence between you and the carrier and other written documentation that may help state your case.
- If applicable, the type of benefit plan involved (i.e., PPO, HMO, indemnity) and specific benefit plan name if it is known (e.g., OK HMO's "Freedom Plan")
- If applicable, the name of the employer through which insurance coverage is provided
- If applicable, attach a copy of your network participation agreement with the insurer or relevant pages of the agreement. It is OK to black out fees and other payment amounts.

Not every complaint will require every item listed above, but the more specifics that you provide with your initial complaint, the quicker we can evaluate it and take action.

Does the Department of Insurance have the authority to investigate all provider complaints against health insurers?

As a regulatory agency, the Department's authority to act on complaints is defined by the laws that it is charged to enforce. Therefore, complaints from consumers and health care providers are analyzed carefully to determine what (if any) action is appropriate, including but not limited to gathering information from the insurer, requesting reconsideration, or demanding reversal of an action. The following considerations necessarily influence our approach in handling a complaint.

- Does the complaint relate to any insurance law or regulation? If so, is it a state or federal law or regulation?
- Does the complaint relate to the possible failure of an insurer to fulfill the terms of the health insurance policy it sold to the employer, employee, or individual?
- Does the complaint relate to the insurer's possible failure to fulfill the terms of its network participation agreement? [Please note: The Department of Insurance does not have broad authority to enforce all provisions of provider contracts, however, issues relating to regulatory concerns can be investigated.]
- Does the complaint provide information or does the Department have additional information from other sources to indicate a general business practice of the insurer?
- Are there other circumstances specific to the case that need to be considered?

Even when we conclude that a specific complaint has no direct regulatory implications, the complaint information still has value. For example, after receiving a large number of complaints regarding a certain issue we may decide to conduct an examination of that company, and/or even seek new laws to address the business practice in question. Finally, complaints give us a better perspective on the problems that health care providers encounter when dealing with managed care plans and other insurers.

Certain complaints do not fall within the jurisdiction of the Department of Insurance and must therefore be referred elsewhere. When a complaint is forwarded, we will send you a letter advising you of this action. In other cases, we

will tell you how to contact the appropriate agency. The following are the general rules for jurisdiction.

- ❑ State Employees Health Plan - All consumer complaints are forwarded to the State Health Plan Office. Some provider complaints may also be forwarded.
- ❑ Self-Funded Employee Health Benefit Plans – Complainants are referred to the plan administrator, the employer’s human resources department, and/or the U.S. Department of Labor.
- ❑ Federal Employees’ Health Plan – Complainants are referred to the U.S. Office of Personnel Management.
- ❑ Medicare (“traditional Medicare”) – Complainants will be referred to the Center for Medicare and Medicaid Services (CMS). Complaints about Medicare HMOs and other Medicare options will be reviewed by the Department to determine whether they fall under the jurisdiction of the Department of Insurance or CMS.
- ❑ Medicaid – Complainants will be referred to the North Carolina Department of Health & Human Services’ Division of Medical Assistance.
- ❑ Workers’ Compensation – Complainants will be referred to the North Carolina Industrial Commission.
- ❑ Provider Licensure/Ethical Issues - Complainants will be referred to the North Carolina Medical Board or other applicable state licensing board.
- ❑ Medical Malpractice or Risk Management Issues - Complainants are referred to their malpractice insurer.
- ❑ Legal/Contract Issues - Complainants with issues related to contract enforcement, fraud and abuse and other similar issues may be instructed to consult with their legal counsel.

What is the Department’s process for handling provider complaints?

1. Complainants are sent (via email or US mail) an acknowledgment of their complaint within 7 days of receipt, unless a final response can be provided in that timeframe.
2. After reviewing the complaint and considering the questions listed in the previous section, the Department determines whether it has the authority to intervene in the case or whether an inquiry is warranted. If the complaint alleges or indicates that the insurer was in violation of North Carolina insurance law, or otherwise at fault in the matter at hand, then an analyst will forward a copy of the complaint to the insurer, direct the insurer to research the matter and take any needed corrective actions, and send the Department a written summary of actions taken.
3. The Department sends the complainant a summary of the Department’s findings, along with a copy of the insurer’s response.

Contact Information for Other State and Federal Agencies

State Employees Health Plan

Attn: Customer Relations Department
4901 Glenwood Ave., Suite 150
Raleigh, NC 27612-3820
Phone: (919) 881-2300
Internet: www.shpnc.org

Self-Insured (Self-Funded or ERISA Plans)

U. S. Department of Labor
Employee Benefits Security Administration
Atlanta Federal Center
61 Forsyth Street SW, Suite 7B54
Atlanta, Georgia 30303

Phone: 866-444-EBSA (3272)
Internet: <http://www.dol.gov/ebsa/aboutebsa/main.html>

Federal Employees

US Office of Personnel Management, Employee Review Retirement & Insurance Group
PO Box 436, Washington, DC 20044
Phone: 202-606-0777

Medicare

- *Part A Claims & Provider Problems*

Palmetto GBA - Medicare Part A
800 S. Duke St.
PO Box 3824
Durham, NC 27702
Phone: 877-567-9249

- *Part B Claims & Provider Problems*

CIGNA-Medicare Part B
4135 Mendenhall Oaks Parkway, Suite 101
Attn. Public Relations
High Point, NC 27265
Phone: 336-882-4562

Medicaid

Division of Medical Assistance
2501 Mail Service Center, Raleigh, NC 27699-2501
Phone: 919-851-8888 or (800) 688-6696 (Provider Inquiries)
Phone: 919-855-4400 or (800) 662-7030 (Medicaid Recipients)

Workers Compensation

NC Industrial Commission
430 N. Salisbury Street, Raleigh, NC 27603-5937
Phone: 919-733-4820

Provider Licensure & Ethics

- For physicians:
NC Medical Board
P.O. Box 20007, Raleigh, NC 27619
Phone: 919-828-1212