Massachusetts Department of Public Health
Office of Patient Protection
Annual Report: January 1, 2003 through December 31, 2003

Introduction

The Massachusetts Department of Public Health's Office of Patient Protection (OPP) operates pursuant to §217 of chapter 111 of the Massachusetts General Laws. Among its duties is enforcement of certain provisions of Chapter 176O of the Massachusetts General Laws, which provides certain protections to health insurance consumers. In addition to the consumer protections, Chapter 176O contains health insurance licensure and accreditation requirements that are administered by the Massachusetts Division of Insurance. It is important to note that Chapter 176O applies to insured health plans that are issued or delivered in the Commonwealth; it does not apply to Medicare, Medicaid, federal employee plans, or self-insured plans.

Under Chapter 176O, OPP is responsible for:

- Monitoring and regulating health plan compliance with requirements for internal grievances and appeals;
- Maintaining contracts with at least three independent external review agencies and administering the external appeal process;
- Ensuring that health plans comply with regulations concerning continuity of coverage under specific circumstances;
- Receiving and posting information reported by health plans; and
- Creating and maintaining a website with information for consumers about managed care.

The Office of the Managed Care Ombudsman, which was created in 1998 under Executive Order 405, merged with OPP in January, 2001. As a result, OPP has an ombudsman and a nurse reviewer who work together to assist consumers with issues and problems concerning managed care.

2003 External Review Statistics

Chapter 176O contains a remedy for denial of coverage by health plans based on medical necessity. Once an insured has exhausted the health plan's internal appeal process and received a final adverse determination, he/she may be eligible for an independent external review through OPP. Requests for external reviews must be received by OPP within 45 days of the date on which the insured receives the final adverse determination letter. In 2003, OPP noted a significant increase in both the number of requests for external review as well as the number of eligible cases.

External Review Agencies

DPH contracts with three independent external review agencies. Cases are assigned on a random basis to one of the three agencies that then forwards it to a physician reviewer

who practices in the same or similar specialty as the physician performing the service in dispute. The three agencies DPH contracts with are:

- Maximus Center for Health Dispute Resolution (Pittsford, NY)
- Island Peer Review Organization (Lake Success, NY) and
- Hayes Plus (Lansdale, PA).

All three agencies are accredited by the Utilization Review Accreditation Commission (URAC).

Except in cases of extreme financial hardship, the insured pays the first $25 of the cost of the review; the health plan pays the remainder of the cost, which averages $500 for a standard review and $700 for an expedited review.

Screening Requests for External Review

When OPP receives a request for external review, it screens the request to ensure that:

1. The insured is enrolled in a health plan that is governed by Chapter 176O;
2. The health plan has complied with all of the applicable requirements of 105 CMR 128.000 (the regulation that governs health plan appeals);
3. The insured has exhausted the health plan's internal appeal process;
4. The health plan's decision meets the definition of an adverse determination (medical necessity denial);
5. The request is submitted on the required form and is accompanied by the required signatures and a check for $25 (waived in cases of extreme financial hardship); and
6. The request does not involve a service or supply that has been explicitly excluded from coverage by the health plan in its evidence of coverage.

In 2003, OPP received 446 requests for external review. This represents a 33% increase in requests over 2002 and a 228% increase over 2001. Ninety-five cases were ineligible for external review according to the above criteria, leaving 351 cases eligible for external review. Fifty-two cases were resolved in favor of the member prior to external review, through OPP working collaboratively with the health plans. The remaining 299 cases eligible for external review were sent to one of the three external review agencies.

Detailed information on specific health plans, categories of appeals, and aggregate data can be found at www.state.ma.us/dph/opp.

Resolved Cases

In 2003, 15% of the requests that were eligible for external review were resolved prior to being sent for review. In some cases, this occurred because the health plan decided to overturn its original denial based on additional clinical information. In other cases, OPP noted compliance issues under 105 CMR 128.000 that required that the health plan resolve the case in favor of the member. OPP also investigated certain cases in which there was a question of adequate access to network providers and determined that when

there was no clinically appropriate facility or provider in the health plan's network, the health plan must cover an out-of-network provider.

Decisions

In general, the three external review agencies overturned or partially overturned 49% of the health plan decisions and upheld 51% of the decisions. When behavioral health decisions are looked at separately, the percentage of decisions overturned rises to 58%. As discussed below, behavioral health appeals continued to be the number one category of eligible cases (156), followed by cosmetic surgery (29 eligible cases) and infertility (23 eligible cases). Please refer to www.state.ma.us/dph/opp for detailed information regarding external review decisions.

Trends and Issues in 2003

A) Behavioral Health:

In 2003, OPP continued to see a rise in the number of external review requests for denials of behavioral health services. The most dramatic increase in the behavioral health category involved requests for external review from patients in inpatient psychiatric, substance abuse, and eating disorder facilities. Equally significant was the fact that the majority of these requests (153 out of 230 requests) were from patients who were insured by Blue Cross Blue Shield of Massachusetts (BCBSMA). Most of these subscribers were enrolled in products for which BCBSMA used Magellan Behavioral Health (Magellan) as its behavioral health administrator.

OPP noted that 60% to 75% of Magellan's denials were being partially or fully overturned by the external review agencies. This indicated to OPP that there may be problems either with Magellan's clinical criteria or with the way Magellan's physician reviewers were applying the criteria to the cases they reviewed.

OPP requested clinical expertise from the Department of Mental Health (DMH). DMH reviewed Magellan's clinical criteria and the external review decisions to assist OPP with further evaluating the issues. OPP also consulted with the Bureau of Managed Care (BMC) in the Division of Insurance (DOI). Together, the three agencies met with representatives from BCBSMA and Magellan. Following this series of meetings, BCBSMA and Magellan revised many of their clinical and administrative processes. As a result, OPP saw a marked decrease in the number of external review requests during the last two months of 2003. OPP and DOI will continue to monitor the situation and to consult with DMH to ensure that the BSBSMA and Magellan improvements are sustained.

B) Infertility:

Massachusetts law requires that insurers provide coverage for medically necessary expenses for diagnosis and treatment of infertility, which is defined in the law as "the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year."

In 2003, OPP saw a noticeable increase in the number of requests for external review for denials of infertility treatment. In 2003, OPP received 30 requests compared with 12 in 2002 and none in 2001. The majority of these requests were from women in their forties, and the disputes focused on whether their requests for assisted reproductive technology (ART) fell within the state-mandated coverage, ie, was the infertility to be expected as a natural course of aging or was it to be considered a medical condition covered under the state mandate?

In an effort to provide additional guidance to the external review agencies, OPP created a summary of the mandate, which is sent with every infertility case. OPP also continues to work closely with the DOI on issues related to interpretation of the infertility mandate.

Health Plan Inspections:

In 2003, OPP continued to inspect health plan grievance files. As in 2002, OPP focused on behavioral health grievance files. OPP formally inspected United Healthcare, Aetna, Neighborhood Health Plan, Fortis Benefits Insurance Company and John Alden Life Insurance Company in 2003. Where OPP noted deficiencies, it requested corrective action plans. These plans are on file with OPP and available to the public for review.

In addition to issues raised during the inspection of United Healthcare (UHC) grievance files, OPP had received complaints from UHC members regarding confusion around whether certain providers were in the network for particular UHC products. OPP brought these concerns to the attention of the DOI and both agencies have been working with UHC staff to correct the problems.

As a result of compliance issues with Harvard Pilgrim Health Care (HPHC)'s behavioral health administrator, Value Options, OPP and DOI had a series of discussions with HPHC representatives. These discussions culminated in a formal presentation by HPHC staff during which the health plan presented revised and improved processes and procedures for handling adverse determinations and appeals.

During 2003, OPP also worked closely with Cigna Healthcare of Massachusetts regarding issues of non-compliance in Cigna's adverse determination letters and appeals processes. Over the course of several months, Cigna revised all of its initial and final adverse determination letters to make them more user friendly and in compliance with the law. Again, due to joint regulatory authority, OPP worked with DOI to resolve these issues.

OPP, again working with DOI, also reviewed the adverse determination letters used by Private Health Care Systems (PHCS). Although PHCS is not a licensed insurer and is not directly subject to the jurisdiction of DOI and OPP, it provides medical review services for Guardian Life Insurance Company of America, New England Life Insurance Company, Trustmark Insurance Company, Metropolitan Life Insurance Company, and GE Group Life Insurance Company, which all offer managed care plans subject to c. 176O. Because of its contractual relationship with these insurers, PHCS agreed to work with OPP and DOI directly. As a result of OPP's review, OPP and DOI requested that

PHCS take corrective actions to bring its letters into compliance with 211 CMR 52.00 (the DOI regulation governing managed care plans subject to chapter 176O) and 105 CMR 128.000.

Bulletins and Advisories:

A) Adverse Determinations

As a result of health plan inspections and meetings with carriers, both OPP and DOI concluded that certain health plans and providers remained confused about when a decision to deny services was to be considered an adverse determination, triggering the external appeal process. Thus, in June, 2003, OPP and the Bureau of Managed Care in the Division of Insurance jointly issued Bulletin-2003-05. The purpose of this bulletin is to clarify the requirements concerning the reduction or modification of health care services and the difference between a benefit denial and an adverse determination.

B) Intermediate Care

OPP was also involved in the creation of Bulletin 2003-11, issued by the Department of Mental Health (DMH) and the DOI in October, 2003. This bulletin defines intermediate care that is mandated to be covered as part of the mental health parity law, and clarifies the expectations of the DOI and DMH regarding mandated coverage of intermediate mental health care by health plans.

Copies of both bulletins can be found on the OPP website at www.state.ma.us/dph/opp.

C) Continuation of Coverage

In the fall of 2003, OPP issued an advisory to the three external review agencies (with copies to all accredited health plans). The advisory provided clarification to the external review agencies and to health plans regarding an insured's right to request that coverage be continued during the period that the case is being reviewed by the external review agency.

Outreach Activities

The Office of Patient Protection continued its activities to increase awareness among consumers and providers. OPP spoke to groups of case managers and physicians at Children's Hospital, Caritas Christi Health Care, Arbour Fuller Health Systems, and the Massachusetts Psychiatric Society. OPP also presented to a group of consumers and providers at a meeting of the Massachusetts Organization for Addiction Recovery. In October, OPP participated in a joint presentation of the Massachusetts Hospital Association and Health Law Advocates focusing on mental health parity and patient appeal rights. This presentation was attended by clinicians from throughout the Commonwealth.

Other Regulatory Activities

OPP meets regularly with the Division of Insurance to discuss managed care issues under Chapter 176O and to refer cases to DOI for investigation and enforcement.

Office of the Managed Care Ombudsman
The Office of the Managed Care Ombudsman fielded more than 2000 calls in 2003. These calls, primarily from consumers, involved questions about health plan denials, appeals, benefits, and policies. The Ombudsman's office assists consumers in resolving disputes with health plans. In addition, if another entity has jurisdiction over the issue, the Ombudsman's office refers callers to the appropriate state or federal agency. The Ombudsman's office also answers general questions from consumers and providers about managed care and Chapter 176O, and refers callers with general health insurance questions to the DOI or other appropriate agency.

Summary
As OPP enters its fourth year of operation, it continues to monitor compliance by health plans with Chapter 176O. OPP will continue to inspect health plan grievance files and to refer patterns of non-compliance to the DOI for enforcement. Through consultation with other state agencies, such as DOI and DMH, OPP will continue to address concerns about managed care.

Greater awareness of OPP among consumers and improved compliance among health plans in informing consumers about appeal rights has led to more people taking advantage of their right to external review under Chapter 176O. OPP and the Ombudsman's office has developed excellent working relationships with health plans and will continue to work closely with health plans, provider organizations, hospitals and other state agencies to provide consumers with the means to resolve disputes with managed care organizations.

Any questions regarding this report should be directed to:
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