

DRAFT

**Proposals for Changes to Utilization Review and Quality Assessment
Regulation 452 CMR 6.00
(Pursuant to Executive Order No. 562)**

ADDITIONS Blue
DELETIONS Red

10/2015

CHAPTER 6.00: UTILIZATION REVIEW AND QUALITY ASSESSMENT

Section

- 6.01: Scope and Authority
- 6.02: Definitions
- 6.03: Preferred Provider Arrangements under Workers' Compensation
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6.01: Scope and Authority

452 CMR 6.00 is promulgated pursuant to M.G.L. c. 152, §§ 5, 13, and 30. 452 CMR 6.00 shall apply to all claims for health care services:

- (a) requires workers' compensation insurers to undertake utilization review for all medical services to be provided to the injured employee after 12 weeks from the date of injury. The insurer may choose to undertake utilization review at any time during the 12 week period immediately following the date of injury. However, the insurer is mandated to undertake utilization review before denying any request for medical services during this initial 12 week period. Treatment guidelines are in effect during this 12 week period.
- (b) references the guidelines and review criteria that the Department of Industrial Accidents (DIA) requires providers to consider when treating certain medical conditions, and sets forth the mechanism for the development, endorsement, dissemination, and implementation of future guidelines;
- (c) sets forth the nature of utilization data that must be reported to the DIA;
- (d) sets forth the methods for quality assessment that will be used by the DIA;
- (e) sets forth the nature of the mechanisms that DIA will use to ensure compliance with 452 CMR 6.00; and
- (f) concerns the appropriateness of the health care service, i.e., whether the service is reasonable, necessary, and effective; and the quality of care provided to workers' compensation recipients, including consideration of the proper costs of services.

6.02: Definitions

~~Adverse Determination means a determination by the utilization review agent that a health care service has been reviewed, and based on the information provided, does not meet the clinical requirements for medical necessity and reasonableness of said service in accordance with medical guidelines.~~

Comment [DN1]: Not Needed

Approved Utilization Review Agent means any person or entity, insurer or self-insurer, including the Commonwealth of Massachusetts, which has been authorized by the DIA to perform utilization review.

~~**Authorization** means a determination by the utilization review agent that a health care service has been reviewed, and based on the information provided, meets the clinical requirements for medical necessity and reasonableness of said service in accordance with medical guidelines.~~

Comment [DN2]: Not Needed

Case Record means the complete record that is maintained by the utilization review agent and pertains to the injured employee's industrial injury. The case record shall include all of the following information and documents: date of injury; date of utilization review request; name of claim adjuster; name, address, telephone number, and school of ordering practitioner; International Classification of Disease (ICD) code and diagnosis; name, title, and credentials of utilization review staff; health care service requested; treatment guideline used to determine medical necessity; type and category of review; and supporting medical documentation.

Cease and Desist Order means a written notice of a violation issued by the Commissioner pursuant to 452 CMR 6.00 et seq., when the Commissioner determines that a utilization review agent, insurer, or self-insurer has failed to comply with all applicable laws, rules, regulations, orders, and requirements of the Commonwealth.

Clinical Reviewer means a licensed health care professional who holds a non-restricted license in any state.

Commissioner means the Commissioner/**Director** of the Department of Industrial Accidents (DIA).

Comment [DN3]: Commissioner is now referred to as Director

Concurrent Review means utilization review conducted during the patient's course of treatment.

Department/DIA means Department of Industrial Accidents.

~~**Detailed Description of Services Rendered** means pursuant to M.G.L. c. 152, § 13 a report demonstrating the diagnosis, medical appropriateness of the service, pertinent physical findings, diagnostic and therapeutic procedures, prognosis, concurrent problems, and follow up care; the injured employee's functional limitations, the ability to perform either regular duties, limited duties, full or part time hours and whether the medical condition is at a point of maximum medical improvement.~~

Comment [DN4]: Not needed

~~**Emergency Treatment** means care of an employee for a work related medical condition requiring immediate attention.~~

Comment [DN5]: Not Needed

Guidelines mean optimal strategies for patient management around which practice patterns should converge.

Health Care Services means treatment services rendered to an injured employee by a provider pursuant to M.G.L. c. 152.

Health Care Services Board means the Board created by M.G.L. c. 152, § 13(3).

Injury means personal injury as defined in M.G.L. c. 152, § 1(7A).

Insurer means an entity defined in M.G.L. c. 152, § 1(7) and any self insured group as defined in M.G.L. c. 152, § 25(E) through (U).

Comment [DN6]: No Parenthesis in statute

Medical Condition means the physical or mental health status of an injured employee as determined by the provider administering health care services.

Medical Director means a board certified physician duly licensed to practice in at least one state in the United States, and in active practice at least eight hours per week. The OHP may waive the active practice requirement for otherwise qualified, licensed physicians with administrative experience in utilization review oversight or quality assessment. Each utilization review organization shall have available a licensed medical director to provide for clinical oversight of the utilization review program.

~~**Medical Report** means a report of the Initial Industrial Accident office visit as defined in 114.3 CMR 40.03 pursuant to 452 CMR 1.13(1).~~

Comment [DN7]: Not Needed

OHP means Office of Health Policy which is a division of the DIA.

~~**Patient Satisfaction Measurement** means use of a standard patient questionnaire form, including, but not limited to, the American College of Physicians questionnaire to determine a particular individual's satisfaction with his or her care.~~

Comment [DN8]: Not Needed

Practitioner means any person who is licensed to practice under the laws of the jurisdiction within which such health care services are rendered including physicians, dentists, chiroprodists, chiropractors, optometrists, osteopaths, physical therapists, podiatrists, psychologists, and other licensed medical personnel.

Preferred Provider Arrangement (P.P.A.) means a contract between or on behalf of an organization and health care provider(s), as defined by M.G.L. c. 176I, 211 CMR 112.00 and M.G.L. c. 152, to provide all or a specified portion of health care services resulting from workers' compensation claims against such organizations by covered persons.

~~**Probationary Approval** means a temporary six month approval status after the utilization review agent fails a quality assessment audit. During this six month period, the utilization review agent may continue to conduct utilization review pending the results of interim follow up audits.~~

Comment [DN9]: Not Needed

Prospective Review means utilization review conducted prior to the delivery of the requested medical service.

Provider means a practitioner, facility, or other organization providing health care services.

Quality Assessment Tool is a guide used to evaluate the utilization review agent's quality assessment compliance rate.

Comment [DN10]: Not Needed

Retrospective Review means utilization review conducted after services have been rendered.

School means a grouping of practitioners as defined by their professional degree. Schools include, but are not limited to, medical, physical and occupational therapy, chiropractic, osteopathic, allopathic, nursing and dentistry.

Utilization Review concerns the quality of care provided to injured employees, including whether the service is appropriate and effective, the proper costs of services, and the quality of treatment. Appropriate service is health care service that is medically necessary and reasonable, and based on objective, clinical findings.

6.03: Preferred Provider Arrangements under Workers' Compensation

- (1) If an insurer receives approval of a preferred provider arrangement (PPA), an injured employee shall, if the arrangement is consented to by the employer and includes a provider in the specialty sought by the employee, be required to see a member of the preferred provider arrangement on the initial scheduled visit. Employees subject to any arrangement shall be provided information regarding their rights and obligations under M.G.L. c. 152, § 30 and M.G.L. c. 176I upon initial approval of the preferred provider arrangement and annually thereafter. Such information shall also be posted in a prominent place in all worksites.
- (2) The list of names of the providers in the preferred provider arrangement within an employee's geographic region or of all health care providers within the arrangement organized geographically shall be distributed to each covered employee immediately following an alleged workplace injury. The names on such lists shall be arranged in order of medical specialty or provider type. A current list shall also be posted at a convenient and prominent place for covered persons to examine at worksites, and shall be given to any covered person upon request.
- (3) Any insurer approved as a preferred provider arrangement for workers' compensation must send to the Department of Industrial Accidents a duplicate copy of all information filed with the Division of Insurance together with a copy of its approval letter.
- (4) The Department of Industrial Accidents may require the approved PPA applicant to survey affected employees with a form of the Department's design to assess the employee's understanding of their rights with regard to participation in PPA's.

6.04: Utilization Review by Insurers

(1) Insurers and self-insurers are required to undertake utilization review for health services rendered to injured employees, either by performing utilization review themselves or by contracting with a Commonwealth approved agent who will conduct utilization review services on their behalf. If an insurer or self-insurer chooses to perform utilization review on its own, it must have its program approved through the OHP. Said utilization review program must remain separate and distinct from case management and all other claim functions. Utilization review organizations conducting Massachusetts reviews at multiple sites must seek separate approval for each site.

For the conditions to which the treatment guidelines endorsed by the Health Care Services Board and adopted by the Commissioner pursuant to M.G.L. c. 152, §§ 13 and 30 apply, the programs shall integrate said treatment guidelines.

(2) Application for Approval: An applicant requesting approval to conduct utilization review in the Commonwealth shall:

- (a) submit a completed application to the OHP ~~for each site where Massachusetts utilization review will be conducted,~~ along with an initial application fee payable to the DIA. The application fee shall be \$1,000.00 if the company is located in Massachusetts, excluding the Commonwealth and the various counties, cities, towns and districts; and \$3,000.00 if the company is located outside of Massachusetts;
- (b) submit a new application to the OHP every two years, along with a renewal fee. The renewal fee shall be \$500.00 if the company is located in Massachusetts; and \$1,500.00 if the company is located outside of Massachusetts; and
- (c) make arrangements with the OHP for a site visit for all new applicants.

Comment [DN11]: Not Needed

(3) Information Required with Application: To conduct utilization review in the Commonwealth, a utilization review agent must seek approval of its utilization review program from the Commissioner in writing and the application shall include, but not be limited to the following:

- (a) corporate and site demographics: name, address, and telephone number of the program's corporate, ~~public,~~ and Massachusetts contacts; and the identification of each site where Massachusetts utilization review will be conducted ~~along with the name and number of the contact person for each site;~~
- (b) a list of all treatment guidelines which will be used by the licensed medical reviewer in rendering a determination, including DIA's ~~Health Care Services Board~~ Treatment Guidelines, approved secondary sources, and internally derived treatment guidelines. The utilization review agent shall also provide information pertaining to the procedures for implementing internal guidelines including the frequency of revisions;
- (c) copies of all current professional licenses issued by the appropriate state licensing agency for all practitioners rendering utilization review determinations, including the medical director;
- (d) a detailed description of the appeal procedures for utilization review determinations, including copies of all materials designed to inform injured employees of the requirements of the utilization review program and their responsibilities and rights under the program;

Comment [DN12]: Not Needed

Comment [DN13]: Not Needed

Comment [DN14]: Not Needed

Comment [DN15]: Provides clarification

- (e) the identity of each insurer/self-insurer for which the utilization review agent performs Massachusetts reviews;
- (f) an attestation in writing that the utilization review agent shall comply with all applicable laws, rules, regulations, orders, and requirements of the Commonwealth; and
- (g) disclosure of any economic incentives for reviewers in the utilization review program.

Any material changes in the information filed in accordance with 452 CMR 6.04 shall be filed with the OHP within thirty (30) days of said change.

(4) The OHP will publish the name and address of each approved UR agent on the DIA web site.

(5) All utilization review agents shall comply with the following procedures:

- (a) All determination letters must ~~identify the treatment guideline and set forth the set forth the relevant section of the treatment guideline referenced and provide a~~ clinical rationale. An adverse determination letter shall include instructions for the procedure to initiate an appeal of the adverse determination, ~~and set forth the relevant section of the treatment guideline.~~ A copy of the relevant section of the guideline must be provided upon request. The start and end dates for all scheduled health care services shall be clearly documented in the utilization review case note summary and on the determination notice. The date of request and the date of receipt of medical information must be documented by the utilization review agent in the utilization review case record.
- (b) Notification of all utilization review determinations issued by the utilization review agent shall be communicated to the injured employee/representative and the ordering provider in writing. For prospective reviews, written notice of the determination shall be given within two business days from receipt of the request for approval of treatment ~~and the receipt of all medical information necessary to conduct the review.~~ For concurrent reviews, ~~written notice of the determination shall be given at least one day prior to implementation, i.e., the start date for the ongoing health care service under review, and the receipt of all medical information necessary to conduct the review.~~ **if the ordering practitioner contacts the UR agent at least three business days prior to the start date for the ongoing treatment, written notice of the determination shall be given at least one day prior to the start/implementation date. If the ordering practitioner fails to request approval of ongoing treatment at least three business days prior to the start date, or fails to provide a start date, the UR agent shall issue the determination within five business days from receipt of the request.** For retrospective reviews, written notice of the determination shall be given within 20 business days from receipt of the request for approval of treatment ~~and the receipt of all medical information necessary to conduct the review.~~ **If additional medical information is necessary in order to complete the review, the utilization review agent shall inform the requesting health care provider of the specific medical information needed, and the time period in which the information must be provided. Prospective and Concurrent Reviews: information must be provided within seven (7) business days from the date of request. Retrospective Reviews: information must be provided within thirty (30) business days from the date of request.**

Comment [DN16]: Clarifies that the letter should not merely state the name of the treatment guideline, but specify the recommendation that is included in the guideline.

Comment [DN17]: Redundant

Comment [DN18]: Not Needed

Comment [DN19]: Confusing

Comment [DN20]: Not Needed

Comment [DN21]: Provides Clarification

Comment [DN22]: Not Needed

Comment [DN23]: Direction added to ensure best outcome for injured worker. This procedure is currently required and on the OHP website.

- (c) Any adverse determination of a health care service issued by a utilization review agent shall be issued by a practitioner of the same school as the ordering provider.
- (d) ~~Utilization review agents shall maintain and make available a written description of the appeal procedure by which the ordering provider or the injured employee may seek review of an adverse determination by the utilization review agent. Adverse determination letters must provide a description of the appeal procedure and .The appeal procedure.~~ at a minimum, shall provide the following:

Comment [DN24]: Language Simplified.

1. When an adverse determination is rendered during prospective or concurrent review, and the injured employee and/or the ordering provider believes that the determination warrants immediate appeal, the injured employee or the ordering provider may initiate the appeal via telephone to the utilization review agent with the right to communicate orally with a practitioner of the same school as the ordering provider on an expedited basis. The ordering provider or injured employee should be instructed to follow-up with a written request for the appeal. If the injured employee or ordering provider fails to comply, the utilization review agent should send a written confirmation of the appeal request. Said notice of appeal to occur no later than 30 days from the date of receipt of notice of adverse determination. Utilization review agents shall complete the adjudication on an expedited basis and render the determination no later than two business days from the date the appeal is initiated, unless the ordering provider agrees to a different time period.

2. Appeal of retrospective reviews shall be made in writing to the utilization review agent and occur no later than 30 days from the date of receipt of notice of adverse determination. Utilization review agents shall complete the adjudication of a retrospective review/standard appeal no later than 20 **business** days from the date the appeal is filed.

Comment [DN25]: Other review time periods refer to "business" days and change will provide consistency for UR Agents.

- (e) Utilization review agents shall make staff available by toll-free telephone system at least 40 hours per week between the hours of 9:00 AM to 5:00 PM, EST each business day.
- (f) Utilization review agents shall have a confidential telephone system capable of accepting and recording incoming telephone calls during other than normal business hours, and the agent shall respond to these calls on the following business day.
- (g) Utilization review agents shall comply with all applicable laws to protect the confidentiality of medical records and when necessary, obtain a medical release.
- (h) Practitioners rendering school to school utilization review determinations and medical directors must provide, and attest in writing to providing, patient care for at least eight hours per week.
- (i) Once an insurer has commenced payment for a work related injury under M.G.L. c. 152, it must issue the employee a card listing the employee name, an identification number assigned to the employee, the name and telephone number of the utilization review agent, and the name of the insurer. The employee must seek approval from the insurer/utilization review agent before receiving medical services. In the case of an emergency, utilization review agents shall allow a minimum of 24 hours after an emergency admission, service, or procedure for an injured employee or injured employee's representative to notify the utilization review agent and request approval for treatment.

(j) Initial level reviews must be conducted at the location of the approved utilization review site.

(6) After exhaustion of the process set forth in 452 CMR 6.04(5) (d), a party may file a claim or complaint in accordance with 452 CMR 1.07 under the provisions of M.G.L. c. 152, § 10.

(7) Injured employees may be liable for care subsequent to the adverse determination after they have been notified of that adverse determination.

(8) Ancillary Services: 452 CMR 6.00 et seq. concerns the requirements for the performance of utilization review. Should an insurer or self-insurer provide ancillary services such as managed care, case management, independent medical exams, or rehabilitation services from vendors who are also approved as utilization review agents, said ancillary services are not to be considered utilization review requirements or expenses. Ancillary services must remain separate and distinct from the utilization review services. Moreover, these ancillary services should not be construed as approved by the OHP by virtue of the OHP's approval of the same vendor to perform utilization review.

(9) Each insurer/self-insurer is required to inform the OHP of the name of the approved utilization review agent currently responsible for conducting the reviews.

6.05: Utilization Reporting

(1) Providers must use, and insurers must accept, standard forms prescribed by the DIA, based on the most recent Center for Medicare & Medicaid Services forms.

(2) The Department may require utilization review agents to provide a sample of up to 100% of all billing records, both inpatient and outpatient, which sample shall be transmitted to the Department of Industrial Accidents so that the Department can implement appropriate utilization oversight. In addition to the standard billing file, for every outpatient service the Department may request information about the insurer, any procedures, and the employer's and provider's identification numbers. For inpatient services, the Department must receive all relevant diagnostic and procedure International Classification of Disease (ICD) codes, Current Procedural Terminology (CPT) and other codes, the length of stay and the cost of any ancillary services. The Department may require both counts of services as well as the amount reimbursed.

6.06: Treatment Guidelines

(1) In promulgating these Utilization Review regulations, the Commissioner hereby utilizes the treatment guidelines developed and endorsed by the Health Care Services Board, recognizing that medical treatment cannot be reduced to regulation and that health care providers must be free to exercise their best judgements about the treatment of their patients.

(2) The Health Care Services Board will review and update treatment guidelines at least annually. Providers shall consider the treatment guidelines endorsed by the Health Care Services Board and adopted by the Commissioner when caring for injured employees or risk

nonpayment. The guidelines should not be construed as including all proper methods of care reasonably directed to obtaining the same results. The ultimate judgement regarding any specific procedure or treatment must be made by the provider in light of all circumstances presented by the injured employee and the needs and resources particular to the locality or facility. The adopted guidelines shall be used by utilization review programs administered by insurers in a form required by the Department, taking into account that appropriate care may vary on a case by case basis.

6.07: Quality Assessment and Enforcement

(1) General Rules for Compliance Enforcement

Pursuant to 452 CMR 6.00 et seq., the Office of Health Policy of the DIA monitors utilization review agents and their programs to ensure full compliance with Massachusetts General Laws and 452 CMR 6.00 et seq. Specific enforcement mechanisms include, but are not limited to, the following:

- (a) The Commissioner may revoke or refuse to renew a license of a self-insurer for the failure of any self-insurer to comply with all applicable laws, rules, regulations, orders, and requirements of the Commonwealth.
- (b) The Commissioner may revoke or refuse to renew the approval of the utilization review agent for failure to comply with all applicable laws, rules, regulations, orders, and requirements of the Commonwealth.

(2) The Department of Industrial Accidents will gather data on compliance with the treatment guidelines through reports from insurers and utilization review agents. ~~If a provider's care is demonstrated to be statistically significantly outside a particular guideline, the provider will be informed of this by the Department and educational material regarding the guideline will be transmitted to the provider. On a periodic basis, the provider's utilization patterns will then be reassessed. If the provider remains statistically significantly outside the guideline, the provider will be warned by the Department, educational materials will again be transmitted, and a clinical evaluation performed. If the provider's care is found to remain significantly and frequently outside the guideline, the matter will be transferred to the Commissioner. At the discretion of the Commissioner, the matter may be referred to the Health Care Services Board which may then refer the matter to the appropriate Board of Registration.~~

Comment [DN26]: The DIA does not monitor individual health care practitioners.

(3) If the Department finds that the care provided to injured employees through an insurer is more frequently deficient than that provided to other employees in receipt of workers' compensation, the Department will address this issue with the insurer ~~in a manner similar to the one specified in 452 CMR 6.07(2), with the exception that any referral by the Health Care Services Board will be to the Division of Insurance instead of a Board of Registration. by referring the matter to the Division of Insurance.~~

Comment [DN27]: Rewording the sentence to remove reference to the Board of Registration.

(4) The Department shall monitor the utilization review techniques used, and determinations made, by utilization review agents. If the Commissioner receives a complaint from a

practitioner, employer, or employee, or has reason to believe that a utilization review agent has been or is engaged in conduct that violates these regulations, the Commissioner shall notify the utilization review agent in writing of the alleged violation. The utilization review agent shall have ~~20~~ 14 days from the date the notice is received to respond to the alleged violation. On or after the ~~20~~14th day, the Commissioner shall render a finding after reviewing all documents submitted by the parties. The Commissioner may also schedule a hearing. If the Commissioner determines that the utilization review agent has violated or is in violation of any law, rule, regulation, order, or requirement, the Commissioner may issue an order requiring the insurer and/or utilization review agent to cease and desist from engaging in the violation(s). The Commissioner may also suspend or revoke the agent's approval to conduct utilization review and may assess a fine.

Comment [DN28]: Complaints should be resolved expeditiously for the interests of IW

If the utilization review agent requests a hearing regarding the findings of the Commissioner, the request must be made in writing within ~~20~~ 14 days from receipt of the findings. Upon receipt of the request, the Commissioner shall schedule a hearing to be conducted pursuant to M.G.L. c. 30A.

If the Commissioner renders a finding that the utilization agent has violated any law, rule, regulation, order, or requirement, the utilization review agent must inform the adjuster handling the injured employee's claim.

(5) A Cease and Desist order may include:

- (a) a summary of the violation(s);
- (b) a summary of the facts giving rise to the violation(s);
- (c) the penalty that the Commissioner intends to apply; and
- (d) information pertaining to the rights and obligations of the utilization review agent; as well as the procedure for the agent to file a written response or request a hearing.

(6) Non-Compliance Categories Include but are not Limited to:

- (a) Failure of an insurer/self-insurer to conduct a proper utilization review in accordance with 452 CMR 6.00 et seq.
- (b) Failure of the utilization review agent to render a written determination to both the injured employee and the ordering provider within the proper time constraints.
- (c) Failure of the utilization review agent to ensure an appeal level review is conducted by a same-school practitioner.
- (d) Failure of the utilization review agent to issue a written introductory letter within the required time period.
- (e) Failure of the utilization review agent to use the diagnosis and/or ICD code selected by the ordering provider when determining medical necessity and appropriateness of care.
- (f) Failure of the utilization review agent to cite the correct, research based treatment guideline when rendering a determination.
- (g) Failure of the utilization review agent to document clinical rationale to support the ~~guideline~~ **determination**.
- (h) Failure of the utilization review agent to utilize only licensed personnel to determine medical necessity and appropriateness for all health care services under review.

Comment [DN29]: Clinical rationale explains the reasoning for the determination.

- (i) Failure of the utilization review agent to maintain all required records in the form and manner prescribed by the OHP.
- (j) Failure to inform the OHP of any material change to the approved utilization review application within 30 days of said change.
- (k) Failure to adhere to the quality assurance and quality control measures set forth in the utilization review application.
- (l) Failure to maintain hours of operation between 9:00 a.m. and 5:00 P.M. EST on each business day, and return after hour calls within one business day.
- (m) Failure to inform the OHP of each site where utilization review is being conducted for Massachusetts claims.
- (n) Failure of the utilization review agent to comply with audits.
- (o) Failure of the medical director and school to school reviewers to maintain an active clinical practice of at least eight hours per week.
- (p) Failure to conduct initial reviews at the approved utilization review site.

(7) Quality Assessment Audit Review Procedures.

- (a) The OHP monitoring of the quality of care rendered to injured employees shall include, but not be limited to: onsite audits; desk audits; and review of patient satisfaction surveys, complaints, and statistical data provided by utilization review agents, insurers, and self-insurers. Desk audits shall consist of review of case records selected by the OHP. The OHP may also monitor the performance of providers reimbursed by insurers.
- (b) Approved utilization review agents shall comply with all requests for onsite and desk audits for continued utilization review approval.
- (c) Utilization review agents are required to pay all reasonable travel expenses for each onsite audit of the OHP representatives.
- (d) The OHP will determine the type of audit to be conducted (onsite or desk). The utilization review agent will be notified prior to the scheduled audit date. The agent shall submit a list of all utilization reviews conducted for the period specified by OHP. The OHP will notify the agent which files must be made available for the audit. The agent will make each sample record available, in hard copy, for review on the audit date.
- (e) **OHP audits are conducted yearly.** ~~If an agent meets the 85% compliance rating score for two consecutive quality assessment audits, the agent's audit schedule may be changed from yearly to every two years.~~ However, if at any time the OHP has reason to believe that the agent is not in full compliance with the laws, rules, regulations, orders, and requirements, by way of complaint or any other means, the agent's approval status may be reviewed and an immediate audit may be conducted.

Comment [DN30]: Audits are conducted yearly and not scored

- (f) ~~If the utilization review agent scores less than 85%, the agent will be placed on a probationary approval status for a period of six months and may be fined up to \$300.00. At the end of six months, and after interim audits, the utilization review agent will be informed as to whether or not the agent meets the 85% compliance rate and is approved to continue to conduct utilization review in Massachusetts. If the agent fails to meet the 85% compliance rate, the Commissioner may schedule a hearing to determine whether or not the utilization review agent's approval to conduct utilization review in the Commonwealth should be revoked.~~

Comment [DN31]: Delete, audits are not scored

(g f) The Office of Health Policy, at the direction of the Commissioner, may implement internal OHP policies and procedures at any time to ensure and improve the quality of the utilization review program.

(8) Fines

(a) Failure to comply with all applicable rules, regulations, orders and requirements of the OHP may result in a fine of up to \$300.00 per violation.

(b) Should the utilization review agent violate a cease and desist order within one year from the issuance date, additional fines may be assessed based on the violation. Penalties shall be additional fines of up to \$300.00 per occurrence, or may result in the Commissioner revoking the utilization review agent's continued approval.

REGULATORY AUTHORITY: 452 CMR 6.00: M.G.L. c. 152, §§ 5, 13, and 30.