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COMMISSIONER OF INSURANCE

BULLETIN 01-10

To: **Commercial Health Insurers, Blue Cross Blue Shield of Massachusetts, Health Maintenance Organizations**

From: **Linda Ruthardt, Commissioner of Insurance**

Howard K. Koh, MD, MPH, Commissioner of Public Health

Date: **August 10, 2001**

Re: **Certain Issues Regarding Managed Care Plans and Internal and External Review Procedures**

The Office of Patient Protection (OPP) at the Department of Public Health (DPH) has been meeting with carriers in order to answer questions and assist health plans in complying with M.G.L. c. 176O (chapter 176O) and 105 CMR 128.000. As a result of the meetings, questions have arisen about the implementation of certain sections of the law. This bulletin is intended to clarify certain requirements and advise carriers of OPP's answers to recurring questions.

Adverse determination letters

105 CMR 128.307 sets forth requirements for the written resolution of grievances. Written resolution of grievances must identify the specific information considered and an explanation of the basis for the decision. In the case of a grievance that involves an adverse determination, the written resolution must include a substantive clinical justification for the denial that is consistent with generally accepted principles of professional medical practice. At a minimum, letters regarding adverse determinations sent to insureds must do the following:

- identify the specific information upon which the adverse determination was based;
- discuss the insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;

- specify alternative treatment options covered by the carrier, if any;
- reference and include applicable clinical practice guidelines and review criteria; and
- notify the insured of the right to external review. This notice must include complete name, both street and electronic addresses, and telephone number for OPP, the filing fee, and the requirement that requests for external appeal must be filed within 45 days of receipt of the adverse determination letter. The notice must also include a copy of the form used to request an external review.

Carriers are cautioned against using form letters for notice of an adverse determination. OPP will refer carriers who fail to fully comply with the above-noted requirements to the Division of Insurance for investigation of noncompliance with chapter 176O pursuant to 211 CMR 52.17.

The 30-day requirement for resolution of grievances

It has come to our attention that carriers are not interpreting the 30-day requirement for the resolution of grievances properly, and that the practices of some carriers may result in noncompliance with the law. Section 13 of chapter 176O requires "a written resolution of each grievance within 30 days from receipt thereof." 105 CMR 128.305 clarifies that this time period is 30 *business* days, but reiterates that carriers must provide a written resolution within those 30 business days. Regardless of the number of steps involved in a carrier's internal appeals process, *a final written resolution must be issued within 30 business days* of the receipt of the grievance. Following an adverse determination rendered within this 30-day time limit, an insured may request an external review through the Office of Patient Protection.

Some carriers appear to be using a two-level approach that does not comply with the law. A carrier may not use a process that provides a resolution within 30 business days, and then require an insured to proceed with a second level of appeals. If a carrier uses a two-level process for internal appeals, the carrier must be able to complete the entire process within the 30-business day period. Because the 30-day period continues to run during the time an insured may be deciding whether to pursue a second level, a carrier may be at risk for exceeding the 30-day limit. OPP therefore strongly recommends that carriers make the second level an optional one, *i.e.,* the written resolution issued at the end of the first level must inform the insured of the right to an optional second level reconsideration by the carrier as well as the right to proceed directly to external review. If the insured chooses to pursue an optional second level, or if a carrier cannot complete the second level within 30 business days, then the carrier must obtain from the insured a written agreement to waive or extend the time requirements. If this second, optional review results in an unfavorable decision, at that time the insured can file a request for an external appeal with the OPP.

Carriers should note that the law provides that "[a] grievance not properly acted on by the carrier within the time limits required by 105 CMR 128.300 through 128.310 shall be deemed resolved in favor of the insured." Thus, carriers not in compliance risk having claim denials

automatically reversed. In addition, pursuant to 211 CMR 52.17(2), OPP can refer the carriers to DOI for investigation of noncompliance with accreditation requirements.

Waiver of time requirements by mutual written agreement

Many of the time requirements set forth in 105 CMR 128.000 can be waived or extended by "mutual written agreement of the insured or the insured's authorized representative and the carrier." See, *e.g.,* 105 CMR 128.302(A); 105 CMR 128.304; 105 CMR 128.305(D). "Mutual written agreement" means an agreement signed by both parties. Thus, call logs, notes, or a letter confirming an oral agreement will not comply with the regulation. Carriers may, however, confirm an oral agreement by letter and request that the insured sign and return the letter to acknowledge the agreement.

Jurisdictional questions

Both DOI and DPH have advised carriers that the requirements of chapter 176O apply to policies issued in Massachusetts. Thus, a group policy issued in Massachusetts must comply with chapter 176O not just for Massachusetts residents but also for group members who may reside outside of Massachusetts. Section 14(e) of chapter 176O states that "[t]he grievance procedures authorized by this section shall be in addition to any other procedures that may be available to any insured pursuant to contract or law, and failure to pursue, exhaust or engage in the procedures described in this subsection shall not preclude the use of any other remedy provided by and contract or law." Thus, for example, a resident of Rhode Island insured by a group policy issued in Massachusetts may have rights under both Rhode Island and Massachusetts law. Carriers must be sure to advise such insureds of rights under all applicable laws.

Questions regarding this bulletin should be directed to Carol Balulescu, Deputy General Counsel, Department of Public Health at (617) 624-5232 or to the Bureau of Managed Care, Division of Insurance at (617) 521-7372.