Massachusetts Department of Public Health
Office of Patient Protection
Annual Report: January 1, 2009 through December 31, 2009

Introduction

The Massachusetts Department of Public Health's (DPH'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 protections to health insurance consumers. Chapter 176O governs insured health plans that are issued or delivered in Massachusetts. The managed care plans offered through the Commonwealth Connector Authority, including those known as Commonwealth Care, are also subject to the consumer protections of Chapter 176O. In addition to consumer protections, Chapter 176O contains health insurance licensure and accreditation requirements that are administered by the Massachusetts Division of Insurance (DOI).

It is important to note that because Chapter 176O does not apply to Medicare, Medicaid, federal employee health insurance, or self-insured employer health benefits, OPP has no jurisdiction over these 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 an 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.

Chapter 176O provides an opportunity for independent review of any denial of coverage by a health plan based on medical necessity. Once an insured has exhausted the health plan's internal appeal process and received a final adverse determination, he or 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 from the health plan.

External Review Agencies

DPH contracts with three independent external review agencies. OPP assigns cases on a random basis to one of the three agencies, which then forwards it to one or more physician reviewers

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

- MAXIMUS Center for Health Dispute Resolution in Victor, NY,
- IPRO (Island Peer Review Organization) in Lake Success, NY and
- IMEDECS (Independent Medical Experts Consulting Services, Inc.) in Lansdale, PA.

All three agencies are accredited by URAC (the American Accreditation HealthCare Commission formerly known as the Utilization Review Accreditation Commission).

Except in cases of extreme financial hardship (which is determined by income based on the federal poverty level), 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. OPP pays the $25 filing fee for all members enrolled in Commonwealth Care, since one criterion for eligibility for Commonwealth Care is income below 300% of the federal poverty level.

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 (unless waived); 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.

Summary of 2009 External Review Activity

In 2009, OPP received 404 requests for external review of actions by health plans. OPP sent 286 of these cases to the external review agencies for independent review. Eighty-seven of the requests were not eligible for external review for a variety of reasons, usually because the health plan was not subject to the jurisdiction of OPP, the request was for services explicitly excluded by the health plan in its evidence of coverage, or the request concerned an area that was not within the jurisdiction of OPP. OPP worked with the health plans to resolve the other 31 cases, obviating the need for external review for those cases. These statistics are fairly consistent with those of previous years.

Detailed information regarding specific health plans, categories of appeals, and aggregate data can be found at www.mass.gov/dph/opp. When reviewing OPP statistics, it is important to understand that the numbers that OPP reports are absolute numbers. They are not reported on a per-member basis. Thus, although a very large plan may have more appeal requests, when membership is considered, the actual percentage of appeals per claim or per member may be

considerably lower that that of a small plan. For example, a plan with 850,000 members and 50 external reviews has fewer external appeals per member than a plan with 50,000 members and five external reviews.

Resolved Cases

In 2009, 31 of the requests for external review were resolved without being sent for review. In most of the cases, this occurred because the health plan decided to overturn its original denial following discussions with OPP or based on additional clinical information. In other cases, OPP noted compliance issues under 105 CMR 128.000 that required the health plan to resolve the case in favor of the member.

Decisions

In general, the three external review agencies overturned or partially overturned 45% of the health plan decisions, *i.e*., disagreed in whole or in part with the health plan's denial. As discussed below, behavioral health continues to be the number one category of external review requests, followed by cases involving services or supplies that fall within the general category of outpatient services. Please refer to www.mass.gov/dph/opp for more detailed statistics regarding external review decisions.

Behavioral Health

Behavioral health continues to be the category with the highest number of requests for external review. The cases in this category include disputes over the medical necessity of continued inpatient care, acute residential treatment, and various levels of care for behavioral health conditions including eating disorders and substance use disorders, and requests for services with behavioral health providers that are not in the health plan's network.

OPP sent out 113 external appeals of denials of coverage for behavioral health services, of which 45% were overturned. The plan with the highest number of eligible requests was Harvard Pilgrim Health Care, with 44 cases. The health plan with the second highest number of requests was Blue Cross Blue Shield of Massachusetts with 30 cases, followed by Fallon Community Health Plan with 23 cases. The remaining health plans had seven or fewer eligible requests for appeals involving behavioral health.

Outpatient Services

This category captures those outpatient services that do not fall within any of the other categories of service. Examples include chiropractic services, skilled nursing care, outpatient surgery, requests for human growth hormone, and requests to see out-of-plan providers. In 2009, OPP sent out 33 eligible cases in this category for review, of which 52% were overturned.

Experimental/Investigational

The third largest category of appeal requests was for coverage of services deemed experimental or investigational by the health plan. This category reflects the rapid

technological developments in medicine, with insureds seeking coverage for services and procedures not yet in widespread use. In 2009, this category accounted for 28 eligible requests with a 57% overturn rate, which is comparable to 2008.

Assisted Reproductive Technology (ART)

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 2009, OPP received 31 requests for ART that were eligible for external review and only 23% were overturned. The vast majority of these requests continue to be from women in their forties and fifties, and the disputes focused on whether their requests for ART fall within the state-mandated coverage, *i.e.*, was the appellant seeking treatment for a medical condition covered under the state mandate or were the ART services being requested by a patient who can no longer conceive without the assistance of technology due to the natural aging process.

Rehabilitation Services

This category is for physical rehabilitation services including physical therapy, occupational therapy and speech therapy. The question for the external reviewers on many of these cases is whether the care is being requested for short-term rehabilitation, which health plans cover, or for custodial or educational care, both of which are generally excluded from coverage. In 2009, OPP sent out 22 eligible rehabilitation cases for review, of which 79% were overturned.

Office of the Managed Care Ombudsman

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 staff OPP's toll-free line to assist consumers with issues and problems concerning managed care. Calls to OPP involve questions about health plan denials, appeals, benefits, and policies. OPP also answers general questions from consumers and providers about managed care and Chapter 176O, and refers callers with other health insurance questions to the Division of Insurance or other appropriate state or federal agencies.

Monitoring Health Plan Compliance

After nine full years of operation, OPP sees very few issues involving compliance with the procedural requirements of chapter 176O, especially with the large local health plans. In 2009, OPP conducted off-site inspections of grievance files for two health plans: Fallon Community Health Plan and Cambridge Health Alliance Network Health. Neither inspection turned up major compliance issues. Where OPP noted deficiencies, it requested and received corrective action plans, as it does when it identifies compliance issues via complaints.

Other Regulatory Activities

Throughout 2009, OPP continued to meet regularly with the Division of Insurance (DOI) to discuss managed care issues under Chapter 176O and to refer cases to DOI for investigation and enforcement. OPP and DOI also met regularly with the Department of Mental Health (DMH) to discuss issues related to the provision of mental health services, to work toward a uniform definition of intermediate care services and to develop a consistent policy around provision and coverage of intermediate care services under mental health parity. As a result of these meetings, DOI and DMH jointly issued Bulletin 2009-11 on September 4, 2009 to clarify mandated benefits for intermediate and outpatient services for mental health and substance use disorders. The bulletin can be found on the DOI website.

Outreach Activities

The Office of Patient Protection welcomes requests for informational presentations from consumer advocacy groups, hospital staff, and provider organizations. OPP continues to work with various professional associations as well as with staff from individual hospitals.

Office Relocation and Integration into the Division of Health Care Quality

In August of 2009, OPP moved to 99 Chauncy Street in Boston. This move was the first step toward the goal of fully integrating OPP into the complaint unit of DPH's Division of Health Care Quality.

Summary

As OPP enters its tenth year of operation, it will continue to provide consumer assistance, monitor compliance by health plans with Chapter 176O and administer the external appeals process. OPP will inspect health plan grievance files as necessary and refer patterns of noncompliance to the DOI for enforcement. Through consultation with other state agencies, including DOI, DMH, and the Office of the Attorney General, OPP will continue to identify and address concerns about managed care.

OPP staff 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. Because OPP is mindful that every appeal will result in a final decision that will be in favor of only one of the two parties involved, it will continue to strive for a process that each party agrees is expedient and fair, regardless of the ultimate result.

For further information about OPP, please visit its website at www.mass.gov/dph/opp. Any questions regarding this report should be directed to:

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