

# COMMONWEALTH OF MASSACHUSETTS



## Office of Consumer Affairs and Business Regulation

### DIVISION OF INSURANCE

One South Station – Boston, MA 02110-2208

(617) 521-7794 • FAX (617) 521-7758

<http://www.mass.gov/doi>

**MITT ROMNEY**  
GOVERNOR

**KERRY HEALEY**  
LIEUTENANT GOVERNOR

**BETH LINDSTROM**  
DIRECTOR, CONSUMER AFFAIRS  
AND BUSINESS REGULATION

**JULIANNE M. BOWLER**  
COMMISSIONER OF INSURANCE

### BULLETIN 2003-05

**TO:** Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations

**FROM:** Julianne M. Bowler, Commissioner of Insurance  
Christine Ferguson, Commissioner of Public Health

**DATE:** June 13, 2003

**RE:** Adverse Determination Notices

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The Office of Patient Protection (OPP) at the Department of Public Health (DPH) and the Bureau of Managed Care (BMC) within the Division of Insurance (DOI) have conducted meetings with carriers and providers to answer questions and assist carriers in complying with M.G.L. c. 176O (chapter 176O), 211 CMR 52.00 and 105 CMR 128.000. Recurrent questions raised during such meetings are associated with adverse determinations and how they are transmitted to providers and covered persons. The DOI has previously addressed issues associated with adverse determination letters in Bulletins 1-10 and 02-04. This bulletin is intended to further clarify what constitutes an "adverse determination" and a carrier's responsibilities in those cases in which it makes an adverse determination.

### **Adverse Determination**

Chapter 176O defines "adverse determination" as "a determination, based upon a review of information provided, by a carrier or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness." The DOI emphasizes that an adverse determination is therefore not only a "denial" but also any decision by a carrier to "reduce," "modify" or "terminate" any requested health care service or coverage based on medical necessity.

According to section 12(a) of chapter 176O, "adverse determinations rendered by a program of utilization review, or other denials of requests for health services shall be made by a person licensed in the appropriate specialty related to such health services and, where applicable, by a provider in the same licensure category as the ordering provider." Section 12(b) requires that initial determinations regarding proposed services "are to be made within two working days of obtaining all necessary information." In the case of an adverse determination (made within the two working days), "the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall provide written or electronic confirmation of the telephone notification to the insured and the provider within one working day thereafter."

According to section 12(c) of chapter 176O, carriers must render decisions based on concurrent review - defined as "utilization review conducted during an insured's inpatient stay or course of treatment" - "within one working day of obtaining all necessary information." If a carrier or utilization review organization makes an adverse determination as a result of concurrent review, section 12(c) requires that "the carrier or utilization review organization shall notify by telephone the provider rendering the service within 24 hours and shall provide written or electronic notification to the insured and the provider within one working day thereafter." All adverse determination notices, whether pre-service or as a result of concurrent review, must include the information required under section 12(d) of chapter 176O and 211 CMR 52.08(6). As noted in Bulletin 2002-04, if the adverse determination concerns inpatient care, the notice must also include information that explains the right to an expedited appeal and the right to continue to receive coverage for care that was initially authorized.

Special circumstances may apply regarding emergency services (see Bulletin 00-14), but in all other cases, carriers must comply with the requirements regarding adverse determinations when the carrier takes any action that "denies," "reduces," "modifies" or "terminates" any requested health care service or coverage. Carriers must properly deliver all such notices of adverse determinations to the provider and the covered person so that they may exercise rights to provider reconsideration

### **Reducing or Modifying Health Care Services**

It has come to the BMC's attention that certain carriers or providers may not consider certain "approvals" or "authorizations" to be "adverse determinations" even though the carrier has authorized less than what was originally requested. As noted above, under chapter 176O, a carrier renders an adverse determination whenever it makes a decision to approve anything less than or different from what was originally requested, based on medical necessity, appropriateness of setting and level of care or effectiveness. A "partial approval" i.e., an approval for a course of treatment - but not necessarily for a specific number of days or visits - that differs from the original request, is still an adverse determination.

It should be noted that carriers may approve an initial inpatient admission or initial services within a proposed course of treatment and require information from providers during a concurrent review process to justify the medical necessity of ongoing care. Such an approval would not be considered an adverse determination provided that the approval clearly explains the next steps in the concurrent review process. The DOI will not consider that a carrier has issued an adverse

determination in these cases until such time as a provider has requested additional services and the carrier has determined that those services are not medically necessary, whether based on duration or frequency of treatment.

For example, if a provider requests that a member's inpatient stay be extended for five days and the carrier makes a determination that only two additional days are medically necessary, the carrier has made an adverse determination. However, a carrier would not be considered to have made an adverse determination solely because it is conducting concurrent review of an inpatient stay or course of treatment that was initially authorized by the carrier. Similarly, a provider may request services at the rate of two visits per week for six weeks. If the carrier makes a determination that only one visit per week is medically necessary, then its decision is an adverse determination. However, if the carrier approves two visits per week and asks for additional information at the end of four weeks of treatment, it will not have issued an adverse determination.

Both DOI and DPH expect that when carriers issue approvals following review of an initial request, the approvals authorize a reasonable number of services and do not impose unnecessary administrative burdens on providers. For example, it would generally not be appropriate for any carrier to approve outpatient treatment one visit at a time for an established diagnosis. All adverse determinations are expected to include the information required by statute and regulation, but if companies need to amend their notices of adverse determination for any disclosures newly added by this bulletin, they are to make those modifications no later than September 30, 2003.

### **Adverse determinations versus benefit denials**

As noted above, an adverse determination is a decision to deny or otherwise modify a request for health care services based on medical necessity. Thus, a denial based on a health plan's contractual benefit limitations rather than a determination that a service is not medically necessary is usually not an adverse determination and does not, therefore, need to meet the above requirements. There are certain types of denials for requests of services, however, that some carriers consider to be benefit denials but which should be treated as adverse determinations. Carriers must treat such denials as adverse determinations and give insureds all of the rights set forth in chapter 176O, including the right to external review.

Examples of cases that should be treated as adverse determinations include:

requests for additional visits beyond a contract limit if the insured or the insured's provider alleges that the additional visits are medically necessary for an illness or injury unrelated to the illness or injury for which the benefit was exhausted. Example: A health plan limits physical therapy to a 60-day period following an illness or injury and the insured is appealing a denial because he says the additional visits are necessary because of an unrelated condition.

requests for cosmetic procedures that are not specifically excluded by a carrier, where the insured or the insured's provider alleges that the procedure is medically necessary because it is intended to do more than alter the member's appearance. Example: A member's provider argues that a proposed rhinoplasty is medically necessary to treat an obstructed airway.

Thus, for a requested service that is not specifically excluded from coverage, if there is an element of medical necessity review by the carrier, if there is an argument by the member or the member's treating clinician that the services in question are medically necessary, or in the event of a time or episode-related benefit exclusion, there is an argument that this is a new condition that would trigger a new benefit, then the carrier must:

treat the initial denial as an adverse determination;  
handle the internal appeal as a medical necessity appeal; and  
advise the insured that the decision may be eligible for an external review through the Office of Patient Protection (OPP) if the appeal results in a final denial.

OPP screens all requests for external review; if it determines that a case is not eligible because it does not meet the definition of an adverse determination, it notifies the insured and the case is not referred to an independent external review agency.

### **Explanations of benefits (EOBs)**

Carriers that issue EOBs to members as part of claims processing must meet all requirements set forth in 211 CMR 52.08(6) if any denial meets the definition of an adverse determination as explained in this bulletin, and must meet the requirements of 211 CMR 52.100: Appendix A, UM 6 Denial Notices for all other benefit denials. Please note especially UM 6.3: Carriers must include information about the appeals process in all denial notifications. Multi-state carriers must include specific information about the rights guaranteed by chapter 176O in their denial notices sent to members insured under a Massachusetts-issued policy; general information is not acceptable. Carriers that do not provide notice of the full rights guaranteed by chapter 176O in initial denials, including EOBs, will be subject to investigation by the DOI for noncompliance with accreditation standards pursuant to 211 CMR 52.17(2).

Questions regarding this bulletin should be directed to the Office of Patient Protection, Department of Public Health at (617) 624-5278 or to the Bureau of Managed Care, Division of Insurance at (617) 521-7372.