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To: External Review Agencies under contract with the Department of Public Health pursuant to M.G.L. c. 176O, § 14

From: Karen Granoff, Director, Office of Patient Protection

Re: Continuation of Coverage pursuant to 105 CMR 128.414

Date: October 23, 2003

The Office of Patient Protection (OPP) would like to clarify its expectations regarding the continuation of coverage described in 105 CMR 128.414. This section of the regulation states:

> If the subject matter of the external review involves the termination of ongoing services, the insured may apply to the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending. Any such request must be made before the end of the second business day following receipt of the final adverse determination. The review panel may order the continuation of coverage or treatment where it determines that substantial harm to the insured's health may result absent such continuation or for such other good cause as the review panel shall determine. Any such continuation of coverage shall be at the carrier's expense regardless of the final external review determination.

If a request for such continuation is received on a timely basis, OPP will specifically refer to the request in its cover letter to the external review agency (ERA), and ask the ERA to issue a determination on continuation of coverage. OPP expects the ERA to render a decision at the outset of the external review process, rather than contemporaneous with the final decision, so that a patient is aware as soon as possible whether he or she may be financially liable for continuing services if the plan's denial is upheld.

Thus, OPP expects that the ERA will review the file and issue a separate determination regarding continuation of coverage within one business day of receipt of the request. The decision may be made by the reviewer or by the ERA. OPP is aware that the ERA may not have the full medical

record at the time that the determination is requested, and understands that the determination will be based on only the information available at the time.

This decision regarding continuation of coverage does not bind the reviewer in rendering the final determination. For example, the ERA can determine that coverage should continue during the pendency of the review and then issue a final decision that upholds the health plan's denial of coverage based on lack of medical necessity. This means that the carrier must cover services through the date the decision is issued, but not beyond that date. Conversely, an ERA may determine that services do not need to continue while the review is pending, but upon receiving the complete medical file, may make a final decision that reverses the health plan's denial. In this case, the final decision would render the continuation of coverage decision moot.

In certain circumstances, it may be necessary to reference the continuation of coverage decision in the final decision letter. For example, if the ERA initially holds that services must continue during the pendency of the review but ultimately determines that services are not medically necessary (or partially overturns the carrier's denial), the final letter must clearly state that services must continue through the date of the letter notwithstanding the final determination regarding medical necessity.

Any questions regarding this memorandum should be directed to Karen Granoff at 617-624-5282.