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Bulletin 2002-04

To: Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, and Health Maintenance Organizations accredited pursuant to M.G.L. c. 176O

From: Commissioner Howard K. Koh, Department of Public Health and H Koh MD MPH
Commissioner Linda Ruthardt, Division of Insurance L Ruthardt

Re: Adverse Determinations, Concurrent Review and Appeal Rights for Inpatient Stays under M.G.L. c. 176O

Date: January 24, 2002

The Bureau of Managed Care in the Division of Insurance and the Office of Patient Protection in the Department of Public Health publish this bulletin jointly consistent with the obligations of each agency imposed by M.G.L. c. 176O (Chapter 176O). The purpose of this bulletin is to clarify the procedures carriers must follow when an insured is hospitalized in order to comply with sections 12 through 14 of Chapter 176O and related sections of 105 CMR 128.000 and 211 CMR 52.00.

Definition of "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." Please note that according to this definition, if a carrier determines that inpatient care is no longer medically necessary, it has made an adverse determination under Chapter 176O and must comply with all requirements regarding adverse determinations, regardless of any contractual relationship with the provider that may hold the insured harmless.

Concurrent Review Requirements under M.G.L. c. 176O, § 12

"Concurrent review" is defined in Chapter 176O as "utilization review conducted during an insured's inpatient hospital stay or course of treatment." Section 12(c) of Chapter 176O states that a carrier must make a concurrent review determination within one working day of receiving all necessary information. In the case of an adverse determination, the carrier must notify the provider by telephone within 24 hours, and must provide written or electronic notification to the insured within one working day thereafter. Please note that the *service must be continued without liability to the insured until the insured has been notified.* Thus, in the case of inpatient care, the insured must be notified in writing of an adverse determination prior to discharge.

Section 12(d) specifies that the written notice of the adverse determination must contain a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and shall, at a minimum:

(1) identify the specific information upon which the adverse determination was based;
(2) 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;
(3) specify any alternative treatment option offered by the carrier, if any; and
(4) reference and include applicable clinical practice guidelines and review criteria.

In addition, because carriers must always make certain that insureds are aware of their rights to appeal adverse determinations, the notice to the *insured* must also include notice of the carrier's internal appeal procedures, as required by 211 CMR 52.100: Appendix A, UM 4.1.10 and UM 6.3. In the case of inpatient care, the notice must clearly advise the insured of the right to an expedited appeal with the right to a decision prior to discharge.

Please note further that the notice to the *provider* must also offer the opportunity to seek reconsideration from a clinical peer reviewer, pursuant to section 12(e). Reconsideration must occur within one working day of the receipt of the request. If the adverse determination is upheld, then the insured or the provider may pursue an internal grievance. Note, however, that the reconsideration process is not required before an internal appeal or an expedited appeal.

Internal Appeals

Under the above requirements, the insured must receive notice of the adverse determination while still an inpatient. As such, the patient is eligible for an expedited appeal pursuant to 105 CMR 128.309(1). *Written resolution of the expedited appeal must be provided to the insured prior to discharge from the hospital.* Please note that during the expedited appeal, which is part of the carrier's internal grievance process, the disputed coverage must be continued at the carrier's expense as required by 105 CMR 128.312.

If the expedited appeal results in an adverse determination, the written resolution must conform to 105 CMR 128.307, including notice of the right to an expedited external review and the right to request continuation of coverage for the services.

External Appeals

The insured can, while still an inpatient, request an expedited external review if the treating physician certifies, in writing, that delay in the continuation of the inpatient services would pose a serious and immediate threat to the health of the insured. *See* 105 CMR 128.401. The insured can also request continuation of services pursuant to 105 CMR 128.414:

> 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. 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.* (Emphasis added.)

The expedited review decision will be issued in five business days pursuant to 105 CMR 128.415.

To summarize, an inpatient must receive all notices of adverse determinations, whether the result of concurrent review or an internal grievance, *prior to discharge*. Carriers should use a separate notice for adverse determinations involving an insured who is an inpatient. These notices should not refer to the 30-day internal appeals process, since all inpatient appeals are required to be expedited. All such notices must contain a clear explanation of the right to proceed to the next level of appeal, whether internal or external, on an expedited basis, and the right to have services continued. These notices must be *received* by the insured or the insured's authorized representative prior to discharge; it will not be acceptable to simply mail a notice to the home of the insured. Carriers that do not provide notice of the full rights guaranteed by Chapter 176O will be subject to investigation by the Division of Insurance for noncompliance with accreditation standards pursuant to 211 CMR 52.17(2).

Questions about this bulletin regarding concurrent review should be directed to the Bureau of Managed Care at (617) 521-7372; questions regarding the internal and external appeals process should be directed to the Office of Patient Protection at (617) 624-5278.