IN RE: HEALTHSOURCE MAINE, INC.) **CONSENT AGREEMENT**
) **BUREAU OF INSURANCE**
) **DOC NO. MCINS 99 - 18**

This document is a Consent Agreement, authorized by 5 M.R.S.A. § 9053(2) entered into by and among Healthsource Maine, Inc. (hereafter "Healthsource") and the Maine Superintendent of Insurance (hereafter also "the Superintendent"). Its purpose is to resolve, without resort to an adjudicatory proceeding, violations of Bureau of Insurance Rule Chapter 850 as set forth below.

FACTS

1. The Superintendent is the official charged with administering and enforcing Maine's insurance laws and regulations.

2. Healthsource Maine, Inc. has been a Maine licensed HMO, License # HMD 4, since 1987.

3. Consumer filed a formal complaint, complaint # 1999505205, with the Bureau of Insurance on April 6, 1999, challenging Healthsource's denial of coverage for additional chiropractic visits. Consumer's complaint was forwarded by the Bureau to Healthsource for a documented response on April 9, 1999.

4. On March 30, 1999, Healthsource sent Consumer a Denial of Services letter, stating in relevant part:

"We have received a referral for [Consumer] from [Provider]. The Medical Director reviewed the information sent in by your doctor and has not approved coverage because: Add'l Chiropractic Visits Denied. Progress Notes Denote Functional Abilities To Complete Daily Activities."

"…If you have any questions or wish to receive a copy of the clinical rationale used to make this determination, please call our Member Services Department."

5. On April 6, 1999, Consumer's provider appealed Healthsource's adverse determination.

6. On April 12, 1999, Healthsource wrote to Consumer's provider, acknowledging receipt of the provider's appeal, and copying Consumer. The April 12th letter stated in relevant part:

"This review will be conducted within 20 days, unless there is an unforeseen delay due to complications in collecting necessary information. Should this occur, Healthsource/CIGNA will notify you in writing of the need for an extended investigation period."

7. Rule 850(8)(G)(1)(c) provides (emphasis added):

"The health carrier or the carrier's designated URE shall notify in writing both the covered person and the attending or ordering provider of the decision <u>within 20 working days</u> following the request for an appeal."

8. On May 24, 1999, 29 working days after the date Healthsource acknowledged receipt of Consumer's April 6, 1999 appeal, Healthsource sent Consumer an adverse determination notice denying her appeal. Healthsource has advised the Bureau that the 20 day time limit was not met because additional time was required to conduct an external review.

9. Rule 850(8)(G)(1)(b) requires that appeals "*shall be evaluated by an appropriate clinical peer or peers*." Healthsource has identified its external clinical peer reviewer as the clinical peer who evaluated the appeal.

10. Rule 850(8)(G)(1)(c)(i) provides that an adverse decision notice must contain:

(i) *The names, titles and qualifying credentials of the person or persons evaluating the appeal."*

11.Although Healthsource's May 24, 1999 adverse determination notice contains the names and titles of the Appeals Committee members, it does not contain the name of the reviewing licensed chiropractor designated by Healthsource as the reviewing clinical peer.

12. Healthsource's May 24, 1999 adverse determination notice states in relevant part:

"*Thank you for your letter of appeal on behalf of [Consumer], requesting Healthsource Maine approve and pay for additional chiropractic visits. The Appeal Committee has reviewed your case, including the [4/6/99] letter from you and office notes dated 2/24/99 and 3/19/99 and determined that this request will be denied. This decision was based on the recommendation of an independent external review, which was conducted by a Licensed Chiropractor in the State of Maine. Additional visits are not medically necessary, specifically numbers 1 and 6, as outlined below. [Consumer] should continue with an independent exercise program to maintain progress, as this would be a medically appropriate treatment plan. Additional chiropractic visits may be considered medically necessary if a re-injury or exacerbation occurs."*

"For future reference, Medically Necessary information is outlined in [Consumer's] Subscriber Agreement on page 9 as follows:

1. Consistent with the symptoms or diagnosis and treatment of the member's condition.….

6. The most appropriate supply, level of care or service which can be safely and effectively provided to the member."

13. On May 28, 1999 Healthsource sent the Bureau of Insurance a written response to Consumer's formal complaint. Healthsource's response states, in relevant part:

"[Provider] received notification of this denial of services when the referral for additional visits was denied on March 30, 1999. The member, primary care physician and specialist are notified of all referral determinations. When Healthsource Maine received [provider's] appeal letter, a hearing was scheduled. [Consumer's] case was reviewed by [Associate Medical Director], at the appeal. He requested a peer review from a licensed chiropractor in the State of Maine. The

denial for continued chiropractic care for this injury was upheld in the appeals process after a peer review was conducted."

14. On June 7, 1999, Consumer's provider wrote to Healthsource requesting additional information. That letter stated in part:

"This letter is not the appeal, it is simply a request for further information so that we can draft an effective appeal... We obviously disagree with that decision and will need a copy of the signed independent external review conducted by a licensed chiropractor... in order to complete our appeal. We also need the name and [curriculum] vitae of the reviewing licensed chiropractor. Also, we need to know the name of the source, reference or guide that is used to complete the review. Lastly, would you please send us a copy of the clinical rational[e] used to make the initial denial determination."

15. On June 9, 1999, Consumer wrote a letter to the Bureau explaining her dissatisfaction with the review of her claim.

16. On June 30, 1999, the Bureau wrote to Healthsource advising that Healthsource's May 24, 1999 adverse determination notice failed to comply with Rule 850. The Bureau's letter also directed Healthsource to send Consumer and her provider a new adverse determination letter containing all of the requirements of Rule 850(8)(G)(1)(c)(i, iii, iv, v).

- Rule 850(8)(G)(1)(c)(i), set forth at paragraph 10 above, requires the names, titles and credentials of the person evaluating the appeal.

- Rule 850(8)(G)(1)(c)(iii), set forth at paragraph 20 below, requires clinical rational in sufficient detail for the covered person to respond.

- Rule 850(8)(G)(1)(c)(iv), set forth at paragraph 23 below, requires a reference to the evidence and the clinical review criteria the decision is based upon.

- Rule 850(8)(G)(1)(c)(v), set forth at paragraph 25 below, requires a description of the process for filing a second level grievance.

17. On July 1, 1999, Healthsource sent Consumer's provider the external reviewer's curriculum vitae, and copies of the notes the external reviewer submitted with his review. Healthsource's letter advised Consumer's provider that:

"Letters of Clinical Rationale for the denied services are provided by the Health Services Department at Healthsource. These letters of clinical rationale will be forwarded to you under separate cover. I enclosed a copy [of] the Group Subscriber Agreement for your reference, Please refer to section 4.A (7) page 14 that refers to the covered services for chiropractic care."

18. On July 15, 1999, in response to the Bureau's June 30th request, Healthsource sent Consumer and her provider a revised adverse appeal determination letter. Except for the addition

of the 2nd level appeal rights required by Rule 850(8)(G)(1)(c)(v), this letter essentially restated the language of the May 24th adverse determination notice cited at paragraph 12.

19. On July 15, 1999, Healthsource also responded to the Bureau's June 30, 1999 letter, in which the Bureau advised that Rule 850 requires adverse utilization review notices to include the names, titles, and credentials of the appeal reviewer. Healthsource stated:

"Rule 850 requires health plans to list the members of the Appeal/Grievance Committees with their credentials. [Healthsource's external peer reviewer] is not a member of our committee. His external review was requested to provide a peer review to determine if the care was appropriate and/or medically necessary. It is Healthsource's understanding that [external peer reviewer's] name and credential's are not required in this letter, but that we are required to release them to the member, or member's representative if asked."

20. The Bureau's June 30, 1999 letter directed Healthsource to provide Consumer with an adverse determination notice which complied with Rule 850(8)(G)(1)(c)(iii). Rule 850(8)(G)(1)(c)(iii) requires adverse determination notices to contain:

(iii) The reviewers' decision in clear terms and the clinical rationale in sufficient detail for the covered person to respond further to the health carrier's position.

21. Healthsource's July 15, 1999 letter responded to the requirements of Rule 850(8)(G)(1)(iii), stating in part:

"Additional chiropractic visits were denied Consumer because they were not medically necessary. The determination letter directly quotes the criteria for medical necessity from the Group Subscriber Agreement (1-6). This quotation provides [Consumer's provider] and [Consumer] with a copy of the criteria and a reference point for its source. The paragraph preceding the quotation provides the reasons why the care was not medically necessary, specifically pointing to 1 and 6. The appropriate treatment plan recommended as a result of this review is a home treatment plan. Additionally [Consumer] is advised that if there is re-injury or an exacerbation of her condition, then continued chiropractic care may then be deemed medically necessary (consistent with the symptoms or diagnosis and treatment)."

22. Healthsource's May 24, 1999 adverse determination letter advised only that the requested services are not medically necessary because they are not:

"*(1)Consistent with the symptoms or diagnosis and treatment of the member's condition,"* and are not

(6) The most appropriate supply, level of care or service which can be safely and effectively provided to the Member."

23. Bureau of Insurance Bulletin 265, dated July 17, 1997, specifically addresses the Bureau's interpretation of statutory requirements that adverse utilization review determination notices

include the clinical rationale in sufficient detail for the covered person to respond further to the health carrier's position. Bulletin 265 provides (emphasis added):

*"It has come to the Bureau's attention that adverse utilization review determinations sometimes fail to communicate any meaningful explanation for the reviewer's conclusion that a requested service is not medically necessary. Examples would include denials on the grounds that the requested service "**is not medically necessary**" or "**does not reflect the most efficacious or effective care possible for this diagnosis.**"*

…Conclusory statements of the sort described above simply repeat the decision rather that "stating the basis for the decision" as required by law. Consistent with the requirements of law, an adverse utilization review determination must explain the reason(s) underlying the conclusion that a requested service is not medically necessary."

24. Rule 850(8)(G)(1)(c)(iv) provides that adverse determination notices must contain:

"(iv) *A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination. The decision shall include instructions for requesting copies of any referenced evidence, documentation or clinical review criteria not previously provided to the covered person."*

25. Healthsource's May 24, 1999 adverse determination notice made no reference to clinical review criteria, or to Consumer's right to request request copies of any clinical review criteria or documentation relied upon by Healthsource in arriving at its decision.

26. Rule 850(8)(G)(1)(c)(v) provides that adverse determination notices must contain:

"A description of the process for submitting a written request for second level grievance review pursuant to section 9(D), the procedures and time frames governing a second level grievance review, and the rights specified in section 9(D)(3)(c)."

The rights specified in 850(9)(D)(3)(c) include the insured's right to:

a. Attend the second level review;

b. Present his or her case to the review panel;

c. Submit supporting material both before and at the review meeting;

d. Ask questions of any representative of the health carrier; and

e. Be assisted or represented by a person of his or her choice.

The sole reference to consumer's second level grievance rights in the May 24, 1999 adverse determination notice stated:

If you are not satisfied with this decision, and you wish further review of the claim, please write to the:

Management Grievance Committee
Healthsource Maine
2 Stonewood Drive
PO Box 447
Freeport ME 04032-0447

Should you have any further questions regarding this matter, please feel free to contact Debbie McClean, Appeals Coordinator at 1-800-524-9230, extension 5789.

27. On July 19, 1999, Consumer's provider again wrote to Healthsource, stating:

"I have enclosed a copy of the revised appeal response letter I received regarding [Consumer]. This revised appeal letter, as you can see, is dated July 15, 1999 and is a rewrite of the May 24, 1999 appeal response letter I received from Healthsource…

In spite of my requests and the requests of the Department of Professional & Financial Regulation, I have yet to receive a copy of the… reference or guide that Healthsource uses to complete the review. I need this information in order to assist my patient in completing her appeal to the Management Grievance Committee."

28. Rule 850(8)(E)(5) provides that adverse determination notices must contain the instructions for requesting the clinical review criteria used for making the initial adverse determination. Rule 850(8)(G)(1)(c)(iv) provides that adverse appeal decisions shall contain instructions for requesting copies of any referenced evidence, documentation or clinical review criteria not previously provided to the covered person.

29. Rule 850(8)(D)(1) provides that, *"A utilization review program shall use documented clinical review criteria that are based on published sound clinical evidence and which are evaluated periodically to assure ongoing efficacy. A health carrier or the carrier's designated URE may develop its own clinical review criteria or may purchase or license clinical review criteria from qualified vendors. Upon request, a health carrier or the carrier's URE shall make available its clinical review criteria to the Superintendent."*

30. On September 17, 1999, Healthsource wrote to the Bureau in response to the Bureau's request that Healthsource provide the Bureau, the Consumer, and the Consumer's provider with a copy of the current clinical review criteria for chiropractic services, and a copy of the clinical review criteria utilized at the time of the March 30, 1999 adverse determination. Healthsource advised:

"I am attaching correspondence from Dr. Kathy Naughton, a chiropractor employed by CIGNA with significant experience in clinical and academic chiropractic settings. She does not believe that currently there are objective clinical review criteria to serve as a benchmark for review. Rather, Healthsource and CIGNA nationally are forced to have their Medical Directors use

general medical judgment in determining whether a condition will improve within the stated short term period defined in the member's Group Subscriber Agreement."

A copy of Dr. Naughten's letter is appended to this Agreement as Exhibit "A".

CONCLUSIONS OF LAW

31. As set forth in paragraphs 5, 6, 7, and 8 above, Healthsource violated Rule 850(8)(G)(1)(c) by failing to provide a written response to Consumer's appeal within 20 days.

32. As set forth in paragraphs 9, 10, 11, 14, and 17, above, Healthsource violated Rule 850(8)(G)(1)(c)(i) by failing to include the name of the reviewing clinical peer in its May 24, 1999 adverse determination notice.

33. As set forth in paragraphs 12, 14, 18, 19, and 20, 21, 22 and 23 above, Healthsource violated Rule 850(8)(G)(1)(c)(iii) in its May 24, 1999 and July 15, 1999 adverse determination notices by failing to articulate the reviewers' decision and clinical rationale in sufficient detail for the covered person to respond further to Healthsource's position. Advising a consumer that a treatment "is not medically necessary" is conclusory because it does not advise the consumer why the treatment is not medically necessary. Healthsource's explanation that the treatment is not "*(1) Consistent with the symptoms or diagnosis and treatment of the member's condition*," is likewise conclusory.It does not advise the Consumer why the treatment recommended by Consumer's provider is not consistent with the symptoms or diagnosis. Advising a consumer that a treatment *"does not reflect the most efficacious or effective care possible for this diagnosis"* is conclusory because it does advise the consumer why the treatment does not reflect the most efficacious or effective care possible. Healthsource's explanation that the treatment recommended by Consumer's provider is not "*(6) The most appropriate supply, level of care or service which can be safely and effectively provided to the Member"* is likewise conclusory. It does not advise the Consumer why the proposed treatment is not the most appropriate level of care which can be safely and effectively provided.

34. As set forth in Paragraph 26, above, Healthsource violated Rule 850(8)(G)(1)(c)(v). Consumer was not advised of the procedures and time frames governing a second level grievance review, or of her right to: 1) attend the second level review, 2) present her case to the review panel, 3) submit supporting material both before and at the review meeting, 4) ask questions of any representative of the health carrier, and 5) be assisted or represented by a person of his or her choice.

COVENANTS

35. A formal hearing in this matter is waived and no appeal will be made.

36. At the time of executing this Agreement, Healthsource will pay to the Maine Bureau of Insurance a civil penalty in the amount of four thousand dollars ($4,000), payable to the Treasurer of the State of Maine.

37. Within 30 days of executing of this Agreement, Healthsource will provide the Bureau with a written explanation of how it determines medical necessity for chiropractic services. Until such time as Healthsource may develop or adopt formal chiropractic clinical review criteria, Healthsource will advise consumers and their providers who request the clinical review criteria upon which an adverse chiropractic utilization review was based that Healthsource does not utilize chiropractic clinical review criteria. Requesting consumers and their providers will instead be provided with the aforementioned written explanation of how Healthsource determines medical necessity for chiropractic services, along with a detailed, patient specific justification for the adverse chiropractic determination at issue.

38. In consideration of Healthsource's execution of and compliance with the terms of this Consent Agreement, the Superintendent agrees to forgo pursuing any disciplinary measures or other civil sanction for the violations relating specifically to Bureau complaint # 1999505205 other than those agreed to in this Consent Agreement.

MISCELLANEOUS

39. This Consent Agreement may only be modified by the written consent of the parties.

40. It is understood by the parties to this Agreement that nothing herein shall affect any rights or interests that any person not a party to this Agreement may possess.

41. Healthsource acknowledges that this Consent Agreement is a public record within the meaning of 1 M.R.S.A. § 402 and will be available for public inspection and copying as provided for by 1 M.R.S.A. § 408.

42. Healthsource has been advised of its right to consult with counsel and has, in fact, consulted with counsel before executing this Agreement.

For Healthsource Maine, Inc.

Dated: _______, 1999

By: ___________________
Signature

For: __________________
Typed Name

____
Typed Title

this _______ day of ________, 1999.

____
Notary Public

FOR THE BUREAU OF INSURANCE

Dated: _________, 1999

____

Alessandro A. Iuppa
Superintendent of Insurance

STATE OF MAINE
KENNEBEC, SS.

Subscribed and sworn to before me
this _______ day of ______, 1999.

____

Notary Public/Attorney-at-Law

FOR THE MAINE ATTORNEY GENERAL

Dated: ____________, 1999

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Judith Shaw Chamberlain
Assistant Attorney General