

Bulletin 265

UTILIZATION REVIEW DETERMINATIONS

I. Adverse Utilization Review Determinations

1. Content of Adverse Determination Notifications

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."

Carriers offering health plans in Maine are hereby reminded of the requirements of the Health Plan Improvement Act, Title 24-A M.R.S.A. § 4301 et. seq., which went into effect on January 1, 1997. Section 4303(4)(A)(1) requires carriers to have grievance procedures in place which, among other things, include (emphasis added):

Notice to the enrollee promptly of any claim denial or other matter by which enrollees are likely to be aggrieved, stating the basis for the decision, the right to file a grievance, the procedure for doing so and the time period in which the grievance must be filed.

Conclusory statements of the sort described above simply repeat the decision rather than "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. Additionally, the notice required by § 4303(4)(A)(1) must be provided in writing, including instances where an adverse determination has initially been communicated by telephone.

2. Requirements of Bureau Rule 850

Effective October 25, 1997, any entity performing utilization review in Maine must comply with the utilization review standards set forth in Bureau of Insurance Rule 850. Carriers on whose behalf UR is performed are also fully accountable for compliance with these standards. Section 8(E)(5) of the Rule requires that written notification of an adverse determination include:

1. The principal reason or reasons for the determination;
2. Instructions for initiating an appeal or reconsideration of the determination;
3. Instructions for requesting a written statement of the clinical rationale; including the clinical review criteria used to make the determination; and,
4. A phone number the covered person may call for information and assistance with initiating an appeal or reconsideration and/or requesting the clinical rationale and review criteria.

Again, the standard that notification must "include the principal reason or reasons for the determination" requires an explanation of the reason a requested service has been determined not to be "medically necessary." The Bureau recognizes that in most cases it will not be necessary to furnish comprehensive documentation to the covered person. However, the Rule requires such documentation to be made available on request, so that a covered person seeking to challenge an adverse determination can adequately respond to the determination. Therefore, "instructions for requesting a written statement of the clinical rationale" must be included with every notice of adverse determination.¹

II. Utilization Review Determinations Approving Services

1. Written Notice of Utilization Review Determinations Required

The Health Plan Improvement Act at Section 4304(2) of the Act states (emphasis added):

Requests by a provider for prior authorization of a nonemergency service must be answered by a carrier within 2 business days. If the information submitted is insufficient to make a decision, the carrier shall notify the provider within 2 business days of the additional information necessary to render a decision. If the carrier determines that outside consultation is necessary, the carrier shall notify the provider and the enrollee for whom the service was requested within 2 business days. The carrier shall make a good faith estimate of when the final determination will be made and contact the enrollee and the provider as soon as practicable. Notification requirements under this subsection are satisfied by written notification postmarked within the time limit specified.

While § 4304(2) is silent on the need to notify the enrollee of utilization review determinations other than in the specified instance where outside consultation is required, as noted above, § 4303(4)(A)(1) requires carriers to provide notice to the enrollee promptly of any claim denial or other matter by which enrollees are likely to be aggrieved. In light of the cited, specific references to enrollee notification and the Act's emphasis on disclosure to enrollees, the Bureau interprets the Act to require notice to the enrollee of every utilization review determination rendered on their behalf. This requirement is formalized in Rule 850 at Section 8(E)(1) which states:

A health carrier or the carrier's designated URE shall maintain written procedures for making utilization review decisions and for notifying covered persons and providers acting on behalf of covered persons of its decisions....Consistent with the requirements of Title 24-A M.R.S.A. § 4304(2), notification requirements under this subsection are satisfied by written notification postmarked within the time limit specified.

2. Content of Utilization Review Authorization Notices

The Bureau frequently receives complaints from health plan enrollees regarding their inability to understand the utilization authorizations provided to them. Frequently enrollee confusion arises as a result of the enrollee having been copied on an authorization directed to the enrollee's provider that indicates by procedure code what services have been approved. While providers are familiar with procedure codes, most consumers are not, and it is not informative to provide an enrollee with notification to the effect that, "procedure code 4341 has been approved." Health plans requiring prior authorization for health care services must provide their enrollees with timely, written notice of authorization in a form that clearly sets forth:

1. the specific services that have been approved;
2. any related restrictions (such as applicable time frames within which approved services must be provided);
3. whether or not the authorization functions as a plan approval of benefits; and,
4. a phone number the enrollee can call for additional information.

1 However, if a covered person has previously requested this information, the covered person cannot be required to repeat the request at each stage in the appeal or grievance process. Any additional rationale or criteria relied upon in issuing subsequent adverse determinations must be provided with the notice of adverse determination.

DATED: July 17, 1997 _____
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