

Minnesota Department of Health
Compliance Monitoring Division
Managed Care Systems Section



Final Report
Revised September 30, 2009

Medica

Quality Assurance Examination
For the period:
January 1, 2006 through February 28, 2009.

Examiners:
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**Minnesota Department of Health
Executive Summary:**

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of Medica to determine whether it is operating in accordance with Minnesota law. MDH has found that Medica is compliant with Minnesota and Federal law, except in the areas outlined in the “Deficiencies” and “Mandatory Improvements” sections of this report. “Mandatory Improvements” are required corrections that must be made to noncompliant policies, documents or procedures where evidence of actual compliance is found in relevant files or where the file sample did not include any instances of the specific issue of concern. The “Recommendations” listed are areas where, although compliant with law, MDH identified improvement opportunities.

To address recommendations, Medica should:

Have the individual making the determination (and cited in the notice) consistently enter the determination into the case notes under their own signature.

To address mandatory improvements, Medica must:

Revise and implement its policy and procedure, “Pharmacy Utilization Management Reviews” to include the specific provisions of law regarding coverage of non-formulary drugs for mental illness and emotional disturbance.

Revise its written plan for providing continuity of care to include more specific information concerning transition plans for members with special needs.

Direct the enrollee to the appropriate regulator for external appeal in its written notifications (rather than to both the Commissioner of Health and the Commissioner of Commerce, as documented in several files).

Revise its policy and procedure to accurately reflect its stated process of joint decision making for cases undergoing same/similar specialty review in which Medica identifies a need for clarification or discussion concerning the review. Further, the policy/procedure must specify the process Medica will follow when a joint decision cannot be made.

To address deficiencies, Medica and its delegates must:

Inform the complainant of the right to submit the complaint at any time to the Commissioner of Health for investigation and the toll-free telephone number in its notifications of complaint decisions.

Advise the complainant of the right to submit a request for an external review to the Commissioner of Health (rather than the Commissioner of Commerce, as documented in several files) as described in section 62Q.73 and the procedure for initiating the external process when the appeal decision is partially or wholly adverse to the complainant.

Identify the enrollee's request for an expedited appeal and if the request does not meet Medica's criteria for expedited appeal review, make reasonable efforts to give the enrollee prompt oral notice of the denial and follow up within two calendar days with a written notice.

Change its policy and practice for utilization reviews concerning prescription drug quantity limits such that licensed physicians make final decisions regarding utilization review denials.

This report including these recommendations, mandatory improvements and deficiencies is approved and adopted by the Minnesota Commissioner of Health pursuant to authority in Minnesota Statutes, chapter 62D.

Darcy Miner, Director
Compliance Monitoring Division

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I. Introduction

A. History:

Medica Health Plans is a not-for-profit, open access health maintenance organization (HMO) that provides coverage for health services in the state of Minnesota by serving approximately 157,000 HMO members. Medica was organized in 1974 as Physicians Health Plan of Greater Minneapolis. Over the years, Medica experienced a number of mergers. The company's most recent restructuring occurred in 2001, at which time Medica separated from Allina Health Systems. Medica contracts with United Healthcare Group to provide certain administrative services for the organization. Medica is accredited through the National Committee for Quality Assurance (NCQA) for both its Commercial and Medicaid products.

B. Membership: Medica's self-reported enrollment as of January 1, 2009 consisted of the following:

Product	Enrollment
<i>Fully insured Commercial</i>	
Large Group	22575
Small Employer Group	31
Individual	1436
<i>Minnesota Health Care Programs – Managed Care (MHCP – MC)</i>	
PMP/PGAMC	94704
MinnesotaCare	28187
Minnesota Senior Care (MSC+)	742
Minnesota Senior Health Options (MSHO)	8804
Special Needs Basic Care (SNBC)	456
<i>Medicare</i>	
Medicare Advantage – Plan elected not to submit	
Medicare Cost – Plan elected not to submit	
Total	156935

C. Onsite Examination Dates: June 15 through 19, 2009.

D. Examination Period: January 1, 2006 through February 28, 2009.

File Review Period: March 1, 2008 through February 28, 2009.

E. National Committee for Quality Assurance (NCQA): Medica accredited by NCQA based on 2007 standards. The Minnesota Department of Health (MDH) evaluated and used results of the NCQA review in one of three ways.

- a. If NCQA standards do not exist or are not as stringent as Minnesota law, the review results will not be used for evaluation [no NCQA box].

- b. If the NCQA review was the same or more stringent than Minnesota law and the health plan was accredited with 100% of the possible points, the NCQA review result was accepted as meeting Minnesota requirements [NCQA] unless evidence existed in files indicating further examination was warranted [NCQA].
 - c. If the NCQA standard was the same or more stringent than Minnesota law, but the review resulted in less than 100% of the possible points on NCQA's score sheet or as an identified opportunity for improvement, MDH conducted its own examination.
- F. Sampling Methodology: Due to the small sample sizes and the methodology used for sample selection for the quality assurance examination, the results cannot be extrapolated as an overall deficiency rate for the health plan.
- G. Performance Standard: For each instance of non-compliance with applicable law or rule identified during the course of the quality assurance examination, which covers a three-year audit period, the health plan is cited with a deficiency. A deficiency will not be based solely on one outlier file if MDH had sufficient evidence obtained through: 1) file review; 2) policies and procedures; and 3) interviews that a plan's overall operation is compliant with an applicable law.

II. Quality Program Administration

Minnesota Rules, Part 4685.1110. Program

Subp. 1.	Written Quality Assurance Plan	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subp. 2.	Documentation of Responsibility	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subp. 3.	Appointed Entity	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subp. 4.	Physician Participation	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subp. 5.	Staff Resources	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subp. 6.	Delegated Activities	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA ¹
Subp. 7.	Information System	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subp. 8.	Program Evaluation	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subp. 9.	Complaints	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	
Subp. 10.	Utilization Review	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	
Subp. 11.	Provider Selection and Credentialing	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subp. 12.	Qualifications	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subp. 13.	Medical Records	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA

Subp. 6. Minnesota Rules, part 4685.1110, subpart 6, states the HMO must develop and implement review and reporting requirements to assure that the delegated entity performs all

¹ NCQA delegation standards are equivalent to Minnesota law for credentialing and quality improvement functions only.

delegated activities. The standards established by the National Committee for Quality Assurance (NCQA) for delegation are considered the community standard and, as such, were used for the purposes of this examination. The following delegated entities and functions were reviewed:

Delegated Entities and Functions								
	UM	UM Appeals	QM	Complaints/ Grievances	Cred	Claims	Network	Care Coord
Delta Dental of Minnesota (MHCP-MC only)	x	x		x	x	x	x	
Medica Behavioral Health (MBH)	x	x	x	x	x	x	x	x
ACN Group, Inc. (Chiro)	x	x		x	x		x	
Evercare (MSHO only)	x						x	x
MedImpact	Approvals only			x QOC		x	x	
Cass County								x
Clay County								x

Medica does very comprehensive oversight on all of its delegated entities for all delegated functions.

Subd. 9. Minnesota Rules, part 4685.1110, subpart 9, states the quality program must conduct ongoing evaluation of enrollee complaints related to quality of care. A total of 20 quality of care complaint and grievance files were reviewed as follows:

Quality of Care File Review	
QOC File Source	# Reviewed
<i>Complaint Files</i>	
Medica	5
MBH	1
<i>Grievance Files</i>	
Medica	11
MBH	3
Total	20

The quality of care files were well investigated, timely, with appropriate physician review and acknowledgement letters.

Minnesota Rules, Part 4685.1115. Activities

- Subp. 1. Ongoing Quality Evaluation Met Not Met NCQA
 Subp. 2. Scope Met Not Met NCQA

Minnesota Rules, Part 4685.1120. Quality Evaluation Steps

- Subp. 1. Problem Identification Met Not Met NCQA
- Subp. 2. Problem Selection Met Not Met NCQA
- Subp. 3. Corrective Action Met Not Met NCQA
- Subp. 4. Evaluation of Corrective Action Met Not Met NCQA

Minnesota Rules, Part 4685.1125. Focused Study Steps

- Subp. 1. Focused Studies Met Not Met
- Subp. 2. Topic Identification and Selection Met Not Met
- Subp. 3. Study Met Not Met
- Subp. 4. Corrective Action Met Not Met
- Subp. 5. Other Studies Met Not Met

Minnesota Rules, Part 4685.1130. Filed Written Plan and Work Plan

- Subp. 1. Written Plan Met Not Met
- Subp. 2. Work Plan Met Not Met NCQA

III. Complaints and Grievance Systems

Complaint System

MDH examined Medica’s fully-insured commercial complaint system under Minnesota Statutes, chapter 62Q. Complaints concerning Medica’s commercial products are handled by the Commercial Customer Service Department, dedicated solely to commercial products.

MDH reviewed a total of 61 Complaints System files as follows:

Complaint System File Review	
Complaint and Appeal File Source	# Reviewed
<i>Complaint Files (oral and written)</i>	
Medica	25
ACN	2
MBH	3
<i>Non-clinical Appeals</i>	
Medica	31
Total	61

Minnesota Statutes, Section 62Q.69. Complaint Resolution

Subd. 1.	Establishment	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 2.	Procedures for filing a complaint	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 3.	Notification of Complaint Decisions	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met

Subd. 2. Minnesota Statutes, section 62Q.69, subdivision 2(a), states that oral complaints must be resolved within ten days of receiving the complaint. MDH noted one file that took longer than ten days to resolve (32 days). The statute goes on to state the contents of the written complaint form, which needs to include the toll-free number of the Commissioner of Health and that the complainant has the right to submit the complaint at any time. MDH noted in one file the wrong complaint form was used (MIC form) which directed complainants to the Commissioner of Commerce rather than Health. In two other files the wrong complaint form was used, however this was noted by the Commercial Customer Service staff and the complainant was directed to the correct commissioner.

Subd. 3(a). Minnesota Statutes, section 62Q.69, subdivision 3(a), states that for written complaints, the health plan must notify the complainant in writing of its decision. MDH noted in one written complaint file, the complainant did not receive a written notification.

Subd. 3(b). Minnesota Statutes, section 62Q.69, subdivision 3(b), states if the decision is partially or wholly adverse to the complainant, the notification must inform the complainant of the right to appeal the decision to the health plan’s internal appeal process and the procedure for initiating an appeal. MDH noted in one file there was no appeal rights included in the notification letter.

Subd. 3(c). Minnesota Statutes, section 62Q.69, subdivision 3(c), states the notification must inform the complainant of the right to submit the complaint at any time to either the Commissioner of Health or Commerce for investigation and the toll-free telephone number of the appropriate commissioner. There were three commercial complaint files where the complainant was directed to the Commissioner of Commerce rather than the Commissioner of Health. **(Deficiency #1)** As a violation of Minnesota Statutes, section 62Q.69, subdivision 3(c), this is a repeat deficiency from the previous Quality Assurance Examination of 2006 (report dated January 10, 2007). This repeat deficiency pertains to commercial files only, as did the deficiency identified during the 2006 examination. Additionally, the files found deficient in the current examination resulted from different processes and involved different staff than the files found deficient in the 2006 examination. Medica fully corrected the processes found deficient in the 2006 examination, and did so prior to the current examination.

Minnesota Statutes, Section 62Q.70. Appeal of the Complaint Decision

Subd. 1.	Establishment	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 2.	Procedures for Filing an Appeal	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

Subd. 3. Notification of Appeal Decisions Met Not Met

Subd. 3. Minnesota Statutes, section 62Q.70, subdivision 3(b), states if the appeal decision is partially or wholly adverse to the complainant, the notice must advise the complainant of the right to submit the appeal decision to the external review process described in section 62Q.73 and the procedure for initiating the external process. In nine non-clinical appeals, the notification letter directs the complainant to submit a request for external review to the Commissioner of Commerce rather than the Commissioner of Health. **(Deficiency #2)**

Minnesota Statutes, Section 62Q.71. Notice to Enrollees

Met Not Met

Minnesota Rules, Part 4685.1900. Records of Complaints

Subp. 1. Record Requirements Met Not Met
 Subp. 2. Log of Complaints Met Not Met

Minnesota Statutes, Section 62Q.73. External Review of Adverse Determinations

Subd. 3. Right to external review Met Not Met

[Refer to Minnesota Statutes, section 62Q.70, subdivision 3(b)]

Grievance System

MDH examined Medica’s Minnesota Healthcare Programs – Managed Care (MHCP – MC) grievance system for compliance with the federal BBA law (42 CFR 438, subpart F) and the DHS 2008 Model Contract, Article 8. Grievances concerning Medica’s MHCP – MC products are handled as follows: by the State Public Programs Customer Service Department (PMAP, GAMC, and MinnesotaCare and the Center for Healthy Aging Customer Service Department (MSHO and SNBC products (serving individuals eligible for both Medicare and Medicaid)).

MDH reviewed grievance system files as follows:

Grievance System File Review	
Grievance File Source	# Reviewed
Medica	24
MBH	9
Subtotal	33
Non Clinical Appeals	
Medica	12

MBH	2
Subtotal	14
Clinical Appeals	
Medica	11
(additional files)	(21)
MBH	10
ACN	14
Subtotal	56
State Fair Hearings	11

Section 8.1. §438.402 General Requirements

- Sec. 8.1.1. Components of Grievance System Met Not Met
 Sec. 8.1.2. Timeframes for Disposition Met Not Met

Section 8.2. §438.404 DTR Notice of Action to Enrollees

- Sec. 8.2.1. General requirements Met Not Met
- Sec. 8.2.2. §438.404 (c) Timing of DTR Notice
- A. §438.404 (c)(1) Previously Authorized Services Met Not Met
- B. §438.404 (c)(2) Denials of Payment Met Not Met
- C. §438.404 (c)(3) Standard Authorizations Met Not Met
- D. §438.404 (c)(4) Extensions of Time Met Not Met
- E. §438.404 (c)(5) Delay in Authorizations Met Not Met
- F. §438.404 (c)(6) Expedited Authorizations Met Not Met
- Sec. 8.2.3. §438.420 (b) Continuation of Benefits Pending Decision Met Not Met

§438.404 (c)(3) and (c)(4)(contract section 8.2.2.C and D. MDH noted that in six MHCP-MC files requesting PCA services, no verbal notification was made to the health care professional. In three of these MHCP-MC files, the determination exceeded 10 business days. No extension was requested on any of the three files (as permitted by §438.404(c)(4), contract section 8.2.2.D). Medica stated that it had identified the issues and had implemented an internal corrective action plan. MDH reviewed the corrective action plan and reviewed ten additional MHCP-MC UM denials from April 2009 for timelines and verbal notice. All files were within the ten business day timeline and all files documented verbal notice to the health care professional. Eleven additional files related to PCA services were reviewed for timelines. All files were within the 10 day timeline. While Medica’s policy permits extensions, it is the Medica practice to resolve all requests within 10 business days. Because Medica found and corrected these problems before the MDH Quality Assurance Exam, MDH does not find a deficiency. [Also see Minnesota Statutes, section 62M.05, subs. 3a(a), (b) and (c)]

Section 8.3. §438.408	Internal Grievance Process Requirements	
Sec. 8.3.1. §438.402 (b)	Filing Requirements	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.3.2. §438.408 (b)(1)	Timeframe for Resolution of Grievances	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.3.3. §438.408 (c)	Timeframe for Extension of Resolution of Grievances	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.3.4. §438.406	Handling of Grievances	
A. §438.406 (a)(2)	Written Acknowledgement	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
B. §438.416	Log of Grievances	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
C. §438.402 (b)(3)	Oral or Written Grievances	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
D. §438.406 (a)(1)	Reasonable Assistance	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
E. §438.406 (a)(3)(i)	Individual Making Decision	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
F. §438.406 (a)(3)(ii)	Appropriate Clinical Expertise	

§438.408(b) (contract section 8.3.2 (A)), requires that all oral grievances must be resolved within 10 days. However, one MBH grievance file exceeded the 10 day timeline for response (22 days). No acknowledgement or extension letter was sent. Medica produced verification that action had taken place on this quality of service complaint.

Section 8.4. §438.408	Internal Appeals Process Requirements	
Sec. 8.4.1. §438.402 (b)	Filing Requirements	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.4.2. §438.408 (b)(2)	Timeframe for Resolution of Standard Appeals	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.4.3 §438.408 (b)	Timeframe for Resolution of Expedited Appeals	
A. §438.408 (b)(3)	Expeditious Resolution and oral notice	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met
B. §438.410 (b)	Punitive Action Prohibited	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
C. §438.410 (c)	Denial of Request for Expedited Appeal	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met
Sec. 8.4.4. §438.408 (c)	Timeframe for Extension of Resolution of Appeals	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.4.5. §438.406	Handling of Appeals	
A. §438.406 (b)(1)	Oral Inquiries	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
B. §438.406 (a)(2)	Written Acknowledgement	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
C. §438.406 (a)(1)	Reasonable Assistance	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
D. §438.406 (a)(3)(i)	Individual Making Decision	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
E. §438.406 (a)(3)(ii)	Appropriate Clinical Expertise	
	[See Minnesota Statutes, section 62M.06, subd. 3(f)]	
F. §438.406 (b)(2)	Opportunity to Present Evidence	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
G. §438.406 (b)(3)	Opportunity to Examine the Case File	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
H. §438.406 (b)(4)	Parties to the Appeal	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.4.6.	Subsequent Appeals	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met

- Sec. 8.4.7. §438.408 (e) Notice of Resolution of Appeals Met Not Met
- Sec. 8.4.8. §438.424 (a) Reversed Appeal Resolutions Met Not Met
- Sec. 8.4.9. §438.420 (d) Upheld Appeal Resolutions Met Not Met

§§ 438.408 (b)(3) and 438.410(c) (contract section 8.4.3.A and C), states if the MCO denies the request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the enrollee prompt oral notice of the denial and follow up within two calendar days with a written notice. In two appeal files Medica did not identify the enrollee’s request for expedited review, although the request was documented in both files, and did not notify the enrollee orally or in writing that the request would not be expedited. **(Deficiency #3)**

Section 8.5. §438.416 (c) Maintenance of Grievance and Appeal Records
Met Not Met

Section 8.7. §438.408 (f) State Fair Hearings

- Section 8.7.2. §438.408 (f) Standard Hearing Decisions Met Not Met
- Section 8.7.5. §438.420 Continuation of Benefits Pending Resolution of State Fair Hearing Met Not Met
- Section 8.7.6. §438.424 Compliance with State Fair Hearing Resolution Met Not Met

Minnesota Rules, Part 4685.1900. Records of Complaints

- Subp. 1. Record Requirements Met Not Met
- Subp. 2. Log of Complaints §438.416 (a) Met Not Met

IV. Access and Availability

Minnesota Statutes, Section 62D.124. Geographic Accessibility

- Subd. 1. Primary Care; Mental Health Services; General Hospital Services Met Not Met
- Subd. 2. Other Health Services Met Not Met
- Subd. 3. Exception Met Not Met

Minnesota Rules, Part 4685.1010. Availability and Accessibility

- | | | | |
|----------|---------------------------------------|---|----------------------------------|
| Subp. 2. | Basic Services | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subp. 5. | Coordination of Care | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subp. 6. | Timely Access to Health Care Services | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

Minnesota Statutes, Section 62Q.55. Emergency Services

- Met Not Met

Minnesota Statutes, Section 62Q.121. Licensure of Medical Directors

- Met Not Met

Minnesota Statutes, Section 62Q.527. Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance

- | | | | |
|----------|--|------------------------------|---|
| Subd. 2. | Required Coverage for Anti-psychotic Drugs | <input type="checkbox"/> Met | <input checked="" type="checkbox"/> Not Met |
| Subd. 3. | Continuing Care | <input type="checkbox"/> Met | <input checked="" type="checkbox"/> Not Met |
| Subd. 4. | Exception to formulary | <input type="checkbox"/> Met | <input checked="" type="checkbox"/> Not Met |

Minnesota Statutes, section 62Q.527, states in pertinent part that the health plan is required to cover antipsychotic drugs if the prescribing provider indicates the drug must be dispensed as communicated and certifies in writing that formulary alternatives were considered and has determined the prescribed drug is best to treat the enrollee's condition. The health plan may not impose a special copayment. The authorization must be good for one year and may be extended annually. Medica policy, *Pharmacy Utilization Management Review*, states that it will "clearly define the process and the responsibilities for review of requests for formulary exceptions," including Minnesota Statutes, section 62Q.527, subdivision 2, Coverage of Non-formulary Drugs for Mental Illness and Emotional Disturbance (effective 1/1/2001). However, no part of the policy states the specific requirements of Minnesota Statutes, section 62Q.527. No files in the MDH sample requested a formulary exception for antipsychotics. **(Mandatory Improvement #1)**

Minnesota Statutes, Section 62Q.535. Coverage for Court-Ordered Mental Health Services

- | | | | |
|----------|------------------------|---|----------------------------------|
| Subd. 1. | Mental health services | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 2. | Coverage required | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

Minnesota Statutes, Section 62Q.56. Continuity of Care

- Subd. 1. Change in health care provider; general notification Met Not Met
- Subd. 1a. Change in health care provider; termination not for cause Met Not Met
- Subd. 1b. Change in health care provider; termination for cause Met Not Met
- Subd. 2. Change in health plans Met Not Met
- Subd. 2a. Limitations Met Not Met
- Subd. 2b. Request for authorization Met Not Met
- Subd. 3. Disclosures Met Not Met

Subd. 1. Minnesota Statutes, section 62Q.56, subdivision 1, states if the enrollee must access services through selected primary care providers, the health plan must prepare a written plan that provides for continuity of care in the event of contract termination between the health plan company and any of the contracted primary care providers, specialists, or general hospital providers. The written plan must explain how the health plan will inform affected enrollees, what other participating providers are available to assume care, how it will facilitate an orderly transfer of its enrollees, how enrollees with special medical needs will be transferred to other participating providers and so on. Medica provided MDH with its policy and procedure CM70P, *Continuity of Care*. The policy identifies the standards and process used in termination for cause and not for cause. File review showed that Medica authorized services for enrollees transitioning into Medica. However, the policy and procedure does not specify Medica’s plan for enrollees with special needs as described in subdivision 1. **(Mandatory Improvement #2)**

Minnesota Rules, 4685.0700. Comprehensive Health Maintenance Services

- Subp. 3. Permissible limitations Met Not Met
- Subp. 4. Permissible exclusions Met Not Met

V. Utilization Review

MDH examined Medica’s utilization management system under Minnesota Statutes, chapter 62M.

MDH reviewed the utilization management system files as follows:

Utilization Management System File Review	
UM Denial and Appeal File Source	# Reviewed
UM Denials	
<i>Commercial</i>	
Medica	31

Pharmacy	12
MBH	15
ACN	12
Subtotal	70
<i>MHCP--MC</i>	
Medica	18
Pharmacy	9
MBH	10
ACN	9
EverCare (disregarded EW services)	6
Subtotal	52
UM Appeals - Commercial	
Medica	30
MBH	9
ACN	4
Subtotal	43
MHCP—MC (see Grievance and Appeal Module)	

Minnesota Statutes, Section 62M.04. Standards for Utilization Review Performance

Subd. 1.	Responsibility on Obtaining Certification	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 2.	Information upon which Utilization Review is Conducted	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 3.	Data Elements	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 4.	Additional Information	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 5.	Sharing of Information	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

Minnesota Statutes, Section 62M.05. Procedures for Review Determination

Subd. 1.	Written Procedures	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 2.	Concurrent Review	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NCQA
Subd. 3.	Notification of Determinations	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 3a.	Standard Review Determination		
	(a) Initial determination to certify (10 business days)	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met <input type="checkbox"/> NCQA
	(b) Initial determination to certify (telephone notification)	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(c) Initial determination not to certify	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(d) Initial determination not to certify (notice of rights to external appeal)	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NCQA
Subd. 3b.	Expedited Review Determination	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met <input type="checkbox"/> NCQA
Subd. 4.	Failure to Provide Necessary Information	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 5.	Notifications to Claims Administrator	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

Subds. 3a(a), (b) and (c). MDH noted that in six MHCP-MC files requesting PCA services, no verbal notification was made to the health care professional. In three of these files MHCP-MC files, the determination exceeded 10 business days. No extension was requested on any of the three files (as permitted by §438.404(c)(4), contract section 8.2.2.D). Medica stated that it had identified the issues and had implemented an internal corrective action plan. MDH reviewed the corrective action plan and reviewed ten additional MHCP-MC UM denials from April 2009 for timelines and verbal notice. All files were within the ten business day timeline and all files documented verbal notice to the health care professional. Eleven additional files related to PCA services were reviewed for timelines. All files were within the 10 day timeline. While Medica’s policy permits extensions, it is the Medica practice to resolve all requests within 10 business days. Because Medica found and corrected these problems before the MDH Quality Assurance Exam, MDH does not find a deficiency. [Also see §438.404 (c)(3) and (c)(4)(contract section 8.2.2.C and D)]

Subd. 3a.(c). Minnesota Statutes, section 62M.05, subdivision 3a(c), states, in pertinent part, when an initial determination is made not to certify, the written notification must be sent to the attending health care professional and enrollee. MDH noted in one file the attending health care professional did not receive a written notification. Additionally, in one ACN file the enrollee letter stated the enrollee’s diagnosis as “somat dysfunc cervic reg”, which may not be understandable to the enrollee.

Subd. 3a.(d). Minnesota Statutes, section 62M.05, subdivision 3a(d), states, in pertinent part, the written notification of a determination not to certify must include the right to internal and external appeal. In 20 UM denial files the written notification directed the enrollee to both Commerce and Health for external review. The notification must direct the enrollee to the appropriate regulator for external review. **(Mandatory Improvement #3)**

Subd. 3b.(b). Minnesota Statutes, section 62M.05, subdivision 3b(b), states the notification of an expedited initial determination to either certify or not to certify must be provided to the hospital, the attending health care professional, and the enrollee, no later than 72 hours from the initial request. MDH noted in one file the notification took longer than 72 hours (4 days).

Minnesota Statutes, Section 62M.06. Appeals of Determinations not to Certify

Subd. 1.	Procedures for Appeal	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 2.	Expedited Appeal	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 3.	Standard Appeal		
	(a) Appeal resolution notice timeline	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(b) Documentation requirements	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(c) Review by a different physician	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met <input type="checkbox"/> NCQA
	(d) Time limit in which to appeal	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(e) Unsuccessful appeal to reverse determination	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met <input type="checkbox"/> NCQA
	(f) Same or similar specialty review	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
	(g) Notice of rights to External Review	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NCQA
Subd. 4.	Notifications to Claims Administrator	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

Subd. 3.(f). Minnesota Statutes, section 62M.06, subdivision 3(f), states in cases of appeal to reverse a determination not to certify for clinical reasons, the HMO must ensure that a physician of the HMO’s choice in the same or a similar specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case. Medica’s policy entitled *Clinical Appeals: Commercial Standard 1st and 2nd Level Appeals (CA20P)* states if a consultant is used to render a determination for same/similar specialty review, “a medical director, who was not involved in the previous determination and not subordinate of any expert, will review the consultant’s recommendation and make the final determination to uphold or overturn the initial denial”. In one file the medical director overturned the specialist’s recommendation, thus the medical director, not of the same/similar specialty, upheld the appeal. Medica must revise its policy/procedure to accurately reflect its stated process of joint decision making for cases undergoing same/similar specialty review in which Medica identifies a need for clarification or discussion concerning the review. Further, the policy/procedure must specify the process Medica will follow when a joint decision cannot be made. **(Mandatory Improvement #4)**

Subd. 3.(g). Minnesota Statutes, section 62M.06, subdivision 3(g), states if the initial determination is not reversed on appeal, the HMO must include in its notification the right to submit the appeal to the external review process described in section 62Q.73 and the procedure for initiating the external process. In four appeal files, the notification letter directs the enrollee to the Minnesota Department of Commerce and the Minnesota Department of Health for external review. Medica must direct the member to the appropriate regulator for external review. **(Mandatory Improvement #3)**

Minnesota Statutes, Section 62M.08. Confidentiality

Met Not Met NCQA

Minnesota Statutes, Section 62M.09. Staff and Program Qualifications

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|-----------|--|---|---|--|
| Subd. 1. | Staff Criteria | <input type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input checked="" type="checkbox"/> NCQA |
| Subd. 2. | Licensure Requirement | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input type="checkbox"/> NCQA |
| Subd. 3. | Physician Reviewer Involvement | <input type="checkbox"/> Met | <input checked="" type="checkbox"/> Not Met | <input type="checkbox"/> NCQA |
| Subd. 3a. | Mental Health and Substance Abuse Review | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met | |
| Subd. 4. | Dentist Plan Reviews | <input type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input checked="" type="checkbox"/> NCQA |
| Subd. 4a. | Chiropractic Reviews | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input type="checkbox"/> NCQA |
| Subd. 5. | Written Clinical Criteria | <input type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input checked="" type="checkbox"/> NCQA |
| Subd. 6. | Physician Consultants | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input type="checkbox"/> NCQA |
| Subd. 7. | Training for Program Staff | <input type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input checked="" type="checkbox"/> NCQA |
| Subd. 8. | Quality Assessment Program | <input type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input checked="" type="checkbox"/> NCQA |

Subd. 3. Minnesota Statutes, section 62M.09, subdivision 3, states a physician must review all cases in which the HMO has concluded that a determination not to certify for clinical reasons is appropriate. In six files (four commercial and two MHCP–MC) involving pharmacy utilization review denials for formulary exceptions for quantity limits, a pharmacist made the initial determination not to certify. Medica’s policy entitled *Professional Licensure (HM27P)* states “Licensed physicians and pharmacists will make final decisions regarding utilization denials.” Medica must change its policy and practice such that licensed physicians make final decisions regarding utilization review denials. **(Deficiency #4)**

Subd. 3a. Minnesota Statutes, section 62M.09 subdivision 3a, states a peer of the treating mental health or substance abuse provider must review requests for outpatient services, provided that a board certified psychiatrist makes the final determination on appeal. In 11 files (eight commercial and three MHCP – MC) MBH utilization benefit denials files, primarily for out of network services, the MBH Medical Director’s determination, rationale and the date were part of the UM staff notes. In other files the psychiatrist entered the determination, notes and the date directly into the electronic case file. For consistency, the individual making the determination (and cited in the notice) should enter the information into the case notes under their own signature. **(Recommendation #1)**

Minnesota Statutes, Section 62M.10. Accessibility and on-site Review Procedures

- Subd. 1. Toll-free Number Met Not Met NCQA
- Subd. 2. Reviews during Normal Business Hours Met Not Met NCQA
- Subd. 7. Availability of Criteria Met Not Met

Minnesota Statutes, Section 62M.11. Complaints to Commerce or Health

Met Not Met

Minnesota Statutes, Section 62M.12. Prohibition on Inappropriate Incentives

Met Not Met NCQA

Minnesota Statutes, Section 62D.12. Prohibited Practices

- Subd. 19. Coverage of service Met Not Met

Minnesota Statutes, Section 62A.25. Reconstructive Surgery

- Subd. 2. Required coverage Met Not Met

VI. Recommendations

1. To better comply with Minnesota Statutes, section 62M.09, subdivision 3a, the individual making the determination (and cited in the notice) should consistently enter the determination into the case notes under their own signature.

VII. Mandatory improvements

1. To comply with Minnesota Statutes, section 62Q.527, Medica must revise and implement its policy and procedure, “Pharmacy Utilization Management Reviews” to include the specific provisions of law regarding coverage of non-formulary drugs for mental illness and emotional disturbance.
2. To comply with Minnesota Statutes, section 62Q.56, subdivision 1, Medica must revise its written plan for providing continuity of care to include more specific information concerning transition plans for members with special needs.
3. To comply with Minnesota Statutes, section 62M.05, subdivision 3a(d) and Minnesota Statutes, section 62M.06, subdivision 3(g), Medica must direct the enrollee to the appropriate regulator for external appeal in its written notifications (rather than to both the Commissioner of Health and the Commissioner of Commerce, as documented in several files).
4. To comply with Minnesota Statutes, section 62M.06, subdivision 3(f), Medica must revise its policy and procedure to accurately reflect its stated process of joint decision making for cases undergoing same/similar specialty review in which Medica identifies a need for clarification or discussion concerning the review. Further, the policy/procedure must specify the process Medica will follow when a joint decision cannot be made.

VIII Deficiencies

1. To comply with Minnesota Statutes, section 62Q.69, subdivision 3(c), Medica must inform the complainant of the right to submit the complaint at any time to the Commissioner of Health for investigation and the toll-free telephone number in its notifications of complaint decisions.
2. To comply with Minnesota Statutes, section 62Q.70, subdivision 3(b), Medica must, when the appeal decision is partially or wholly adverse to the complainant, advise the complainant of the right to submit a request for an external review to the Commissioner

of Health (rather than to the Commissioner of Commerce, as documented in several files) as described in section 62Q.73 and the procedure for initiating the external process.

3. To comply with §438.410 (contract section 8.4.3), Medica must identify the enrollee's request for an expedited appeal. If the request does not meet Medica's criteria for expedited appeal review, Medica must make reasonable efforts to give the enrollee prompt oral notice of the denial and follow up within two calendar days with a written notice.
4. To comply with Minnesota Statutes, section 62M.09, subdivision 3, Medica must change its policy and practice for utilization reviews concerning prescription drug quantity limits such that licensed physicians make final decisions regarding utilization review denials.