

Minnesota Department of Health
Compliance Monitoring Division
Managed Care Systems Section



Final Report

**HealthPartners, Inc.
and
Group Health, Inc**

Quality Assurance Examination
For the period:
April 1, 2006
through
November 30, 2008

Final Issue Date:
June 11, 2009

Examiners:
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Minnesota Department of Health Executive Summary:

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of HealthPartners, Inc. and Group Health, Inc. (hereafter referred to as HealthPartners) to determine whether it is operating in accordance with Minnesota law. MDH has found that HealthPartners 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 policy, documents, procedures, or processes to be compliant with the law but have not yet adversely affected enrollees or enrollee rights. The “Recommendations” listed are areas where, although compliant with law, MDH identified improvement opportunities.

To address mandatory improvements, HealthPartners must:

Categorize and store complaints and appeals in a manner that permits accurate retrieval of complaints to be consistent with Minnesota law.

Revise its policy to ensure that extensions of the resolution timeline are not requested or taken on expedited clinical appeals.

Revise its policy regarding appeal to reverse a determination not to certify for clinical reasons to fully describe its same or similar specialty review process and to ensure that the determination is made by a physician in the same or specialty as typically manages the medical condition, procedure or treatment under discussion.

Revise its policy regarding Appeals-Level Consultations to ensure the physician making the final determination of a clinical appeal is a board certified specialist.

To address deficiencies, HealthPartners and its delegates must:

File notice with the Commissioner of Health 30 days before modifying its written quality assurance plan.

Provide notice for denials of standard authorizations to the attending health care professional and hospital by telephone within one working day after making the determination, and in writing to the hospital, attending health care professional and enrollee and policies must reflect this.

Resolve oral grievances within ten days of receipt.

Ensure that when an initial determination is made not to certify, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal.

This report including these 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

Date

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I. Introduction

A. History: Founded in 1957, HealthPartners provides care and coverage to members across Minnesota and western Wisconsin. HealthPartners, Inc. is a nonprofit Minnesota corporation and the parent company of a family of corporations known as HealthPartners. Corporations in the HealthPartners enterprise include, among others, HealthPartners, Inc. and Group Health, Inc. (each separately licensed health maintenance organizations), HealthPartners Insurance Company, HealthPartners Administrators, Inc. (a registered third party administrator), HealthPartners Research Foundation, and HealthPartners Institute for Medical Education. HealthPartners corporations that provide direct care include, among others, Group Health Plan, Inc. (dba HealthPartners Medical Group and HealthPartners Dental Group), Central Minnesota Group Health, Inc. (dba HealthPartners Central Minnesota Clinics), and Regions Hospital. HealthPartners provides services to its members through a network consisting of these employed providers along with contracted medical and dental centers, physician groups, hospitals, and related healthcare providers.

B. Membership: HealthPartners self-reported enrollment as of December 31, 2007 consisted of the following:

Product	HealthPartners Enrollment	Group Health Enrollment
Fully insured Commercial	244,746	23,384
Prepaid Medical Assistance Program*	37,896	
MinnesotaCare*	13,028	
Medicare Cost	33,473	
Medicare Advantage		2,064
MSC*	1,680	
MSC+*	0	
Minnesota Senior Health Options*	2,702	
Special Needs Basic Care*	1,325	111
Total	334,850	25,559

*Part of Minnesota Health Care Programs—Managed Care (MHCP—MC), as contracted by the Minnesota Department of Human Services.

C. Onsite Examination Dates: February 17 through 24, 2009.

D. Examination Period: April 1, 2006 through November 30, 2008.

E. National Committee for Quality Assurance (NCQA): HealthPartners is 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 indicating further investigation 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.

II. Quality Program Administration

Minnesota Rules, Part 4685.1110. Program

Subp. 1.	Written Quality Assurance Plan	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subp. 2.	Documentation of Responsibility	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" 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 checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input 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 type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subp. 8.	Program Evaluation	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" 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, states the HMO must develop and implement review and reporting requirements to assure that the delegated entity performs all 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:

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

Delegated Entities and Functions				
	UM	Claims	Network	Disease Mgmt
MedImpact (PBM)		x	x	
Landmark (Chiro)	x	x	x	
Accordant				x
Alere				x

HealthPartners does very comprehensive oversight on all of its delegated entities. Landmark and MedImpact are two new delegates as of 2008 and both had comprehensive pre-delegation assessments completed prior to the delegation.

Subd. 9. A total of 24 quality of care files were reviewed, consisting of 10 commercial and 14 Minnesota Health Care Program—Managed Care (MHCP—MC) files. The files were thoroughly investigated through a collaborative and timely process between customer service and the quality department.

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
- Subp. 3. Amendments to Plan Met Not Met

Subp. 3. Minnesota Rules, part 4685.1130, subpart 3, states that the HMO may change its written quality assurance plan by filing notice with the commissioner 30 days before modifying its quality assurance program or activities. MDH received HealthPartners last filed written quality assurance plan (dated April 2007) in October 2007 and it was approved. HealthPartners made modifications to its written plan that was subsequently approved by the Board of Directors in June 2008. This plan had not been submitted to MDH for approval. **(Deficiency #1).**

III. Complaint and Grievance Systems

Complaint System

MDH examined HealthPartners fully-insured commercial complaint system under Minnesota Statutes, chapter 62Q.

MDH reviewed a total of 24 Complaints System files:

Complaint System File Review	
Complaint and Appeal File Source	# Reviewed
Complaint Files (oral)	17
Appeal Files Non-Clinical (also see MS §62M.06 in the Utilization Review Section)	7
Total	24

Minnesota Statutes, Section 62Q.69. Complaint Resolution

- Subd. 1. Establishment Met Not Met
- Subd. 2. Procedures for filing a complaint Met Not Met
- Subd. 3. Notification of Complaint Decisions Met Not Met

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

- Subd. 1. Establishment Met Not Met
- Subd. 2. Procedures for Filing an Appeal Met Not Met
- Subd. 3. Notification of Appeal Decisions Met Not Met

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

Met Not Met

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

- Subd. 3. Right to external review 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

Subp. 2. Minnesota Rules, part 4685.1900, subpart 2 A, states “A health maintenance organization shall keep retrievable documentation of complaints submitted to the health maintenance organization by complainants.” HealthPartners categorizes all expressions of dissatisfaction as “first or second level appeals” rather than as “complaints” and “appeals” which are the terms used in statutes and rules.

MDH draws randomized file samples to verify resolution of complaints and appeals consistent with Minnesota law. We drew a complaint sample from HealthPartners’ file lists of written nonclinical *complaints* categorized by HealthPartners as benefit issues. In fact this sample actually contained primarily *appeals* of written clinical denials rather than *complaints*. In addition, HealthPartners identified only 28 clinical and non-clinical *appeals*. The number of appeals identified is unreasonably low given HealthPartners’ large commercial enrollment.

Based on the files reviewed, MDH believes that HealthPartners’ internal complaint and appeal resolution is excellent. However, the way in which HealthPartners categorizes complaints is inaccurate since it results in certain appeals being mis-categorized as complaints. HealthPartners must improve the way in which it identifies and stores complaints submitted to it by complainants to be consistent with Minnesota law. **(Mandatory Improvement #1)**

Grievance System

MDH examined HealthPartners’ MHCP—MC grievance system for compliance with the federal BBA law (42 CFR 438, subpart F) and the DHS 2008 Model Contract, Article 8.

MDH reviewed a total of 72 grievance system files:

Grievance System File Review	
Grievance and Appeal Files	# Reviewed
Grievance Files (Oral and Written)	25
Appeal Files (Clinical and Non-clinical)	42
State Fair Hearing	5
Total	72

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 (Contract section 8.2.1) states that the Managed Care Organization (MCO) must send a DTR notice to the enrollee. It was noted that in one file, no DTR was sent to the enrollee.

§438.404 (c)(3) (Contract section 8.2.2(C)) states that for standard authorizations that deny or limit services, the MCO must provide notice to the attending health care professional and hospital by telephone within one working day after making the determination, to the provider and enrollee within 10 business days, and in writing to the hospital, attending health care professional and enrollee. In six MHCP—MC files, there was no verbal (fax) notification to the attending health care professional within one working day. In five of those files (rehabilitative and habilitative files), the verbal (fax) went to the vendor of the service rather than the attending health care professional and one file took longer than one working day. In those same five

MHCP—MC files there was no written (fax) notification to the attending health care professional. The written notifications were sent to the vendor of the service rather than the attending health care professional. Policies relating to notifications (Prior Authorization for Commercial Products (UM04-C) and “Notification of Determinations” (UM05)) state the denial notice must be sent to the “provider” rather than the more specific term of “attending health care professional”. **(Deficiency #2)** [Cross reference to 62M.05, subdivision 3a (c)].

It was also noted that in one file the written notification was greater than 10 business days or 14 calendar days (20 calendar days). [Cross reference to 62M.05, subdivision 3a (a)]

§438.404 (c)(4) (Contract section 8.2.2.(D)) states that the MCO may extend the timeframe by an additional 14 days for resolution of a standard authorization if the provider or enrollee requests the extension or if the MCO justified a need for additional information. The MCO must provide written notice to the enrollee of the reason for the extension and the enrollee’s right to file a grievance if he/she disagrees. It was noted that in one file the written notice of the extension did not include the enrollee’s right to file a grievance. A total of 10 extension files were reviewed and in the other nine files all written notices did include the right to file a grievance.

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 type="checkbox"/> Met <input checked="" 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	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met

§438.408 (b)(1) (Contract section 8.3.2) states that oral grievances must be resolved within ten days of receipt. Two files involving gift card incentives took longer than ten days (18 and 20 days). **(Deficiency #3)**

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 Met Not Met
- Sec. 8.4.3 §438.408 (b) Timeframe for Resolution of Expedited Appeals Met Not Met
 A. §438.408 (b)(3) Expeditious Resolution and oral notice Met Not Met
 B. §438.410 (b) Punitive Action Prohibited Met Not Met
 C. §438.410 (c) Denial of Request for Expedited Appeal Met Not Met
- Sec. 8.4.4. §438.408 (c) Timeframe for Extension of Resolution of Appeals Met Not Met
- Sec. 8.4.5. §438.406 Handling of Appeals
- A. §438.406 (b)(1) Oral Inquiries Met Not Met
 B. §438.406 (a)(2) Written Acknowledgement Met Not Met
 C. §438.406 (a)(1) Reasonable Assistance Met Not Met
 D. §438.406 (a)(3)(i) Individual Making Decision Met 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 Met Not Met
 G. §438.406 (b)(3) Opportunity to Examine the Case File Met Not Met
 H. §438.406 (b)(4) Parties to the Appeal Met Not Met
- Sec. 8.4.6. Subsequent Appeals Met 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)(2) (Contract section 8.4.2), states that the MCO must resolve each appeal as expeditiously as the enrollee’s health requires, not to exceed 30 days. One MHCP—MC appeal file took longer than thirty days (62 days). [Cross reference to Minnesota Statutes, section 62M.06, subdivision 3 (a)].

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 Met Not Met
Subp. 5. Coordination of Care Met Not Met
Subp. 6. Timely Access to Health Care Services Met 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 Met Not Met
Subd. 3. Continuing Care Met Not Met
Subd. 4. Exception to formulary Met Not Met

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

- Subd. 1. Mental health services Met Not Met
Subd. 2. Coverage required Met 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

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

Utilization Review Files	
Utilization Review File Source	# Reviewed
UM Denials Commercial	22
UM Denials (determined by Landmark) Commercial	8
UM Denials MHCP—MC	74
UM Denials (determined by Landmark) MHCP—MC	10
UM Appeals Commercial	21
UM Appeals MHCP—MC	42
Total	177

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

- Subd. 1. Responsibility on Obtaining Certification Met Not Met
- Subd. 2. Information upon which Utilization Review is Conducted Met Not Met
- Subd. 3. Data Elements Met Not Met
- Subd. 4. Additional Information Met Not Met
- Subd. 5. Sharing of Information Met Not Met

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

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

Subd. 3a (a). Minnesota Statutes, section 62M.05, subdivision 3a (a), states an initial determination on all requests for utilization review must be communicated to the provider and enrollee within 10 business days (14 calendar days). In one MHCP—MC file the written

notification was greater than 14 calendar days (20 days). [Cross reference to §438.404 (c)(3) (Contract section 8.2.2(C))].

Subd. 3a (c). Minnesota Statutes, section 62M.05, subdivision 3a (c), states that when an initial determination is made not to certify, notification must be provided by telephone within one working day after making the determination to the attending health care professional and written notification must be sent to the attending health care professional and enrollee. In six MHCP—MC files, there was no verbal (fax) notification to the attending health care professional within one working day. In five of those files (rehabilitative and habilitative files), the verbal (fax) notice went to the vendor of the service rather than the attending health care professional and in one file the notice took longer than one working day. In five MHCP—MC files there was no written (fax) notification to the attending health care professional. The written notifications were sent to the vendor of the service rather than the attending health care professional. Policies relating to notifications (Prior Authorization for Commercial Products (UM04--C) and “Notification of Determinations” (UM05)) state the denial notice must be sent to the “provider” rather than the more specific term of “attending health care professional”. **(Deficiency #2)** [Cross reference to §438.404 (c)(3) (Contract section 8.2.2(C))].

Subd. 3a (d). Minnesota Statutes, section 62M.05, subdivision 3a (d), states when an initial determination is made not to certify, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal. In a total of 28 utilization denial files (25 MHCP—MC and 3 commercial files) the attending health care professional was not informed of his or her appeal rights. These were primarily pharmacy and PCA denials utilizing a fax notification process. **(Deficiency #4)**

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 type="checkbox"/> Met	<input checked="" 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 type="checkbox"/> Met	<input type="checkbox"/> Not Met <input checked="" 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 type="checkbox"/> Met	<input type="checkbox"/> Not Met <input checked="" 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 type="checkbox"/> Not Met <input checked="" type="checkbox"/> NCQA
Subd. 4.	Notifications to Claims Administrator	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

Subd. 2. Minnesota Statutes, section 62M.06, subdivision 2, requires an expedited appeal process. It does not include an extension for the expedited appeal timeline. The HealthPartners policy “Expedited Medical Appeals” states “The review timeline can be voluntarily extended with the enrollee’s permission.” MDH found no files where HealthPartners requested an

extension of expedited appeals. Minnesota law for commercial, fully insured products does not allow for an extension of an expedited appeal. Consequently, HealthPartners policy is not consistent with law. **(Mandatory Improvement #2)**

Subd. 3 (a). Minnesota Statutes, section 62M.06, subdivision 3 (a), states that the HMO will notify the enrollee and attending health care professional in writing within 30 days upon receipt of the appeal. One MHCP—MC appeal file was greater than 30 days (62 days). [Cross reference to §438.408 (b)(2) (Contract section 8.4.2)].

Subd. 3 (f). Minnesota Statutes, section 62M.06, subdivision 3 (f), states an appeal of a denial for clinical reasons must be reviewed by a physician “in the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion.” MDH has consistently interpreted this law to mean that the physician making the determination of a clinical appeal is a specialist.

HealthPartners policy and procedure, Appeals Level Consultation with Specialists, states HealthPartners will ensure that a physician of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion will review a clinical appeal. If a HealthPartners Medical Director is not in the same or similar specialty, HealthPartners will seek review by an appropriate specialist. The policy and procedure also states that when the specialist review is complete, the Medical Director must “consider” the specialist’s “recommendation.” According to the policy, a HealthPartners’ Medical Director makes the final decision. As written, the policy allows the Medical Director the authority, whether or not a specialist, to overrule the specialist’s review.

In additional comments, HealthPartners stated that the policy “might appear to disregard the specialist’s medical necessity determination, such is neither the policy nor the practice of the Member Services Department.” HealthPartners further described its process, including a second specialty review when the Medical Director disagrees with the first specialist’s determination.

In seven UM appeal files, the Medical Director making the final decision was not in the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion. In interviews, staff acknowledged that a medical director, on occasion, has overruled the specialty reviewer. (These cases are tracked.) Policies and procedures, staff interviews, and file review did not describe any additional specialty review.

MDH received three conflicting explanations as to HealthPartners’ process for same or similar specialty review of appeals. While MDH did not see specific files where the Medical Director making the final decision overruled the specialist opinion, HealthPartners policies and procedures regarding specialty review of clinical appeals, as currently written, are not consistent with law. **(Mandatory Improvement #3)**

Minnesota Statutes, Section 62M.08. Confidentiality

Met Not Met NCQA

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

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 checked="" type="checkbox"/> Met	<input 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 checked="" 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 checked="" 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 type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subd. 7.	Training for Program Staff	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subd. 8.	Quality Assessment Program	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA

Subd. 6. Minnesota Statutes, section 62M.09, subdivision 6, states the plan must use physician consultants in the appeal process (described in section 62M.06, subdivision 3) and the physician consultants must be board certified.

MDH has consistently interpreted this law to mean the physician making the determination in a clinical appeal must be a board-certified specialist in the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion. The health plan may use the specialist of its choice, so whether the specialist is employed by the plan or hired through another arrangement, the physician making the determination must be board certified.

HealthPartners’ policy, Appeals-Level Consultations with Specialists, states, “In deciding a medical appeal, HealthPartners will ensure that a physician 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.” The policy does not state that the specialist must be board certified. The policy also states the HealthPartners Medical Director makes the final determination of coverage. As written, the policy allows the Medical Director, whether or not a board certified specialist, the authority to overrule the specialist review.

While a Medical Director may wear many hats within a health plan, when a Medical Director is participating in the appeal process in section 62M.06, he or she must be board certified as referenced by section 62M.09.

In the same seven files noted above (section 62M.06, subdivision 3 (f)), HealthPartners sent the appeals to an external review organization for specialty review. The HealthPartners Medical Director making the final determination was not board certified. HealthPartners’ additional comments state that its Medical Directors do not overrule the specialist’s review. MDH did not see any file where the Medical Director overruled the board certified specialty reviewer. However, HealthPartners policies and procedures regarding review of clinical appeals by board certified specialists are not consistent with Minnesota law. **(Mandatory Improvement #4)**

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.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. Mandatory Improvements

1. To comply with Minnesota Rules, part 4685.1900, subpart 2, HealthPartners must categorize and store complaints and appeals in a manner that permits accurate retrieval of complaints to be consistent with Minnesota law.
2. To comply with Minnesota Statutes, section 62M.06, subdivision 2, HealthPartners must revise its policy to ensure that extensions of the resolution timeline are not requested or taken on expedited clinical appeals.
3. To comply with Minnesota Statutes, sections 62M.06, subdivision 3 (f), HealthPartners must revise its policy regarding appeal to reverse a determination not to certify for clinical reasons to fully describe its same or similar specialty review process and to ensure that the determination is made by a physician in the same or specialty as typically manages the medical condition, procedure or treatment under discussion.
4. To comply with Minnesota Statutes, sections 62M.09, subdivision 6, HealthPartners must revise its policy regarding Appeals-Level Consultations to ensure the physician making the final determination of a clinical appeal is a board certified specialist.

VII. Deficiencies

1. To comply with Minnesota Rules, part 4685.1130, subpart 3, HealthPartners must file notice with the Commissioner of Health 30 days before modifying its written quality assurance plan.
2. To comply with §438.404 (c)(3) (Contract section 8.2.2(C)) and Minnesota Statutes, section 62M.05, subdivision 3a (c), HealthPartners must provide notice for denials of standard authorizations to the attending health care professional and hospital by telephone within one working day after making the determination. Written notice must be sent to the hospital, attending health care professional and enrollee. HealthPartners' policies must reflect this.
3. To comply with §438.408 (b)(1) (Contract section 8.3.2), HealthPartners must resolve oral grievances within ten days of receipt.
4. To comply with Minnesota Statutes, section 62M.05, subdivision 3a (d), HealthPartners must ensure that when an initial determination is made not to certify, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal.