

Minnesota Department of Health
Compliance Monitoring Division
Managed Care Systems Section



Final Report

HealthPartners

Quality Assurance Examination
For the Period:
December 1, 2008 – March 31, 2012

Final Issue Date:

Revised February 14, 2013

Examiners:
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Minnesota Department of Health Executive Summary

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of HealthPartners to determine whether it is operating in accordance with Minnesota law. Our mission is to protect, maintain and improve the health of all Minnesotans. MDH 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. Deficiencies are violations of law. “Mandatory Improvements” are required corrections that must be made to non-compliant policies, documents or procedures where evidence of actual compliance is found 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, HealthPartners should:

Consider getting formal approval from the Board of Directors of the annual evaluation as it has in previous years.

Explain in its complaint resolution policies/procedures that the “outcome notification” is the date the issue is closed with the enrollee and the clock stops.

Include in the notification of a UM denial the enrollee’s further right to file a complaint at any time with the Commissioner of the Department of Health.

To address mandatory improvement, HealthPartners must:

Clearly document the reporting of quality activities at least quarterly in HealthPartners’ governing body minutes.

Clearly reflect review of the annual evaluation in HealthPartners governing body minutes.

Revise its COC for *Open Access Choice* to delete the additional 14 day language that states “This time period may be extended for an additional 14 calendar days.”

Revise its policies to be consistent with statute and state that the notification of an expedited initial determination be no later than 72 hours from the initial request.

To address deficiencies, HealthPartners and its delegates must:

Ensure that the CCMI/Landmark DTR provides the enrollee with a clear detailed description of the reasons for the denial.

This report including these deficiencies, mandatory improvements and recommendations 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

History:

- A. Founded in 1957, HealthPartners provides care and coverage to over one million members across Minnesota and western Wisconsin. Its affiliates are an integrated healthcare network, including HealthPartners Medical Group, medical and dental clinics, hospitals, JourneyWell, disease management and health improvement, a research foundation, and the Institute for Medical Education. It has 12,000 employees with medical/dental facilities in 70 locations. HealthPartners offers products for the fully-insured commercial market and publicly funded Minnesota HealthCare Programs—Managed Care (MHCP-MC).
- B. Membership: HealthPartners self-reported enrollment as of December 31, 2011, is comprised of the following:

Product	Enrollment
<i>Fully Insured Commercial</i>	
Large Group	252,668
Small Employer Group	104,348
Individual	23,689
<i>Minnesota Health Care Programs- Managed Care (MHCP-MC)</i>	
Families & Children	60,172
MinnesotaCare	19,516
Minnesota Senior Care (MSC+)	1,218
Minnesota Senior Health Options (MSHO)	2,911
Special Needs Basic Care (SNBC)	
<i>Medicare</i>	
Medicare Advantage	0
Medicare Cost	41,366
<i>Total</i>	505,888

- C. Onsite Examinations Dates: June 11-15, 2012
- D. Examination Period: December 1, 2008 through March 31, 2012
File Review Period: April 1, 2011 through March 31, 2012
Opening Date of the exam: March 22, 2012
- E. National Committee for Quality Assurance (NCQA): HealthPartners is accredited by NCQA based on 2010 standards. The Minnesota Department of Health (MDH) evaluated and used results of the NCQA review in one of three ways:
1. If NCQA standards do not exist or are not as stringent as Minnesota law, the accreditation results will not be used in the MDH examination process [No NCQA checkbox].

2. If the NCQA standard was the same or more stringent than Minnesota law and the health plan was accredited with 100% of the possible points, the NCQA results were accepted as meeting Minnesota requirements [NCQA - 3. 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 quality assurance examination, that 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	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input type="checkbox"/>
Subp. 2.	Documentation of Responsibility	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input checked="" type="checkbox"/>
Subp. 3.	Appointed Entity	Met <input type="checkbox"/>	Not Met <input checked="" type="checkbox"/>	NCQA <input type="checkbox"/>
Subp. 4.	Physician Participation	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input checked="" type="checkbox"/>
Subp. 5.	Staff Resources	Met <input type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input checked="" type="checkbox"/>
Subp. 6.	Delegated Activities	Met <input type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input type="checkbox"/>
Subp. 7.	Information System	Met <input type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input checked="" type="checkbox"/>
Subp. 8.	Program Evaluation	Met <input type="checkbox"/>	Not Met <input checked="" type="checkbox"/>	NCQA <input type="checkbox"/>
Subp. 9.	Complaints	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>	
Subp. 10.	Utilization Review	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>	
Subp. 11.	Provider Selection and Credentialing	Met <input type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input checked="" type="checkbox"/>
Subp. 12.	Qualifications	Met <input type="checkbox"/>	Not Met <input type="checkbox"/>	NCQA <input checked="" type="checkbox"/>
Subp. 13.	Medical Records	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>	

Subp. 3. Minnesota Rules, part 4685.1110, subpart 3, states the governing body shall designate a quality assurance entity for operation of quality assurance activities and this entity shall maintain records and meet with the governing body at least quarterly. The governing body at HealthPartners meets quarterly. In the September 2011 governing body minutes there was no documentation of quality improvement activity reporting. However, in the packet of information sent to the governing body prior to the Board meeting there were numerous quality activity documents and minutes from both the quality committee of the Board and Quality Council.

HealthPartners' governing body minutes must clearly document reporting of quality activities at least quarterly. **(Mandatory Improvement #1)**

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 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								
Entity	UM	UM Appeals	QM	Complaints/ Grievances	Cred	Claims	Network	Care Coord
Landmark Healthcare	X							
ChiroCare of Minnesota							X	
Sherburne County								X
Anoka County								X

Subp. 8. Minnesota Rules, part 4685.1110, subpart 8, states the results of the annual quality evaluation shall be communicated to the governing body. The June 2011 governing body minutes did not reflect review of the annual evaluation. In previous years the governing body minutes indicated formal approval of the annual evaluation. The annual evaluation was in the June 2011 Board packet sent to the Board prior to the meeting and the Medical Director gave a Power Point presentation highlighting aspects of the annual evaluation to a subcommittee of the Board. The HealthPartners governing body minutes must clearly reflect review of the annual evaluation. **(Mandatory Improvement #2)** HealthPartners should consider getting formal approval from the Board of this valuable document as it has in previous years. **(Recommendation #1)**

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 15 quality of care complaint and grievance files were reviewed as follows:

Quality of Care File Review	
QOC File Source	# Reviewed
<i>Complaints—Commercial Products</i>	5
<i>Grievances—MHCP-MC Products</i>	10
Total	15

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. Focus 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

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

III. Complaints and Grievance Systems

Complaint System

MDH examined HealthPartners fully-insured commercial complaint system under Minnesota Statutes, chapter 62Q. MDH reviewed a total of 58 Complaint System files.

Complaint System File Review	
Complaint Files (Oral and email)	36
Written Complaints (1 st Level Appeals)	17
Non-Clinical Appeal (2 nd Level Appeals)	5
Total # Reviewed	58

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

Subd. 2. Minnesota Statutes, 62Q.69, subdivision 2(b), states that if a complaint is submitted orally, the resolution of the complaint must be resolved to the satisfaction of the complainant, as determined by the complainant, within ten days. If the complaint is partially or wholly adverse to the complainant, or the oral complaint is not resolved to the satisfaction of the complainant, by the health plan company within ten days of receiving the complaint, the health plan company must inform the complainant that the complaint may be submitted in writing. MDH reviewed 18 oral and 18 electronic (email) complaints. HealthPartners calls these email complaints written, however its policy is to handle them orally or via email within 10 days. There were five email complaints where the close date was greater than 10 business days. The electronic complaint system used requires that the closed date be, for example, when the claim is actually adjusted, not upon resolution of the issue with the enrollee. It is designated in the system by “Outcome Notification” when the enrollee is notified and satisfied and requires no further assistance. HealthPartners should explain in its policy/procedure that the “outcome notification” is the date the issue is closed with the enrollee and the clock stops. **(Recommendation #2)**

In one file the complaint resolution took 19 days. HealthPartners informed the complainant that it was going to take longer and offered a written complaint form and assistance but the complainant refused and asked member services to continue working the case. The complainant was offered a written complaint form a second time. The file had excellent documentation of numerous complainant telephone contacts keeping the enrollee informed, per her request. MDH discussed with HealthPartners that this file was handled appropriately given the excellent documentation of offering the complaint form and complainant contacts.

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

Grievance System

MDH examined HealthPartners’s Minnesota Health Care Programs Managed Care Programs-Managed Care (MCHP-MC) grievance system for compliance with the federal law (42 CFR 438, subpart D) and the DHS 2011 Model Contract, Article 8.

MDH reviewed a total of 21 grievance system files:

Grievance System File Review	
File Source	# Reviewed
Grievances	8
Non-Clinical Appeals	8
State Fair Hearings	5
Total	21

Section 8.1. §438.402 General Requirements

Sec. 8.1.1 Components of Grievance System Met Not Met

Section 8.2. §438.408 Internal Grievance Process Requirements

Sec. 8.2.1. §438.402 (b) Filing Requirements Met Not Met

Sec. 8.2.2. §438.408 (b)(1) Timeframe for Resolution of Grievances
Met Not Met

Sec. 8.2.3. §438.408 (c) Timeframe for Extension of Resolution of Grievances
Met Not Met

Sec. 8.2.4. §438.406 Handling of Grievances
(A) §438.406 (a)(2) Written Acknowledgement Met Not Met
(B) §438.416 Log of Grievances Met Not Met
(C) §438.402 (b)(3) Oral or Written Grievances Met Not Met
(D) §438.406 (a)(1) Reasonable Assistance Met Not Met
(E) §438.406 (a)(3)(i) Individual Making Decision Met Not Met
(F) §438.406 (a)(3)(ii)Appropriate Clinical Expertise
Met Not Met

Sec. 8.2.5. §438.408 (d)(1) Notice of Disposition of a Grievance
(A) §438.408 (d)(1) Oral Grievances Met Not Met
(B) §438.408 (d)(1) Written Grievances Met Not Met

Section 8.3. §438.404 DTR Notice of Action to Enrollees

Sec. 8.3.1. General Requirements Met Not Met

Sec. 8.3.2. §438.404 (c) Timing of DTR Notice
(A) §438.210 (c) Previously Authorized Services
Met Not Met

- (B) §438.404 (c)(2) Denials of Payment Met Not Met
- (C) §438.210 (c) Standard Authorizations Met Not Met
- (1) As expeditiously as the enrollee's health condition requires Met Not Met
- (2) To the attending health care professional and hospital by telephone or fax within one working day after making the determination Met Not Met
- (3) To the provider, enrollee and hospital, in writing, and must include the process to initiate an appeal, within ten (10) business days following receipt of the request for the service, unless the MCO receives an extension of the resolution period Met Not Met
- (D) §438.210 (d)(2)(i) Expedited Authorizations Met Not Met
- (E) §438.210 (d)(1) Extensions of Time Met Not Met
- (F) §438.210 (d) Delay in Authorizations Met Not Met
- Sec. 8.3.3. §438.420 (b) Continuation of Benefits Pending Decision Met Not Met

42 CFR 438.210 (c) (contract section 8.2.3 (C)(3)), states the plan must provide the DTR within ten business days of receipt of the request for the service. In file review, MDH found five of ten CCMI/Landmark UM denials identified the receipt date as the date requested additional information was received, rather than the date of the original request. HealthPartners identified this error in its annual delegation oversight file review and provided MDH with the CCMI corrective action plan and internal audits showing that the issue was corrected in December 2011. MDH review of files after December showed the issue was corrected. MDH commends HealthPartners for identifying and correcting the issue as a part of its ongoing quality improvement activities.

42 CFR 438.10 (contract section 8.3). The DHS contract requires that, if the plan denies, reduces or terminates services, the plan must send a DTR notice that meets the requirements of the contract. In one UM appeal file, MDH found the notice sent to one MHCP-MC enrollee included the rights of a commercial product enrollee.

42 CFR 438.404(b) (contract section 8.3.1 (B)), states 12 elements the DTR must contain, including (B)(3), a clear detailed description in plain language of the reasons for the Action. HealthPartners delegates utilization review of chiropractic services to CCMI/Landmark. In all ten CCMI UM denial files reviewed, CCMI sent the provider a clear detailed description of the denial, including the number of services approved, if any, and the number denied. However, the DTR sent to the enrollee contained only the standard statement, "The reason for this decision is: NOT MEDICALLY NECESSARY. BASED ON MEDICAL STANDARDS, THE CARE REQUESTED FOR YOU WILL NOT MAINTAIN OR HELP YOUR HEALTH." The DTR did not provide the enrollee a clear detailed description of the reasons for the denial. **(Deficiency #1)**

Section 8.4. §438.408

Internal Appeals Process Requirements

- Sec. 8.4.1. §438.402 (b) Filing Requirements Met Not Met
- Sec. 8.4.2. §438.408 (b)(2) Timeframe for Resolution of Expedited Appeals

- Met Not Met
- Sec. 8.4.3. §438.408 (b) Timeframe for Resolution of Expedited Appeals
- (A) §438.408 (b)(3) Expedited Resolution of Oral and Written Appeals Met Not Met
- (B) §438.410 (c) Expedited Resolution Denied Met Not Met
- (C) §438.410 (a) Expedited Appeal by Telephone 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) Individual Making Decision Met Not Met
- (E) §438.406(a)(3) Appropriate Clinical Expertise Met Not Met
- [See Minnesota Statutes, sections 62M.06, and subd. 3(f) and 62M.09]
- (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
- (I) §438.410 (b) Prohibition of Punitive Action Met Not Met
- Sec. 8.4.6. Subsequent Appeals Met Not Met
- Sec. 8.4.7. §438.408 (d)(2) and (e) Notice of Resolution of Appeals Met Not Met
- (A) §438.408 (d)(2) and (e) Written Notice Content Met Not Met
- (B) §438.210 (c) Appeals of UM Decisions Met Not Met
- (C) §438.210 (c) and .408 (d)(2)(ii) Telephone Notification of Expedited Appeals Met Not Met
- [Also see Minnesota Statutes section 62M.06, subd. 2]
- Sec. 8.4.8. §438.424 Reversed Appeal Resolutions Met Not Met

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

Section 8.9. §438.416 (c) State Fair Hearings

- Sec. 8.9.2. §438.408 (f) Standard Hearing Decisions Met Not Met
- Sec. 8.9.5. §438.420 Continuation of Benefits Pending Resolution of State Fair Hearing Met Not Met
- Sec. 8.9.6. §438.424 Compliance with State Fair Hearing Resolution 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

V. Utilization Review

UM System File Review	
File Source	#Reviewed
<i>UM Denial Files</i>	
Commercial	
HealthPartners	30
Chiropractic	10
MHCP-MC	8
<i>Subtotal</i>	48
<i>Clinical Appeal Files</i>	
Commercial	8
MHCP-MC	28
<i>Subtotal</i>	36
Total	84

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. 1. Minnesota Statutes, section 62M.04, subdivision 1, states that a health plan that includes utilization review requirements must specify the process for notifying the utilization review organization in a timely manner and obtaining certification for health care services. Each health plan company must provide a clear and concise description of this process to an enrollee as part of the policy, subscriber contract, or certificate of coverage (COC). In the HealthPartners COC for *Open Access Choice*, it states that “when an authorization for a service is requested, we will make an initial determination within 14 calendar days, as long as all information reasonably needed to make the decision has been provided. This time period may be extended for an

additional 14 calendar days. If we request additional information, you have up to 45 days to provide the information requested.” Minnesota HMO law does not allow for an additional 14 calendar days in addition to extensions for lack of information. Minnesota Statutes, section 62M.05, subdivision 4, states the plan needs to have written procedures to address lack of information. MDH did not see the additional 14 day extension used in any files nor in any policy. HealthPartners must revise its COC to delete the additional 14 day language. **(Mandatory Improvement #3)**

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 right 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 that an initial determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within ten business days of the request. One commercial UM denial file exceeded the 10 business days.

Subd. 3b. Minnesota Statutes, section 62M.05, subdivision 3b, states that 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 as expeditiously as the enrollee's medical condition requires, but no later than 72 hours from the initial request. HealthPartners policies *Notifications of Determinations* (UM05) and *Failure to Provide Necessary Information* (UM 08-C) state that the decision for expedited initial determinations can be extended for an additional 48 hours due to lack of information with the decision and notification no later than 120 hours from the receipt of the request. The statute clearly states the decision must be communicated no later than 72 hours from the initial request. HealthPartners must revise its policies to be consistent with statute. All expedited UM files reviewed were within the 72 hours per statute. **(Mandatory Improvement #4)**

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

- Subd. 1. Procedures for Appeal Met 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 type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
	(f) Same or similar specialty review	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	
	(g) Notice of rights to external; review	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input type="checkbox"/> NCQA
Subd. 4.	Notification to Claims Administrator	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met	

MDH commends HealthPartners for the quality of its commercial appeal notification letters.

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 Requirements	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" type="checkbox"/> NCQA
Subd. 3.	Physician Reviewer Involvement	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	<input checked="" 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 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

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

Met Not Met

Minnesota Statutes, section 62M.11, states, notwithstanding the provisions of sections 62M.01 to 62M.16, an enrollee may file a complaint regarding a determination not to certify directly to the commissioner responsible for regulating the utilization review organization. In the 30 HealthPartners UM denial files and the 10 chiropractic denial files, the notification of the denial did not contain notice of the enrollee's right to file a complaint with the commissioner of the Department of Health. HealthPartners and its delegates could better inform its enrollees of their additional rights through inclusion in the UM denial notifications. **(Recommendation #3)**

VI. Recommendations

1. To better comply with Minnesota Rules, part 4685.1110, subpart 8, HealthPartners should consider getting formal approval from the Board of Directors of the annual evaluation as it has in previous years.
2. To better comply with Minnesota Statutes, 62Q.69, subdivision 2(b), HealthPartners should explain in its complaint resolution policies/procedures that the “outcome notification” is the date the issue is closed with the enrollee and the clock stops.
3. To better comply with Minnesota Statutes, section 62M.11, HealthPartners and its delegates could better inform its enrollees of their additional right to complain to the Commissioner of the Department of Health through inclusion in the UM denial notification.

VII. Mandatory Improvements

1. To comply with Minnesota Rules, part 4685.1110, subpart 3, HealthPartners governing body minutes must clearly document reporting of quality activities at least quarterly.
2. To comply with Minnesota Rules, part 4685.1110, subpart 8, HealthPartners governing body minutes must clearly reflect review of the annual evaluation.
3. To comply with Minnesota Statutes, section 62M.04, subdivision 1, HealthPartners must revise its COC for *Open Access Choice* to delete the additional 14 day language that states “This time period may be extended for an additional 14 calendar days.”
4. To comply with Minnesota Statutes, section 62M.05, subdivision 3b, HealthPartners must revise its policies to be consistent with statute and state that the notification of an expedited initial determination be no later than 72 hours from the initial request.

VIII. Deficiencies

1. To comply with 42 CFR 438.404(b), (contract section 8.3.1 (B)), HealthPartners and its delegates must ensure that the CCMI/Landmark DTR provides the enrollee with a clear detailed description of the reasons for the denial.