

Minnesota Department of Health  
Compliance Monitoring Division  
Managed Care Systems Section



## **Final Report**

# **Itasca Medical Care**

Quality Assurance Examination  
For the Period:  
July 1, 2009 through July 31, 2012

*Final Issue Date:*  
March 20, 2013

Examiners  
Susan Margot, MA  
Elaine Johnson, RN, BS, CPHQ

## **Minnesota Department of Health Executive Summary**

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of Itasca Medical Care (IMCare) 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 has found that IMCare 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, IMCare should:**

Add the reports/documents/information used to complete the annual oversight report for all of the functions delegated to increase credibility of the oversight process.

Include graphs and tables in its PIP summaries to more effectively present the evaluation of data.

Revise the DTR language.

Work with the appropriate primary care providers to ensure that the appropriate referral and authorization requests are submitted to IMCare in a timely manner.

Inform enrollees they are not liable for denied claims unless the provider notifies the enrollee before the services are provided.

Update its provider webpage to include revised policies/procedures 024-014 and 024-015 and other revised policies/procedures to ensure readily available and accurate information.

### **To address mandatory improvement, IMCare must:**

Ensure the complete quality of care investigation and actions are reported to IMCare and documented in the IMCare quality of care files and credentialing files, as appropriate.

Revise its *Site Visits (005-018)* policy to include continually monitoring member complaints for all practitioner sites and perform a site visit within 60 days if the threshold is met.

Revise the procedure 008-002 to state all appeals must receive an acknowledgement letter.

Clearly inform providers of their responsibility to provide referrals and the specific procedures to be followed. Policies/procedures must reflect actual practice, be consistent across policies/procedures and, the certificate of coverage and provider manual must consistently describe the procedures.

Revise its policy/procedure 012-003, *Court-Ordered Mental Health/CD Services*, to state that it is financially liable for the evaluation if performed by a participating provider.

Revise policies/procedures 004-001, *Continuity of Care*, and 024-013 and 024-017, *pre- and post-service reviews*, to include an explanation of who will identify enrollees with special needs or at special risk and how continuity of care will be provided for those enrollees.

Revise its policy/procedure *MCHP-MC Appeals (008-002)* to include a peer of the treating mental health or substance abuse provider, a doctoral-level psychologist, or a physician must review requests for outpatient services in which the utilization review organization has concluded that a determination not to certify a mental health or substance abuse service for clinical reasons is appropriate.

Revise its policy/procedure *MCHP-MC Appeals (008-002)* to include a chiropractor must review all appeals in which the utilization review organization has concluded that a determination not to certify a chiropractic service or procedure for clinical reasons is appropriate.

**To address deficiencies, IMCare and its delegates must:**

Submit all revisions to its written quality plan to MDH for approval.

In its notifications of an expedited determination not to certify, inform the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal process with the verbal notification of 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

## Table of Contents

I. Introduction .....	5
II. Quality Program Administration .....	6
Minnesota Rules, Part 4685.1110. Program .....	6
Minnesota Rules, Part 4685.1115. Activities.....	8
Minnesota Rules, Part 4685.1120. Quality Evaluation Steps .....	8
Minnesota Rules, Part 4685.1125. Focus Study Steps.....	9
Minnesota Rules, Part 4685.1130. Filed Written Plan and Work Plan.....	9
III. Grievance Systems .....	9
Section 8.1. §438.402 General Requirements .....	10
Section 8.2. §438.408 Internal Grievance Process Requirements.....	10
Section 8.3. §438.404 DTR Notice of Action to Enrollees.....	10
Section 8.4. §438.408 Internal Appeals Process Requirements .....	11
Section 8.5. §438.416 (c) Maintenance of Grievance and Appeal Records.....	12
Section 8.9. §438.416 (c) State Fair Hearings.....	12
IV. Access and Availability .....	12
Minnesota Statutes, Section 62D.124. Geographic Accessibility.....	12
Minnesota Rules, Part 4685.1010. Availability and Accessibility .....	13
Minnesota Statutes, Section 62Q.55. Emergency Services .....	14
Minnesota Statutes, Section 62Q.121. Licensure of Medical Directors .....	14
Minnesota Statutes, Section 62Q.527. Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance.....	14
Minnesota Statutes, Section 62Q.535. Coverage for Court-Ordered Mental Health Services ....	15
Minnesota Statutes, Section 62Q.56. Continuity of Care .....	15
V. Utilization Review .....	16
Minnesota Statutes, Section 62M.04. Standards for Utilization Review Performance .....	16
Minnesota Statutes, Section 62M.05. Procedures for Review Determination.....	16
Minnesota Statutes, Section 62M.06. Appeals of Determinations not to Certify.....	17
Minnesota Statutes, Section 62M.08. Confidentiality .....	17
Minnesota Statutes, Section 62M.09. Staff and Program Qualifications .....	17
Minnesota Statutes, Section 62M.11. Complaints to Commerce or Health .....	18
VI. Recommendations.....	18
VII. Mandatory Improvements.....	19
VIII. Deficiencies.....	19

## **I. Introduction**

### **A. History:**

The Itasca Medical Care (IMCare) program is administered by Itasca County Health and Human Services (ICHHS). IMCare enrollees are eligible for benefits under Minnesota Health Care Programs—Managed Care (MCHA-MC) residing in Itasca County. Prepaid Medicaid was implemented on July 1, 1985, as a demonstration project and expanded to include MinnesotaCare in 1996. IMCare has since become a county based purchasing organization. Minnesota Senior Care (MSC+) was added in June of 2005 and a Medicare Advantage product, Minnesota Senior Health Option (MSHO), was added in January 2006.

IMCare receives monthly capitation from the Minnesota Department of Human Services (DHS) for all IMCare enrollees. The Itasca County primary care physicians, hospitals, mental health providers, dentists, vision providers, and chiropractors assume financial risk in their contracts with ICHHS/IMCare. IMCare staff administers the program and pays claims to the medical providers. IMCare staff is ICHHS employees; the administrative costs of the IMCare program are reimbursed to ICHHS out of the IMCare program funds. The IMCare program does not use any Itasca County levy money.

Eligible persons enrolled in IMCare choose their primary care physician, pharmacy, mental health provider, and chiropractor, and have access to their choice of network dental and vision providers.

The network of primary care providers for IMCare includes:

- All primary care clinics in Itasca County and three clinics in Hibbing
- Three hospitals in Itasca County and the hospital in Hibbing
- All Itasca County pharmacies and three pharmacies in Hibbing
- All chemical dependency providers in Itasca County
- Most of the Itasca County dentists, mental health providers, vision providers, and chiropractors.

Referrals are made to out-of-area providers to meet special treatment needs of the enrollees.

IMCare works closely with Itasca County Public Health and Social Services to coordinate enrollee medical, social and community needs.

### **B. Membership:**

IMCare self-reported enrollment as of December 31, 2011, consisted of the following:

<b>Product</b>	<b>Enrollment</b>
<b><i>Minnesota Health Care Programs- Managed Care (MHSP-MC)</i></b>	
Families & Children	4,341
MinnesotaCare	1,240
Minnesota Senior Care (MSC+)	135
Minnesota Senior Health Options (MSHO)	485
<b><i>Total</i></b>	<b>6,201</b>

- C. Onsite Examination Dates: October 1 through 4, 2012
- D. Examination Period: July 1, 2009 through July 31, 2012  
 File Review Period: August 1, 2011 through July 31, 2012, except where earlier dates were requested to review as large a sample as possible or 30 files.  
 Opening Date: July 6, 2012
- E. 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.
- F. 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"/>
Subp. 2.	Documentation of Responsibility	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>
Subp. 3.	Appointed Entity	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>
Subp. 4.	Physician Participation	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>
Subp. 5.	Staff Resources	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>
Subp. 6.	Delegated Activities	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>
Subp. 7.	Information System	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>
Subp. 8.	Program Evaluation	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>
Subp. 9.	Complaints	Met <input type="checkbox"/>	Not Met <input checked="" 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 checked="" type="checkbox"/>
Subp. 12.	Qualifications	Met <input checked="" type="checkbox"/>	Not Met <input type="checkbox"/>

Subp. 13. Medical Records

Met  Not Met

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
CVS/Caremark						x	x	
Itasca County								x

The CVS/Caremark annual oversight report did not contain a listing or attachments that indicated the specific reports/information used to make the determination that “generally speaking, CVS/Caremark is performing well in all areas listed above” (pharmacy network, retail network auditing, help desk, maintaining member eligibility, point-of-sale claims processing, paper claims, formulary management, medication management, patient safety, quality management, specialty pharmacy rebate arrangements). Reports were provided to MDH upon request when onsite. To increase credibility of the oversight process, IMCare may want to add the reports/documents/information used to complete the annual oversight report and a more precise measurement of performance instead of “generally speaking”. **(Recommendation #1)**

Specialty Pharmacy and Medication Therapy Management (MTM) reporting were two areas of improvement that were noted on the report that will be addressed in 2012. MDH expects to see written improvement plans and documentation of follow up on these areas that will be reviewed at mid-cycle.

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 seven quality of care grievance files were reviewed. IMCare has thorough policies/procedures regarding quality of care grievances, including a definition of quality of care and assignment of levels of severity. IMCare followed its policy/procedures and performed thorough investigations. However, MDH noted that, while the policies/procedures identified “behavior” as a quality of care concern, files do not document review of “behavior” issues. In two files, the enrollee allegations were forwarded to a facility, but the documentation of the facility’s investigation and follow-up were not present in the file. In both circumstances, IMCare was able to provide documentation to confirm the facility’s actions. IMCare is ultimately responsible for the quality of care provided to its enrollees. IMCare must ensure the complete quality of care investigation and actions are reported to IMCare and documented in the IMCare quality of care files and credentialing files, as appropriate. **(Mandatory Improvement #1)**

Subp. 11. Minnesota Rules, part 4685.1110, subpart 11, states that the health plan must have procedures for credentialing and recredentialing providers that are, at a minimum, consistent

with accepted community standards. MDH understands the community standard to be NCQA credentialing and recredentialing standards. MDH reviewed a total of 33 credentialing and recredentialing files (including physician, allied and organizational providers) from IMCare as follows:

<b>Credentialing and Recredentialing File Review</b>	
<b>File Source</b>	<b># Reviewed</b>
<b><i>Initial Credentialing</i></b>	
Initial Physician	8
Initial Allied Practitioners	8
Initial Organizational Providers	0
<b><i>Recredentialing</i></b>	
Recredentialed Physician	8
Recredentialed Allied Practitioners	8
Recredentialed Organizational Providers (all files)	1
<b>Total</b>	<b>33</b>

MDH noted that IMCare’s credentialing processes have greatly improved since the previous examination.

The standards state to assure office site quality, the organization must continually monitor member complaints for all practitioner sites and performing a site visit within 60 days of determining its complaint threshold is met. IMCare’s policy *Site Visits (005-018)* does not include this standard. IMCare must revise its policy to include continually monitoring member complaints for all practitioner sites and perform a site visit within 60 days if the threshold is met. **(Mandatory Improvement #2)**

**Minnesota Rules, Part 4685.1115. Activities**

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

**Minnesota Rules, Part 4685.1120. Quality Evaluation Steps**

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



Subps. 1 and 4. Minnesota Rules, part 4685.1120, subpart 1 and subpart 4, state the plan shall identify the existence of actual or potential problems by ongoing evaluation of data and to continue to monitor data after interventions to determine effectiveness. Graphs and tables are used in IMCare’s 2011 Annual Program Evaluation. However, while it contained informational and concise summaries of the performance improvement projects (PIPs), it did not contain tables or graphs that could visually depict the effectiveness and/or status of the projects. IMCare may wish to include graphs in its PIP summaries to more effectively present the evaluation of data. **(Recommendation #2)**

**Minnesota Rules, Part 4685.1125. Focus Study Steps**

Subp. 1.	Focused Studies	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 2.	Topic Identification and Selection	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 3.	Study	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 4.	Corrective Action	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 5.	Other Studies	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

In addition to its mandatory performance improvement projects, IMCare also conducted three focus studies which included the Prenatal Initiative, Controlled Substance Focus Study and Emergency Department Utilization Study.

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

Subd. 1.	Written Plan	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 2.	Work Plan	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 3.	Amendment to Plan	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met

Subp. 3. Minnesota Rules, part 4685.1130, subpart 3, states the plan may change its written quality assurance plan by filing notice with MDH for approval. IMCare revised its written quality plan in 2011 as evidenced by quality committee and Board minutes, however IMCare did not submit the 2011 plan for MDH approval. IMCare must submit all revisions to its written quality plan to MDH for approval. **(Deficiency #1)**

**III. Grievance Systems**

MDH examined IMCare’s Minnesota Health Care Programs Managed Care Programs-Managed Care (MCHP-MC) grievance system for compliance with the federal law (42 CFR 438, subpart F) and the DHS 2012 Model Contract, Article 8.

MDH reviewed a total of 40 IMCare grievance system files:

<b>Grievance System File Review</b>	
<b>File Source</b>	<b># Reviewed</b>
Grievances (all files)	9
Non-Clinical Appeals	30
State Fair Hearing (all files)	1
<b>Total</b>	<b>40</b>

**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

#### **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

§438.406 (a)(2) (Contract section 8.4.5 (B)), states in pertinent part, the MCO must send a written acknowledgment within ten (10) days of receiving the request for an appeal. Page 4 of policy/procedure 008-002, *MHCP-MC Appeals*, so states. In practice, all enrollee appeals were received orally. Enrollees received an acknowledgement letter and a plan-completed complaint form. However, the procedures (page 9 (j)), states, the PIP Coordinator/Compliance Officer, within 10 days of receipt of an oral appeal, generates the Acknowledged—Appeal letter to the enrollee on CaseTrakker. The DHS contract does not distinguish oral appeals; therefore IMCare must revise the procedure 008-002 to state all appeals must receive an acknowledgement letter. **(Mandatory Improvement #3)**

**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	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 5.	Coordination of Care	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
Subp. 6.	Timely Access to Health care Services	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

Subp. 5, B. Minnesota Rules, part 4685.1010, subpart 5, B, states, in pertinent part, that in health plans where referrals to specialty providers and ancillary services are required, the primary care provider or the plan must initiate referrals and the plan must inform its providers of their responsibility to provide written referrals and any specific procedures that must be followed in providing referrals.

IMCare’s Provider Manual policies/procedures are fragmented and confusing. Policy/procedure, *Prior Authorization of Services* (page 26) states IMCare enrollees must have a referral from their primary care clinic for out-of network services. Policy/Procedure *Physician Services—Referral Process*, (page 50) states under “Service Authorization/Referral Requirements,” that “All IMCare enrollees **must have a referral** from their primary care clinic for out-of-network services, home care” and refers to an attached authorization list. The referral form, ‘entitled “*IMCare Referral/Authorization Request*,” is also attached.’ The policy/procedure goes on to state that only the primary care provider may refer out of network, but IMCare issues the referral letter authorizing or denying the requested services. [Underline emphasis added.] The policy/procedure descriptions confuse the requirements for referral and service (prior) authorizations and appear to use the terms interchangeably.

In practice, out-of-network services require both a referral and a service/prior authorization. All referrals and service/prior authorizations come through the provider to IMCare for a determination. However, IMCare policies/procedures do not clearly describe the process. The certificate of coverage correctly defines “referral” and “service authorization” but does not clearly explain that out-of-network services require a referral and a prior authorization. Some services require service authorization whether provided in network or out of network. In addition, IMCare must clearly inform providers of their responsibility to provide referrals and the specific procedures to be followed. The policies/procedures must reflect actual practice, be consistent across policies/procedures and, the certificate of coverage and provider manual must consistently describe the procedures. **(Mandatory Improvement #4)**

IMCare’s confusing policies/procedures further complicate review of enrollee appeals. 42 CFR 438.404(b) (Contract section 8.3.1 (B) (3) and (4)), states the Denial, Termination or Reduction notice (DTR) must include a clear, detailed description in plain language of the reasons for the action and the specific federal or state regulations that support or require the action. In 19 of 30 non-clinical appeals reviewed, the original DTR included a statement that the claim was denied for lack of referral (reason code 0401). The denial was based on Minnesota Rules, section 9505.0220. The DTR then quotes the rule, stating “health services are not eligible for payment when a required prior authorization was not obtained” [emphasis added]. This explanation is confusing because referrals and service/prior authorizations are two different types of determinations, but IMCare is using the terms interchangeably. Minnesota Statutes, section 62D.12, subdivision 19, prohibits a plan from denying or limiting coverage solely for lack of

prior authorization. However, because IMCare uses both terms in the DTR, it appears that IMCare may be denying claims for a reason not permitted in Minnesota Statutes. IMCare can better serve its enrollees by revising the DTR language. **(Recommendation #3)**

All the non-clinical appeals were completed correctly and within the appropriate time frame. However, 29 of the 30 non-clinical appeals reviewed were overturned (one appeal was partially overturned). Nineteen of the 30 files were originally denied for lack of referral/prior authorization. In the current process of claims denials, enrollees receive notice of a denied claim with the right to appeal. The non-participating provider receives a notice that the claim is denied (it is not clear whether the non-participating provider is notified of the right to appeal). However, it appears the cause of the claims denial is that the primary care provider has not submitted the referral or service authorization information to IMCare. Unfortunately, under the current process, the primary care provider has the necessary information, but does not receive notice of the claims denial. It becomes incumbent on the non-participating provider and/or the enrollee to appeal and upon IMCare to get the necessary information from the primary care provider. MDH also noted that most of the appeals regarding missing referral/service authorizations are related to a small number of primary care providers.

IMCare can better serve its enrollees working with the appropriate primary care providers to ensure that the appropriate referral and authorization requests are submitted to IMCare in a timely manner. **(Recommendation #4)**

As a result of denying claims for lack of a referral and/or service/prior authorization, IMCare enrollees appealed, in part, because they believed they might be liable for denied charges. MHCP-MC enrollees are not responsible for denied charges unless the provider notifies the enrollee of the liability before the services are provided. IMCare can better serve its enrollees by informing enrollees they are not liable for denied claims unless the provider notifies the enrollee before the services are provided. **(Recommendation #5)**

**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

Subd. 4. Minnesota Statutes, section 62Q.527, subdivision 4, states in pertinent part that the plan must promptly grant an exception to the drug formulary when the provider prescribing the drug indicates that the formulary drug:

- (1) causes an adverse reaction in the patient;
- (2) is contraindicated for the patient; or
- (3) the provider demonstrates that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.

MDH reviewed policies/procedures 024-014 and 024-015. While the policies/procedures submitted were revised to include these provisions in May 2012, the online 2012 provider manual had not been updated to include these policies/procedures. As of March 2013, the revised policies/procedures were not yet available in the website provider manual. IMCare should update its provider webpage to include these policies/procedures other revised policies/procedures to ensure readily available and accurate information. **(Recommendation #6)** Because a number of policies/procedures were not hyperlinked in the 2012 online Provider Manual, MDH will review the online Provider Manual during the Mid-cycle Review to ensure the updated and accurate.

**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

Subd. 2. Minnesota Statutes, section 62Q.535, subdivision 2(a), states, in pertinent part, that the plan is financially liable for the behavioral care evaluation which is the basis for court-ordered mental health services, if performed by a participating provider. IMCare's policy does not address financial liability for the evaluation. IMCare must revise its policy/procedure 012-003, *Court-Ordered Mental Health/CD Services*, to state that it is financially liable for the evaluation if performed by a participating provider. **(Mandatory Improvement #6)**

**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

Subds. 1 and 1a. Minnesota Statutes, section 62Q.56, subdivisions 1 and 1a, state in pertinent part, that the plan must explain who will identify enrollees with special medical needs or at special risk and what criteria will be used for this determination; and how continuity of care will be provided for enrollees identified as having special needs or at special risk, and whether the plan has assigned this responsibility to its contracted primary care providers.

IMCare’s policies/procedures 004-001, Continuity of Care, and 024-013 and 024-017, pre- and post-service reviews do not include an explanation of who will identify enrollees with special needs or at special risk and how continuity of care will be provided for those enrollees.

**(Mandatory Improvement #7)**

**V. Utilization Review**

<b>UM System File Review</b>	
<b>File Source</b>	<b>#Reviewed</b>
<i>UM Denial Files</i>	30
<i>Clinical Appeal Files</i>	17
<b>Total</b>	<b>47</b>

**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

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

- Subd. 1. Written Procedures Met Not Met
- Subd. 2. Concurrent Review Met Not Met
- Subd. 3. Notification of Determinations Met Not Met
- Subd. 3a. Standard Review Determination
  - (a) Initial determination to certify (10 business days) Met Not Met
  - (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
- Subd. 3b. Expedited Review Determination Met Not Met
- Subd. 4. Failure to Provide Necessary Information Met Not Met
- Subd. 5. Notifications to Claims Administrator Met Not Met



Subd. 3b. Minnesota Statutes, section 62M.05, subdivision 3b, states when an expedited initial determination is made not to certify, the utilization review organization must also notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal process. In two UM expedited denial files there was no documentation that the enrollee or provider was offered the right to an expedited appeal with the verbal notification of the denial. **(Deficiency #2)**

**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 |
| (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 |
| (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 |
| Subd. 4. | Notification to Claims Administrator         | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

**Minnesota Statutes, Section 62M.08. Confidentiality**

Met Not Met

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

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

Subd. 3a. Minnesota Statutes, section 62M.09, subdivision 3a, states that a peer of the treating mental health or substance abuse provider, a doctoral-level psychologist, or a physician must review requests for outpatient services in which the utilization review organization has concluded that a determination not to certify a mental health or substance abuse service for clinical reasons is appropriate. *MCHP-MC Appeals (008-002)* policy states the

physician/Specialty reviewer reviews the appeal. The policy does not contain the provision regarding mental health and substance abuse reviews. The policy must be revised to include this provision. **(Mandatory Improvement #8)**

Subd. 4a. Minnesota Statutes, section 62M.09, subdivision 4a, states a chiropractor must review all cases in which the utilization review organization has concluded that a determination not to certify a chiropractic service or procedure for clinical reasons is appropriate and an appeal has been made by the attending chiropractor, enrollee, or designee. *MCHP-MC Appeals (008-002)* policy does not contain this provision. The policy must be revised to address this provision. **(Mandatory Improvement #9)**

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

Met Not Met

## **VI. Recommendations**

1. To better comply with Minnesota Rules, part 4685.1110, subpart 6, IMCare may want to add the reports/documents/information used to complete the annual oversight report for all of the functions delegated to increase credibility of the oversight process.
2. To better comply with Minnesota Rules, part 4685.1120, subpart 1 and subpart 4, IMCare may wish to include graphs and tables in its PIP summaries to more effectively present the evaluation of data.
3. To better comply with Minnesota Rules, part 4685.1010, subpart 5, B, IMCare can better serve its enrollees by revising the DTR language.
4. To better comply with Minnesota Rules, part 4685.1010, subpart 5, B, IMCare can better serve its enrollees by working with the appropriate primary care providers to ensure that the appropriate referral and authorization requests are submitted to IMCare in a timely manner.
5. To better comply with Minnesota Rules, part 4685.1010, subpart 5, B, IMCare can better serve its enrollees by informing enrollees they are not liable for denied claims unless the provider notifies the enrollee before the services are provided.
6. To better comply with Minnesota Statutes, section 62D.527, subdivision 4, IMCare should update its provider webpage to include revised policies/procedures 024-014 and 024-015 and other revised policies/procedures to ensure readily available and accurate information. [MDH will review the on-line Provider Manual during the Mid-cycle Review.]

## **VII. Mandatory Improvements**

1. To comply with Minnesota Rules, part 4685.1110, subpart 9, IMCare must ensure the complete quality of care investigation and actions are reported to IMCare and documented in the IMCare quality of care files and credentialing files, as appropriate.
2. To comply with Minnesota Rules, part 4685.1110, subpart 11, IMCare must revise its *Site Visits (005-018)* policy to include continually monitoring member complaints for all practitioner sites and perform a site visit within 60 days if the threshold is met.
3. To comply with 42 CFR 438.406 (a)(2) (Contract section 8.4.5 (B)), IMCare must revise the procedure 008-002 to state all appeals must receive an acknowledgement letter.
4. To comply with Minnesota Rules, part 4685.1010, subpart 5, B, IMCare must clearly inform providers of their responsibility to provide referrals and the specific procedures to be followed. Policies/procedures must reflect actual practice, be consistent across policies/procedures and, the certificate of coverage and provider manual must consistently describe the procedures.
5. To comply with Minnesota Statutes, section 62Q.535, subdivision 2(a), IMCare must revise its policy/procedure 012-003. Court-Ordered Mental Health/CD Services, to state that it is financially liable for the evaluation if performed by a participating provider.
6. To comply with Minnesota Statutes, section 62Q.56, subdivisions 1 and 1a, IMCare must revise policies/procedures 004-001, Continuity of Care, and 024-013 and 024-017, pre- and post-service reviews, to include an explanation of who will identify enrollees with special needs or at special risk and how continuity of care will be provided for those enrollees.
7. To comply with Minnesota Statutes, section 62M.09, subdivision 3a, IMCare must revise its *MCHP-MC Appeals (008-002)* to include a peer of the treating mental health or substance abuse provider, a doctoral-level psychologist, or a physician must review requests for outpatient services in which the utilization review organization has concluded that a determination not to certify a mental health or substance abuse service for clinical reasons is appropriate.
8. To comply with Minnesota Statutes, section 62M.09, subdivision 4a, IMCare must revise its policy *MCHP-MC Appeals (008-002)* to include a chiropractor must review all appeals in which the utilization review organization has concluded that a determination not to certify a chiropractic service or procedure for clinical reasons is appropriate.

## **VIII. Deficiencies**

1. To comply with Minnesota Rules, part 4685.1130, subpart 3, IMCare must submit all revisions to its written quality plan to MDH for approval.

2. To comply with Minnesota Statutes, section 62M.05, subdivision 3b, IMCare must, in its notifications of an expedited determination not to certify, inform the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal process with the verbal notification of denial.