

Minnesota Department of Health
Compliance Monitoring Division
Managed Care Systems Section



Final Report

PrimeWest Health System

Quality Assurance Examination
For the period:

July 1, 2008 – May 31, 2011

Final Issue Date:
February 16, 2012

Examiners:
Susan Margot, M.A.
Elaine Johnson, RN, BS, CPHQ

Minnesota Department of Health Executive Summary:

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of PrimeWest Health System (PrimeWest) to determine whether it is operating in accordance with Minnesota law. MDH has found that PrimeWest is compliant with Minnesota and Federal law, except in the areas outlined in the “Deficiencies” and “Mandatory Improvements” sections of this report. “Mandatory Improvements” are required corrections that must be made to noncompliant policies, documents or procedures where evidence of actual compliance is found 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 mandatory improvements, PrimeWest must:

Revise its credentialing policies/procedures as follows:

- State that staff must sign/initial and document the date and the credential verified.
- Describe the process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the decision.

Revise its grievance policies/procedures to include the following:

- State that to extend the timeframe for resolution of a written, as well as an oral, grievance by an additional 14 days, prior written notice must be provided to the enrollee and the notice of resolution must be issued no later than the date the extension expires.
- State that, if the resolution of an oral grievance is partially or wholly adverse to the enrollee, assistance will be offered and describe what that assistance will be.

To address deficiencies, PrimeWest and its delegates must:

Include in the DTR a clear and detailed description in plain language of the reasons for the denial. PrimeWest initiated a corrective action in June 2011 when preparing for the MDH examination.

For standard authorization decisions that deny or limit services, provide the notice to the attending health care professional by telephone or fax within one working day of the determination.

Implement the correct standard in its Wait Time Survey and revise its policy/procedure CC05, *Access to Care*, to establish a standard for behavioral health urgent care as available within 24 hours (consistent with the definition in Minnesota Rules, part 4685.0100, subpart 16).

Have a physician review all cases in which the HMO has concluded that a determination not to certify for clinical reasons is appropriate and revise its *Service Authorization Policy CC06* to reflect this.

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

A. History:

Implementation: 2003-Present

MDH approved PrimeWest CBP application in October 2002, in accordance with Minnesota Statutes §256B.692 (the “county-based purchasing” statute), and in April 2003, DHS awarded PrimeWest the contract for administering the PMAP program in its 10 Joint Powers counties beginning July 2003. The participating counties were: Pipestone, Renville, McLeod, Meeker, Big Stone, Douglas, Grant, Pope, Stevens, and Traverse. By July 2004, PrimeWest reached the counties’ projected total PMAP enrollment of approximately 10,000 members.

From 2005 to present, PrimeWest experienced rapid expansion in the number of Minnesota Health Care Programs it was administering in the 10-county service area. In 2005, PrimeWest began serving the MinnesotaCare population. That same year, PrimeWest also became the first MHCP health plan to administer Minnesota Senior Care (MSC) and Minnesota Senior Health Options (MSHO) programs in greater Minnesota (June and September 2005 respectively). This included being the first Medicare Advantage Special Needs Plan (SNP) for people who are dual-eligible for Parts A and B. PrimeWest added Part D to its MSHO program and Medicare Advantage SNP in January 2006. In March 2008, PrimeWest began administering the Special Needs BasicCare (SNBC) program for dual-eligible individuals under age 65.

Geographic Expansion: 2006-2008

PrimeWest secured MDH’s approval to conduct CBP in Beltrami, Clearwater, and Hubbard counties and DHS awarded PrimeWest PMAP and MSC+ contracts. PrimeWest began serving the PMAP, MSC+ and MinnesotaCare populations in these counties in March 2008.

Today, PrimeWest serves nearly 23,000 members in 13 counties enrolled in one of five PrimeWest MHCP programs, including PMAP, MinnesotaCare, MSC+, MSHO, and SNBC.

B. Membership: PrimeWest self-reported enrollment as of December 31, 2010, consisted of the following:

Product	Enrollment
<i>Minnesota Health Care Programs-Managed Care (MHCP-MC)</i>	
Families & Children MA	15,627
MinnesotaCare	2,390
Minnesota Senior Care (MSC+)	812
Minnesota Senior Health Options (MSHO)	2,190
Special Needs Basic Care (SNBC)	265
<i>Total</i>	21,285

- C. Onsite Examination Dates: September 12 - 15, 2011
- D. Examination Period: July 1, 2008 – May 31, 2011
File Review Period: June 1, 2010 – May 31, 2011
PrimeWest MDH Examination opened: May 9, 2011
- 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 course of the quality assurance examination, which covers a three-year audit period, the health plan is cited with a deficiency. A deficiency will not be based solely on one outlier file if MDH had sufficient evidence obtained through: 1) file review; 2) policies and procedures; and 3) interviews that a plan’s overall operation is compliant with an applicable law.

II. Quality Program Administration

Minnesota Rules, Part 4685.1110. Program

Subp. 1.	Written Quality Assurance Plan	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 2.	Documentation of Responsibility	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 3.	Appointed Entity	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 4.	Physician Participation	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 5.	Staff Resources	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 6.	Delegated Activities	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 7.	Information System	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 8.	Program Evaluation	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
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 checked="" type="checkbox"/> Not Met
Subp. 12.	Qualifications	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 13.	Medical Records	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> 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									
	UM	UM Appeals	QM	Complaints/ Grievances	Cred	Claims	Network	Care Coord	Customer Service
Prime Therapeutics, Inc. (PTI)	X					X	X		X
Douglas County								X	
Meeker County								X	
MN Rural Health Cooperative (MRHC)					X				
Hutchinson Area Health Care (HAHC)					X				

PrimeWest has a very thorough delegation oversight process. MDH commends PrimeWest for most counties in 2010 exhibiting 100% compliance in all elements of the oversight audit.

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 five quality of care complaint files were reviewed. MDH found that the quality of care complaints were investigated, reviewed and documented according to its policy.

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 100 credentialing and recredentialing files (including physician, allied and organizational providers) from PrimeWest as follows:

Credentialing and Recredentialing File Review			
File Source	# Reviewed Physician	#Reviewed Allied	# Reviewed Organizational
<i>Initial Credentialing</i>			
PrimeWest	12	8	
Minnesota Rural Health Cooperative	9		Na
Hutchinson Area Health Care	5		Na
<i>Recredentialing</i>			
PrimeWest	12	12	14
Minnesota Rural Health Cooperative	6	6	Na
Hutchinson Area Health Care	6	6	Na
Total = 100	50	36	14

PrimeWest noted during the re-assessment of organizational providers in January of 2011 that two organizations with system contracts were beyond the 36 month time frame and instituted a corrective action plan (CAP). In each of these organizations it was found that one of the organizations was re-assessed and the other was not. The Provider Services Contracting team

reviewed all organizational providers within the network and combined all entities within an organization into one assessment review using the date of the oldest, thus ensuring compliance within the 36 month time frame. Provider Relations updated the provider management system and the manager reviews organizational providers bi-annually to ensure timely re-assessment. This CAP was completed on April 1, 2011.

In April 2010 PrimeWest initiated a CAP for its recredentialing process as it was noted to be out of compliance, specifically in the areas of recredentialing timelines and complaint monitoring. PrimeWest had changed credentialing software which caused a disconnect between the software and its CVO systems. In response, work flows and processes were revised, an internal monitoring system was initiated, and complaints are monitored electronically (pend and trend reports) rather than with flagging a hard copy file. In addition, PrimeWest changed CVO vendors to ensure better timeline compliance. MDH found that no recredentialing files were out of compliance after initiating the examination on May 9, 2011. MDH wants to commend PrimeWest on discovering and correcting these issues.

A health plan must have a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. MDH found that credentialing policies/procedures included the following errors or omissions:

- Health plans must verify credentials with primary sources. Telephone verification may be used, however, the plan staff who verified the credentials must date, sign or initial and note the credentials verified. *CR03 Primary Source Verification* policy/procedure (page 3 A.1.c.i) allows phone verification of state licensure, but the policy/procedure must state that staff must sign/initial, document the date and the credential verified.
- Policies/procedures must describe the process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the decision. PrimeWest’s policy/procedure states that it will notify the provider, but does not describe the process.

(Mandatory Improvement #1)

Minnesota Rules, Part 4685.1115. Activities

- | | | | |
|----------|----------------------------|---|----------------------------------|
| Subp. 1. | Ongoing Quality Evaluation | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subp. 2. | Scope | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

Minnesota Rules, Part 4685.1120. Quality Evaluation Steps

- | | | | |
|----------|---------------------------------|---|----------------------------------|
| Subp. 1. | Problem Identification | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subp. 2. | Problem Selection | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subp. 3. | Corrective Action | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subp. 4. | Evaluation of Corrective Action | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

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

PrimeWest, in addition to its performance improvement projects, completed ten focus studies in the three year examination cycle.

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

PrimeWest has a very thorough work plan and it is a dynamic document. The work plan is electronic and updates and tracking are done through an electronic system on an ongoing basis.

III. Grievance System

MDH examined PrimeWest’s Minnesota Health Care Programs-Managed Care (MHCP-MC) grievance system for compliance with the federal law (42 CFR 438, subpart F) and the DHS 2010 Model Contract, Article 8.

MDH reviewed a total of 23 grievance system files:

Grievance System File Review	
Grievance File Source	# Reviewed
Grievances	8
Non Clinical Appeals	10
State Fair Hearings	5
Total	23

Section 8.1. §438.402 General Requirements

- Sec. 8.1.1. Components of Grievance System Met Not Met

§438.402 (contract section 8.1.1) 42 CFR 438.402 states that the plan must have a Grievance System in place that includes a grievance process, an appeal process and access to the State Fair Hearing system. MDH found that grievance policies/procedures included the following errors or omissions:

- §438.408 (c) (contract section 8.2.3) 42 CFR 438.408 (c) states the plan may extend the timeframe for resolution of a grievance by an additional 14 days if prior written notice is

provided to the enrollee and the notice of resolution is issued no later than the date the extension expires. Policy/procedure *QMAG 01 Grievance System* states these requirements under oral grievances, but not in written grievances.

- §438.404 (a) (contract section 8.2.5 A) 42 CFR §438.404 (a) states that if the resolution of an oral grievance is partially or wholly adverse to the enrollee, or is not resolved to the satisfaction of the enrollee, the plan must notify the enrollee that the grievance may be submitted in writing, including an offer to complete the grievance form and send it for signature. Policy/procedure *QMAG 01, Grievance System*, does not state that assistance will be offered or what that assistance will include.

(Mandatory Improvement #2)

Section 8.2. §438.408	Internal Grievance Process Requirements	
Sec. 8.2.1. §438.402 (b)	Filing Requirements	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.2.2. §438.408 (b)(1)	Timeframe for Resolution of Grievances	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.2.3. §438.408 (c)	Timeframe for Extension of Resolution of Grievances	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.2.4. §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
Sec. 8.2.5. §438.408 (d)(1)	Notice of Disposition of a Grievance.	
(A) §438.408 (d)(1)	Oral Grievances	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
(B) §438.408 (d)(1)	Written Grievance	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met

Section 8.3. §438.404	DTR Notice of Action to Enrollees	
Sec. 8.3.1.	General requirements	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met
Sec. 8.3.2. §438.404 (c)	Timing of DTR Notice	
(A) §438.210 (c)	Previously Authorized Services	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
(B) §438.404 (c)(2)	Denials of Payment	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
(C) §438.210 (c)	Standard Authorizations	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met
(D) §438.210 (d)(2)(i)	Expedited Authorizations	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
(E) §438.210 (d)(1)	Extensions of Time	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
(F) §438.210 (d)	Delay in Authorizations	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.2.3. §438.420 (b)	Continuation of Benefits Pending Decision	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met

§438.404. 42 CFR 438.404, (contract section 8.3.1(B)), states the DTR must include a clear detailed description in plain language of the reasons for the action. Three dental files did not contain a clear description in plain language of the reasons for the denial. For example, one DTR reason for denial stated, *“The records sent to us do not support the medical necessity for the level of service requested. No auth required for D7140 per DHS Guidelines. D9220 is not an eligible benefit (21+) unless there is a documented medical necessity or is performed in an Ambulatory Surgical or Outpatient Surgery Center.”* **(Deficiency #1)** PrimeWest initiated a corrective action plan in June 2011 when preparing for the MDH examination. Current DTRs now contain more understandable explanations about why the authorization request was denied as evidenced by the seven random additional dental DTRs pulled for review.

§438.210 (c). 42 CFR 438.210 (c) (contract section 8.3.2 (C)), states for standard authorization decisions that deny or limit services, the MCO must provide the notice to the attending Health Care Professional by telephone or fax within one working day of the determination and to the provider and enrollee in writing within ten business days following receipt of the request for the service. In eight dental UM denial files the telephone/fax notification exceeded one working day. **(Deficiency #2)** MDH noted that dental denials were done at the dental office then sent back to PrimeWest, where they were date stamped as denied upon arrival. The date stamp should have been when actually denied by the dentist, not when it arrived at PrimeWest. In one file the written notification to the enrollee and attending health care professional exceeded ten business days. [Also see 62M.05, subd. 3a (a) and (c)]

Section 8.4. §438.408	Internal Appeals Process Requirements	
Sec. 8.4.1. §438.402 (b)	Filing Requirements	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.4.2. §438.408 (b)(2)	Timeframe for Resolution of Standard Appeals	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.4.3 §438.408 (b)	Timeframe for Resolution of Expedited Appeals	
(A) §438.408 (b)(3)	Expedited Resolution of Oral and Written Appeals	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
(B) §438.410 (c)	Expedited Resolution Denied	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
(C) §438.410 (a)	Expedited Appeal by Telephone	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.4.4. §438.408 (c)	Timeframe for Extension of Resolution of Appeals	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
Sec. 8.4.5. §438.406	Handling of Appeals	
(A) §438.406 (b)(1)	Oral Inquiries	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
(B) §438.406 (a)(2)	Written Acknowledgement	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
(C) §438.406 (a)(1)	Reasonable Assistance	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met .
(D) §438.406 (a)(3)	Individual Making Decision	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met
(E) §438.406 (a)(3)	Appropriate Clinical Expertise	

[See Minnesota Statutes, sections 62M.06, 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)(3). (contract section 8.4.5 (D)), 42 CFR 438.406 (a)(3) states the MCO must ensure that the individual making the decision was not involved in any previous level of review or decision-making. In one clinical appeals file the physician who made the initial denial upheld the denial upon appeal. [Also see Minnesota Statutes, section 62M.06, subdivision 3(c)]

42 CFR 438.406 (a)(3), (contract section 8.4.5 (E)). [See Minnesota Statutes, 62M.09]

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

Section 8.9. §438.408 (f) State Fair Hearings

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

Subp. 2. Minnesota Rules, part 4685.1010, subpart 2, states the plan must develop and implement written standards or guidelines that assess the capacity of each provider network to provide timely access. Minnesota Rules, part 4685.0100, subpart 16, defines urgently needed care as needed as soon as possible, usually within 24 hours. Policy/procedure CC05, *Access to Care*, states the acceptable time frame a member must wait for urgent or acute care is same day access or an appointment with 24 hours; “48 hours for behavioral health.” Minnesota law does not identify a separate timely access standard for urgently needed mental health services. In addition, the 2011 Annual Evaluation stated that in the 2010 Wait Time Survey, “the majority of the [mental health] facilities could see the individual within two days.” PrimeWest set an incorrect standard for behavioral health urgent care (as defined in Minnesota Rules, part 4685.0100, subpart 16) and implemented the incorrect standard in its 2010 Wait Time Survey. **(Deficiency #3)**

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

- 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 PrimeWest</i>	
Medical, Pharmacy, DME	8
Dental	30
<i>Subtotal</i>	38
<i>Clinical Appeal Files PrimeWest</i>	
Medical, Pharmacy, DME	24
Other	12
<i>Subtotal</i>	36
Total	74

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
- 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 rights 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. 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 in writing within ten business days of the request. In one file the written notification to the enrollee and attending health care professional exceeded ten business days (18 calendar days). [Also see 42 CFR 438.210(c) (contract section 8.3.2(C))]

Subd. 3a.(c) Minnesota Statutes, section 62M.05, subdivision 3a.(c), states when an initial determination is made not to certify, notification must be provided by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox within one working day after making the determination to the attending health care professional and hospital. In eight dental UM denial files the telephone/fax notification exceeded one working day. (Deficiency #2) [Also see 42 CFR 438.210 (c) (contract section 8.3.2 (C))]

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

- Subd. 1. Procedures for Appeal Met Not Met
- Subd. 2. Expedited Appeal Met Not Met
- Subd. 3. Standard Appeal
 - (a) Appeal resolution notice timeline Met Not Met

- (b) Documentation requirements Met Not Met
- (c) Review by a different physician Met Not Met
- (d) Time limit in which to appeal Met Not Met
- (e) Unsuccessful appeal to reverse determination Met Not Met
- (f) Same or similar specialty review Met Not Met
- (g) Notice of rights to External Review Met Not Met
- Subd. 4. Notifications to Claims Administrator Met Not Met

Subd. 3.(c) Minnesota Statutes, section 62M.06, subdivision 3(c), states prior to upholding the initial determination not to certify for clinical reasons, the HMO shall conduct a review of the documentation by a physician who did not make the initial determination not to certify. In one clinical appeal file the physician who made the initial denial upheld the denial upon appeal.

[Also see 42 CFR 438.406 (a)(3) (contract section 8.4.5 (D))]

Minnesota Statutes, Section 62M.08. Confidentiality

Met Not Met

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

- Subd. 1. Staff Criteria Met Not Met
- Subd. 2. Licensure Requirement Met Not Met
- Subd. 3. Physician Reviewer Involvement Met Not Met
- Subd. 3a. Mental Health and Substance Abuse Review Met Not Met
- Subd. 4. Dentist Plan Reviews Met Not Met
- Subd. 4a. Chiropractic Reviews Met Not Met
- Subd. 5. Written Clinical Criteria Met Not Met
- Subd. 6. Physician Consultants Met Not Met
- Subd. 7. Training for Program Staff Met Not Met
- Subd. 8. Quality Assessment Program Met Not Met

Subd. 3. Minnesota Statutes, section 62M.09, subdivision 3, states a physician must review all cases in which the HMO has concluded that a determination not to certify for clinical reasons is appropriate. Three clinical and one non-clinical pharmacy appeals were reviewed by a pharmacist rather than a physician. PTI does the initial denial and upon appeal it is sent to PrimeWest for pharmacist review. The pharmacist upholds the denial upon appeal. All appeals, with the exception of dental, chiropractic and behavioral health must be reviewed by a physician. In addition, *Service Authorization Policy* CC06 states final medication review denials are reviewed by a licensed health care provider and registered pharmacist. The policy/procedure must clarify that only a physician, dentist, chiropractor or a doctoral-level psychologist may uphold the determination to deny for clinical reasons. **(Deficiency #4)**

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

- | | | | |
|----------|--------------------------------------|---|----------------------------------|
| Subd. 1. | Toll-free Number | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 2. | Reviews during Normal Business Hours | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 7. | Availability of Criteria | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

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

Met Not Met

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

Met Not Met

VI. Recommendations

None

VII. Mandatory Improvements

1. To comply with Minnesota Rules, part 4685.1110, subpart 9, PrimeWest must revise its credentialing policies/procedures as follows:
 - *CR03 Primary Source Verification* policy/procedure must state that staff must sign/initial and document the date and the credential verified.
 - Describe the process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the decision.
2. To comply with 42 CFR 438.402 (contract section 8.1.1) PrimeWest must revise its grievance policies/procedures to include the following:
 - §438.408 (c) (contract section 8.2.3). Policy/procedure *QMAG 01 Grievance System* must state that to extend the timeframe for resolution of a written, as well as an oral, grievance by an additional 14 days if prior written notice must be provided to the enrollee and the notice of resolution must be issued no later than the date the extension expires.
 - §438.404 (a) (contract section 8.2.5 (A)). Policy/procedure *QMAG 01, Grievance System*, must state that, if the resolution of an oral grievance is partially or wholly adverse to the enrollee, assistance will be offered and describe what that assistance will be.

VIII. Deficiencies

1. To comply with 42 CFR 438.404 (contract section 8.3.1(B)) PrimeWest must include in the DTR a clear and detailed description in plain language of the reasons for the denial. PrimeWest initiated a corrective action in June 2011 when preparing for the MDH examination.
2. To comply with 42 CFR 438.210 (c) (contract section 8.3.2 (C)) and Minnesota Statutes, section 62M.05, subdivision 3a (a) and (c), PrimeWest, for standard authorization decisions that deny or limit services, must provide the notice to the attending health care professional by telephone or fax within one working day of the determination.
3. To comply with Minnesota Rules, part 4685.1010, subpart 2, PrimeWest must implement the correct standard in its Wait Time Survey and must revise its policy/procedure CC05, *Access to Care*, to establish a standard for behavioral health urgent care as available within 24 hours (consistent with the definition in Minnesota Rules, part 4685.0100, subpart 16).
4. To comply with Minnesota Statutes, section 62M.09, subdivision 3, PrimeWest must have a physician review all cases in which the HMO has concluded that a determination not to certify for clinical reasons is appropriate and must revise its *Service Authorization Policy CC06* to reflect this.