Technical Advisory Interpreting 28 Pa. Code §9.752 (f) (Relating to UR System Standards) requiring a UR decision to include a contractual basis and clinical reasons for denial

On February 24,2004, the Bureau of Managed Care initiated a compliance audit of managed care plan performance against the standards for utilization review (UR) established by Article XXI of the Insurance Company Law of 1921 (40 P.S. §§991.2101-991.2193), commonly referred to as "Act 68," and the Department of Health's Managed Care Regulations at 28 Pa. Code §§ 9.752 and 9.753 (relating to UR system standards; Time frames for UR).

Aggregate findings from the UR audit of Pennsylvania managed care plans showed that many plans were out of compliance with several specific regulatory requirements. One of these common areas of noncompliance was related to the specific requirements for information, which must be contained in each UR decision denial to enrollees and providers. Specifically the regulations require " If a UR decision includes a denial, it shall include the contractual basis and clinical reasons for the denial." 28 Pa. Code §9.752(f).

The Bureau has developed the following Technical Advisory to provide managed care plans with the Bureau's interpretation of its regulation and to aid the plans in achieving compliance with this standard.

1. When a plan UR denial decision is transmitted to the enrollee and provider, the UR denial must reference the contractual basis for the denial as well as clinical factors that constitute the rationale.

In the UR denial decision letter, the terms of the contract must be sufficiently specific to allow the enrollee or provider to identify the specific contract documents and provisions that apply to the denial in question. The contractual basis for denial must describe all related sections of the contract that were specifically used by the plan for the contractual basis of the denial.

2. The preferred method to convey the basis of the contractual denial is for the UR denial letter to include the section numbers and actual language from the contract in the letter. An acceptable alternative would be for the UR denial decision letter to include reference to the specific contract section number(s) used as the basis for the denial, along with language that informs the enrollee that he or she may request a copy of the contract language by contacting the plan and provides the plan's toll free phone number for this purpose.

3. Plans are required to be accurate in their references to contract language and should avoid paraphrasing language which is not actually in the contract exactly as quoted. (Contract "folklore")

General references to the denial being solely "based on the terms of the contract" are not acceptable and are not in compliance with the regulations. Such language does nothing to help the enrollee or provider understand the plan's rationale for the denial, and to provide them with the information necessary to consider the possibilities of an appeal. Further, such vague references contribute to enrollee dissatisfaction and additional unnecessary appeals.

4. If plan medical policies are used as part of the decision making process, the relationship of those policies to contract language must be referenced in the subscriber contract. Reference to plan medical policy as the sole basis for the denial is unacceptable. Medical policies are secondary to contract language and the UR denial letter must include the contractual basis with the medical policy as the secondary basis. If there is no direct linkage to the contract, the use of medical policies cannot be the sole basis for the denial.

An example of an acceptable linkage between policies and contract would be a request for service where a Plan medical policy has been developed that defines "xyz service to be considered cosmetic, and excluded under the terms of the contract, unless certain medical criteria are met." The reference to such criteria in the medical policy alone as the basis for the denial is not sufficient and there needs to be a clear linkage to the terms of the subscriber contract that excludes cosmetic services.

Denial letters referencing medical policy must identify that medical criteria used for decision-making are available upon request if the denial is based on medical criteria.

5. Medical Assistance Plans must refer to guidance provided by the Pennsylvania Department of Public Welfare on this matter.

6. "Administrative" concurrent and retrospective denials of medical care or higher levels of payment in which the enrollee is held financially harmless by the provider and the plan were also a problem for some plans. These situations typically involve disputes about medical necessity, but are characterized by plans as payment disputes.

These types of denials in which the enrollee is held financially harmless, (downgrades in acuity or levels of care, denied days, etc.) should not be communicated to the enrollee to avoid unnecessary upsetting or confusing the enrollee. However, decision letters to providers must include specific contractual and clinical information, to explain exactly why the service was determined not to meet plan criteria for coverage or payment, and must be communicated with the required UR time frames. Providers should be advised of appeal rights within appropriate time frames under any mutually agreed upon Informal Dispute Resolution process or their right to appeal under Act 68, if applicable.

Comments, suggestions or questions should be directed to the Bureau of Managed Care at phone 717-787-5193 or in writing to the attention of Stacy Mitchell, Director, Bureau of Managed Care, 912 Health and Welfare Building, Harrisburg, PA 17120.