Department of Insurance
State of Arizona

Telephone: (602) 912-8400
Telecopier: (602) 912-8453

JANE DEE HULL	2910 North 44th Street, Suite 210	**CHARLES R. COHEN**
Governor	**Phoenix, Arizona 85018-7258**	**Director Of Insurance**

REGULATORY BULLETIN 2001-10

TO: All Health Care Insurers, Health Care Services Organizations, Hospital Service Corporations, Prepaid Dental Plan Organizations, Medical Service Corporations, Dental Service Corporations, Optometric Service Corporations, Utilization Review Agents, Insurance Trade Associations And Interested Parties

FROM: Charles R. Cohen
Director of Insurance

DATE: July 26, 2001

SUBJECT: **Health Care Appeals Procedures for External Independent Review**

Effective March 1, 2001, amendments to A.R.S. §§ 20-2537 through 20-2540 restructured the manner in which external independent medical reviewers for health care appeals are selected. The purpose of this bulletin is to discuss issues about the proper submission of cases for review and the billing procedures for services performed under this portion of the health care appeals law.

This bulletin is not intended to present a comprehensive review of the many other procedural changes to the health care appeals law. For further details please refer to Circular Letter 2000-13 and Circular Letter 2000-6 (pp. 18-22) which may be viewed on the Department's web site at www.state.az.us/id.

Submitting Cases to the Department for External Independent Review

To promote independence of the external review level of the health care appeals process, the Department of Insurance (Department) is now authorized to initiate the procurement of contracts directly between the State of Arizona and Independent Review Organizations (IROs). The Department, rather than the health insurer, now selects an IRO to conduct medical reviews for each case that has reached the external level of review.

Under the revised process, a health insurer must submit a case for external review to the Department within 5 business days of receiving a request from an insured member. The attached Transmittal Form P-1098 (Rev. 02/01) must accompany the case. The Transmittal

Form is also available on the Department's web site under the heading "Forms" and the subcategory, "Health Care Appeals." The form must be completed in its entirety as the Department uses the information when it issues final notification of the reviewer's decision.

For cases involving issues of "medical necessity," it is essential that the insurer forward two separate, identical case packets to the Department. To ensure compliance with the statutory timeframes outlined in the law, each of the two packets must contain the documentation noted at the bottom of the Transmittal Form. The following guidelines are offered to clarify case documentation requirements:

- A complete copy of the policy, certificate, evidence of coverage or similar document is always required. It is not sufficient to provide only the pages on which "relevant" provisions appear.
- Sufficient medical records are necessary to enable the physician reviewer to adequately review the issue on appeal. Include, as applicable:
  - ⇨ all correspondence from the member's physician(s) related to the condition at issue;
  - ⇨ all relevant consultation reports, medical history, doctor's orders, progress notes, medication notes;
  - ⇨ any relevant laboratory, x-ray, and diagnostic reports;
  - ⇨ any relevant surgical reports, operating and anesthesia records;
  - ⇨ any relevant evaluations and progress notes when any type of ongoing treatment or therapies are at issue;
- All documentation should be in either a chronological order or other organized manner in which the materials can be readily identified.

If the health care insurer has delegated the preparation and submission of cases for external review to a utilization review agent, it is imperative that the agent have the access and ability to provide all the required documentation. In order to promote a smooth administration of the 5-day time frame within which the Department must review the case, select an appropriate reviewer, and send the case to the IRO, it is not possible to receive cases in a piecemeal fashion from separate sources. The health insurer should implement appropriate internal procedures to ensure timely submission of required documentation.

If an insurer submits a case to the Department for external review of an issue of coverage and the Department is unable to reach a determination or recognizes that the decision requires resolution of a medical question in addition to the coverage issue, the case is referred to an IRO. The Department's authority for this option is provided in A.R.S. §20-2537(G) which states:

> If the director finds that the case involves a medical issue or is unable to determine issues of coverage, the director shall submit the member's case to the external independent review organization in accordance with subsections E and K of this section.

When the Department chooses to exercise this option, it is often necessary to obtain additional medical records that the health insurer did not consider when rendering a coverage-only decision. In such circumstances, or in any case in which an IRO indicates that the medical records are insufficient to render a decision, the Department will immediately telephone and fax the insurer's contact person to advise of the need for additional medical records. Once the insurer obtains the requested information, it should express mail or, if practical, fax the records to the Department which will in turn immediately forward them to the IRO.

In order to maintain the independence of the review process, all insurer contact related to a pending external review as well as the final determination should be handled through the Department, not the assigned IRO.

Upon receipt of the IRO's decision in an individual case, the Department has 5 business days to notify the insurer, the utilization review agent (if different than the insurer), the member, and the member's treating provider.

The Independent Review Organizations

Through Arizona's competitive procurement process, contracts to perform medical review services were awarded to six IROs. Each organization bid two "per case rates," one for standard cases and one for expedited review. The contracts, which became effective March 1, 2001, have a one-year term with four separate one-year renewal options.

The six contracted IROs are:

- CarePoint Analytics, Inc. dba Permedion
- CORE, Inc.
- Hayes Plus, Inc.
- Health Services Advisory Group, Inc.
- Maximus, Inc. dba Center for Health Dispute Resolution
- Prest & Associates, Inc.

Revolving Billing Procedures

A.R.S. §20-2540 establishes a health care appeals revolving fund from which the Department pays the IRO and then bills the health insurer whose payment reimburses the revolving fund for the cost of the medical review. At the time the IRO sends its decision on an individual case to the Department, it includes an invoice in the amount of the "per case rate," either standard or expedited, as provided in its contract. A copy of the IRO invoice form is attached. The Department pays the IRO from the revolving fund and then bills the health insurer to recover the amount paid to the IRO. The invoice is sent to the insurer's accounts payable department unless the insurer has provided the Department with a preferred address. The invoice must be paid by the insurer within 30 days of receipt. The Department will promptly follow up on any invoices that remain outstanding after 30 days. Payment delinquency will be regarded as failure to comply with the requirements of A.R.S. Title 20, and will be dealt with as appropriate in each case. A sample of this invoice form is also attached. In response to insurer requests,

the Department includes the insured's identification or member number on the invoice to assist the insurer in referencing the payment. Insurers that would prefer to designate a person to receive health care appeals invoices should contact Elise Bartlett at 602-912-8443.

Withdrawing Cases

Occasionally an insurer will reverse a denial upon its own reconsideration after a case has been sent to the Department for external review. If the Department receives written notice that the insurer has taken such action, and the Department has not yet sent the case to an IRO, it will allow the insurer to withdraw the case from the process. However, once a case has been sent to an IRO for medical review and preliminary review has begun, the Department, and in turn the insurer, will be billed for the entire cost of a medical review.

For questions regarding this bulletin or any other health care appeal issues, please contact Elise Bartlett, Health Care Appeals Manager by telephone at 602-912-8443, by fax at 602-912-8447, or by e-mail at ebartlett@id.state.az.us.

STATE OF ARIZONA HEALTH CARE APPEALS TRANSMITTAL FORM

Please send case to:** ***Health Care Appeals Program*, 2910 N. 44th St., Suite 210, Phoenix, AZ 85018-7256*
Please direct questions to: ***Health Care Appeals Hotline*** *• Phone: (602) 912-8443 • Fax: (602) 912-8447*

Is this an Expedited External Independent Review Request? ☐ Yes ☐ No
This case is a denial based on: ☐ lack of medical necessity ☐ a coverage issue

Insured Member's Name:			
• Mailing Address:			
• City, State, Zip Code:			
• Insured's Telephone #:		• Member I.D. #:	
Insurer's Name:			
• Insurer NAIC #:			
• Insurer's Street Address:			
• City, State, Zip Code:			
• Telephone # :		• FAX #:	
• Contact Person Name		• Contact Phone #:	
Treating Provider's Name:**			
• Office Address			
• City, State, Zip Code			
• Mailing Address, if different than above:			
• City, State, Zip Code			
• Provider's Telephone #		• FAX #:	
• Treating Provider's Medical Specialty			

(**If multiple providers, please list other providers on reverse)

Utilization Review Agent Name:			
• UR Agent's Street Address			
• City, State, Zip Code			
• UR Agent Telephone #		• FAX #:	
• Contact Person			

External Review requested by: ☐ insured member ☐ insurer ☐ UR Agent ☐ Az D O I

Date external review requested:		Date of Level 2 decision:	

Decision to deny or not authorize service or claim was made by:
☐ Insurance Company ☐ Health Care Services Org. ☐ UR Agent

For medical necessity cases: Name(s) and credentials of provider(s) issuing the Level 1 & 2 decisions:

***With this form, transmit all items listed below. <u>For medical necessity cases, submit 2 copies</u>** <u>of all items</u>.

1. Copy of the insured's policy, certificate, evidence of coverage or similar document
2. All medical records
3. Supporting documentation used to render the decision
4. Summary description of the applicable issues
5. A statement of the utilization review agent's or insurer's decision
6. The utilization review agent's or insurer's criteria used and the clinical reasons for the decision
7. The relevant portions of the utilization review agent's utilization review plan
8. The insured's or provider's letter or appeal form requesting the appeal, and all pertinent correspondence between the member/enrollee and the insurer.

ARIZONA DEPARTMENT OF INSURANCE

HEALTH CARE APPEALS
IRO TRANSMITTAL FORM

ADOI CASE NUMBER: _____ **PURCHASE ORDER #: HC**

☐ **Expedited Appeal** *[Decision must be sent to ADOI within 5 days of receipt of case]*

☐ **Standard Appeal** *[Decision must be sent to ADOI within 21 days of receipt of case]*

To:

Insurance company whose case is being reviewed:

NOTE: PLEASE IMMEDIATELY CALL THE INSURANCE DEPARTMENT HEALTH CARE APPEALS SECTION AT (602) 912-8443 IF YOU ARE UNABLE TO REVIEW THIS CASE BECAUSE OF A POTENTIAL CONFLICT OF INTEREST. A.R.S. § 20-2538 STATES, "**The independent review organization and its individual reviewer shall not have a substantial interest in the member, provider or health care insurer involved in the particular case under review or any other conflict of interest that will preclude the reviewer from making a fair and impartial decision. The individual reviewer shall not be a policyholder or insured member of a company whose case is being reviewed.**"

Please use this form as your billing invoice. The price shown must be the same price as provided in your organization's response to RFP AD010188. Please complete the following:

Expedited Review @ $_____ OR

Standard Review @ $_____

PAYMENT FOR SERVICES SHALL BE SENT TO THE ADDRESS SPECIFIED IN YOUR ORGANIZATION'S RESPONSE TO THE REQUEST FOR PROPOSALS (AD010188), WHICH SERVES AS THE CONTRACT BETWEEN THE STATE OF ARIZONA AND YOUR ORGANIZATION, OR AS UPDATED IN WRITING.

Certification of Compliance with A.R.S. §20-2538(C)

To the best of my knowledge and belief, this IRO and the individual reviewer assigned to this case have no substantial interest in the member, provider, or health care insurer involved in the case nor any other conflict of interest that precluded the reviewer from making a fair and impartial decision. The individual reviewer assigned to this case was not a policyholder of the company whose case was reviewed.

_____

Signature of Authorized Representative Date

_____

Printed Name and Title

Please mail or fax this form with your written decision to:

Elise Bartlett, Manager
Health Care Appeals Program, 2910 N. 44th Street, Suite 210, Phoenix, AZ 85018
Phone: (602) 912-8443 Fax: (602) 912-8447

Form P-1330 Rev. 02/2001

Invoice

Date	Invoice #
7/26/2001	37

Arizona Department of Insurance
Health Care Appeals Fund
2910 N 44th St, # 210
Phoenix, AZ 85018-7256

Send payment with copy of invoice to:

Health Care Appeals Program
2910 North 44th Street, Suite 210
Phoenix, Arizona 85018

P.O. No.	Terms

Description	Amount
Independent External Medical Review MEMBER ID#	0.00
	Total $0.00

PAYMENT DUE ON OR BEFORE 7/26/2001