

HEALTH POLICY COMMISSION

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3.001: Scope and Purpose

958 CMR 3.000 applies to all carriers subject to the requirements of M.G.L. c. 176O. 958 CMR 3.000 establishes requirements for carriers in administering their internal grievance procedures and establishes the requirements for the conduct of external reviews of carriers' medical necessity adverse determinations. 958 CMR 3.000 also sets out requirements for continuity of care, referral to specialty care, and carrier reporting requirements.

3.003: Authority

958 CMR 3.000 is promulgated pursuant to M.G.L. c. 6D, § 16 and M.G.L. c. 176O.

3.020: Definitions

As used in 958 CMR 3.000 the following words shall have the following meanings:

Actively Practicing means that a health care professional regularly treats patients in a clinical setting.

Adverse Determination means a determination, based upon a review of information provided, by a carrier or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness, including a determination that a requested or recommended health care service or treatment is experimental or investigational.

Authorized Representative means an insured's guardian, conservator, holder of a power of attorney, health care agent designated pursuant to M.G.L. c. 210, family member, or other person authorized by the insured in writing or by law with respect to a specific grievance or external review, provided that if the insured is unable to designate a representative, where such designation would otherwise be required, a guardian, conservator, holder of a power of attorney, or family member in that order of priority

may be the insured's representative or may appoint another responsible party to serve as the insured's authorized representative. If the authorized representative is a health care provider, the insured must specify a named individual who will act on behalf of the authorized representative and a telephone number for that individual.

Carrier means an insurer licensed, or otherwise authorized to transact accident or health insurance under M.G.L. c.175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization organized under M.G.L. c. 176G; and an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer. Carrier shall not include any entity to the extent it offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services.

Clinical Review Criteria means the written screening procedures, decisions, abstracts, clinical protocols and practice guidelines used by a carrier to determine the medical necessity and appropriateness of health care services.

Commission means the Health Policy Commission.

Complaint means:

- (a) any inquiry made by or on behalf of an insured to a carrier or utilization review organization that is not explained or resolved to the insured's satisfaction within three business days of the inquiry; or
- (b) any matter concerning an adverse determination. In the case of a carrier or utilization review organization that does not have an internal inquiry process, a complaint means any inquiry.

Covered Benefits or Benefits means health care services to which an insured is entitled under the terms of the health benefit plan.

Days means calendar days, unless otherwise specified.

Evidence of Coverage means any certificate, contract or agreement of health insurance including riders, amendments, endorsements and any other supplementary inserts or a summary plan description pursuant to §104(b)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1024(b), issued to an insured specifying the benefits to which the insured is entitled.

External Review Agency means an independent review organization, which is an entity or company under contract with the Commission to conduct independent reviews of adverse determinations pursuant to M.G.L. c. 176O. Each external review agency shall be accredited by a national accrediting organization.

Facility means a licensed institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Final Adverse Determination means an adverse determination made after an insured has exhausted all remedies available through a carrier's formal internal grievance process.

Financial Affiliation or Financial Relationship means any financial interest in a carrier provided that the term financial affiliation shall not include revenue received from a carrier by a clinical reviewer for health services rendered to insureds.

Grievance means any oral or written complaint submitted to the carrier that has been initiated by an insured, or the insured's authorized representative, concerning any aspect or action of the carrier relative to the insured, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, rescission of coverage, quality of care and administrative operations, in accordance with the requirements of 958 CMR 3.000.

Health Benefit Plan means a policy, contract, certificate or agreement entered into, offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

Health Care Professional means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with law.

Health Care Provider or Provider means a health care professional or facility.

Health Care Services means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

Inquiry means any communication by or on behalf of an insured to the carrier or utilization review organization that has not been the subject of an adverse determination and that requests redress of an action, omission or policy of the carrier.

Insured means an enrollee, covered person, insured, member, policy holder or subscriber of a carrier, including an individual whose eligibility as an insured of a carrier is in dispute or under review, or any other individual whose care may be subject to review by a utilization review program or entity as described under the provisions of M.G.L. c. 176O, 211 CMR 52.00 and 958 CMR 3.000.

Material Familial Affiliation means any relationship as a spouse, child, parent, sibling, spouse's parent, spouse's child, child's parent, child's spouse, sibling's spouse, domestic partner, aunt, uncle, foster parent or foster child.

Material Professional Affiliation means any any health care professional-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a financial affiliation.

Medical Necessity or Medically Necessary means health care services that are consistent with generally accepted principles of professional medical practice as determined by whether the service:

- (a) is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;
- (b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
- (c) for services and interventions not in widespread use, is based on scientific evidence.

Office of Patient Protection means the office within the Commission established by M.G.L. c. 6D, § 16.

Participating Provider means a provider who, under a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the carrier.

Primary Care Provider means a health care professional qualified to provide general medical care for common health care problems, who supervises, coordinates, prescribes, or otherwise provides or proposes health care services, initiates referrals for specialist care, and maintains continuity of care within the scope of his or her practice.

Same or Similar Specialty means that the health care professional has similar credentials and licensure as those who typically provide the treatment in question and has experience treating the same condition that is the subject of the grievance. Such experience shall extend to the treatment of children in a grievance involving a child where the age of the patient is relevant to the determination of whether a requested service or supply is medically necessary.

Service Area means the geographical area as approved by the Commissioner of Insurance within which the carrier has developed a network of providers to afford adequate access to members for covered health services.

Terminal Illness means an illness that is likely, within a reasonable degree of medical certainty, to cause one's death within six months, or as otherwise defined in section 1861(dd)(3)(A) of the Social Security Act (42 U.S.C. 1395x(dd)(3)(A)).

Utilization Review means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to,

ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

Utilization Review Organization means an entity that conducts utilization review under contract with or on behalf of a carrier, but does not include a carrier performing utilization review for its own health benefit plans.

3.100: Clinical Decisions

The physician treating any insured shall make all clinical decisions regarding the medical treatment to be provided to the insured, including the provision of durable medical equipment and hospital lengths of stay:

- (1) Clinical decisions shall be made in accordance with generally accepted principles of professional medical practice and in consultation with the insured.
- (2) Nothing contained herein shall be construed as altering, affecting or modifying either the obligations of any third party payor or the terms and conditions of any agreement or contract between either the treating physician or the insured and any third party.
- (3) Carriers shall pay for health care services ordered by a treating physician or other practitioner acting within the scope of his or her practice if the services are a covered benefit under the insured's health benefit plan, and the services are medically necessary.

3.101: Carrier's Medical Necessity Guidelines

- (1) A carrier may develop guidelines to be used by the carrier in determining if services are medically necessary. Any such guidelines used by a carrier in determining if covered services are medically necessary shall be, at a minimum:
 - (a) developed with input from practicing physicians in the carrier's or utilization review organization's service area;
 - (b) developed in accordance with standards adopted by national accreditation organizations;
 - (c) updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice;
 - (d) evidence based, if practicable;
 - (e) applied in a manner that considers the individual health care needs of the insured; and,
 - (f) otherwise compliant with applicable state and federal law .
- (2) In instances where the insured is enrolled in a health benefit plan where the carrier or utilization review organization provides only administrative services, the obligations of the carrier or utilization review organization related to payment as provided by M.G.L. c. 176O, §16 and 958 CMR 3.100 are limited to recommending to the third party payer that coverage should be authorized.

(3) Utilization review criteria and medical necessity criteria and protocols shall be made available by carriers to the Office of Patient Protection and to members of the public upon request and at no charge.

3.200: Internal Inquiry Process

(1) A carrier or utilization review organization may maintain an internal inquiry process, in addition to the internal grievance process in 958 CMR 3.300 through 3.313.

(2) The inquiry process is a process prior to the grievance process during which a carrier or utilization review organization may attempt to answer questions and/or resolve concerns communicated on behalf of an insured to the insured's satisfaction within three business days.

(a) This process shall not be used for review of an adverse determination, which must be reviewed through the internal grievance process set forth in 958 CMR 3.300 through 3.313.

(b) When this inquiry process fails to answer the insured's questions or resolve the insured's concerns to his/her satisfaction within three business days, the inquiry will, at the option of the insured, be subject to the internal grievance process.

(3) When a carrier or utilization review organization provides an internal inquiry process, the following shall be included in that process:

(a) the provision in writing to insureds of a clear, concise and complete description of the carrier's internal inquiry process;

(b) a protocol to receive and address an inquiry as expeditiously as possible, and to determine whether the insured's inquiry has been resolved to the insured's satisfaction;

(c) a protocol to provide written notice to an insured whose inquiry has not been explained or resolved to the insured's satisfaction within three business days of the inquiry, of the right to have the inquiry processed as an internal grievance under 958 CMR 3.300 through 3.313 at his/her option, including the rights to reduction of an oral inquiry to writing by the carrier, written acknowledgment and written resolution of the grievance as set forth in 958 CMR 3.300 through 3.313; and,

(d) a system for maintaining records of each inquiry communicated by an insured or on his behalf, and response thereto, for a period of two years, which records shall be subject to inspection by the Commissioner of Insurance and the Office of Patient Protection.

(4) For carriers or utilization review organizations that have an internal inquiry process, the 30 day time period for written resolution of a grievance that does not require the review of medical records begins:

(a) on the day immediately following the three business day time period for processing inquiries pursuant to 958 CMR 3.200, if the inquiry has not been addressed within that period of time; or

- (b) on the day the insured or the insured's authorized representative, if any, notifies the carrier or utilization review organization that s/he is not satisfied with the response to an inquiry under 958 CMR 3.200.

3.300: Right to an Internal Grievance Process

- (1) A carrier or utilization review organization shall maintain an internal grievance process that provides for adequate consideration and timely resolution of grievances.
- (2) There shall be only one level of review for an internal grievance, regardless of whether the carrier contracts with a utilization review organization or other entity that provides utilization review services or otherwise reviews internal grievances and issues determinations regarding these grievances.
- (3) A carrier may waive the internal grievance process, and allow the insured to seek immediate external review of an adverse determination, at the carrier's discretion and upon receiving a written request from the insured or the insured's authorized representative which clearly seeks a waiver of the internal grievance process and includes a request to proceed directly to external review. Any such request by the insured or insured's authorized representative must be provided to the carrier in writing within 48 hours of the insured's or insured's authorized representative's receipt of the notice of adverse determination. If the carrier waives the internal grievance process, the carrier shall notify the insured and the insured's authorized representative in writing within 48 hours of receiving the written request, and the insured or insured's authorized representative shall provide a copy of this written waiver to the Office of Patient Protection along with the timely request for external review.

3.301: Information on Internal Grievance Process

- (1) The carrier or utilization review organization shall provide insureds with:
 - (a) A clear, concise and complete written description of the carrier's internal grievance process.
 - (b) A toll-free telephone number for assisting insureds in resolving such grievances and the consumer assistance toll-free number maintained by the Office of Patient Protection, and if applicable, the designated state consumer assistance program.
 - (c) Notification about the availability of these resources.
- (2) A notice of adverse determination shall comply with applicable Massachusetts and federal law, including applicable regulations and guidance issued by the Commissioner of Insurance.
- (3) The carrier or utilization review organization shall provide certain additional information to the insured or insured's authorized representative where, during the internal grievance process, the carrier or utilization review organization considers, generates, or relies upon new evidence or a new rationale for its decision to deny

coverage which was not provided to the insured or insured's authorized representative with the adverse determination.

(a) The carrier or utilization review organization shall provide the insured or insured's authorized representative, free of charge, with any new or additional evidence considered, relied upon, or generated by the carrier or utilization review organization (or at the direction of the carrier or utilization review organization) in connection with the grievance. Such evidence must be provided as soon as possible and sufficiently in advance of, and no fewer than seven days prior to, the date on which the carrier or utilization review organization is required to provide the notice of final adverse determination, to give the insured or insured's authorized representative a reasonable opportunity to respond prior to that date; and

(b) Before the carrier or utilization review organization can issue a final adverse determination based on a new or additional rationale, the insured or insured's authorized representative must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of, and no fewer than seven days prior to, the date on which the carrier or utilization review organization is required to provide the notice of final adverse determination, to give the insured or insured's authorized representative a reasonable opportunity to respond prior to that date.

3.302: Form and Manner of Request

- (1) Each carrier or utilization review organization shall adopt a process to accept grievances by telephone, in person, by mail, or by electronic means, provided that an oral grievance made by the insured or the authorized representative shall be reduced to writing by the carrier and a copy thereof forwarded to the insured by the carrier or utilization review organization within 48 hours of receipt.
- (2) Each grievance filed pursuant to 958 CMR 3.300 through 3.313 that requires the review of medical records shall include the signature of the insured or the insured's authorized representative on a form provided by the carrier authorizing the release of medical and treatment information relevant to the grievance to the carrier or utilization review organization, consistent with state and federal law. The carrier shall provide the insured or authorized representative with the form in paper format, and electronic format if requested, within one business day following the day of the receipt of the grievance. The insured and the authorized representative shall have access to any medical information and records relevant to the grievance relating to the insured which is in the possession of the carrier and under its control. The carrier shall request this authorization from the insured when necessary for requests reduced to writing by the carrier and for any written requests lacking an authorization.

3.303: Carrier and Utilization Review Organization Records of Grievances

The carrier or utilization review organization shall establish a system for maintaining records of each grievance filed by an insured or on his behalf, and responses thereto, for a

period of seven years, which records shall be subject to inspection by the Commissioner of Insurance and the Office of Patient Protection.

3.304: Carrier and Utilization Review Organization Acknowledgment of Internal Grievances

(1) A written acknowledgment of the receipt of a grievance shall be sent by the carrier or utilization review organization to the insured or the insured's authorized representative, if any, within 15 days of receipt, except where an oral grievance has been reduced to writing by the carrier or utilization review organization pursuant to 958 CMR 3.302(1).

(2) In its written acknowledgement, the carrier or utilization review organization shall describe the carrier's process for considering the grievance and the date by which the insured will receive a decision.

3.305: Time Limits for Resolution of Non- Expedited Internal Grievances

(1) A carrier or utilization review organization shall provide the insured or the insured's authorized representative, if any, with a written resolution of a grievance within 30 days of receipt of the oral or written grievance.

(2) When a grievance requires the review of medical records, the 30 day period will not begin to run until the insured or the insured's authorized representative submits a signed authorization for release of medical records and treatment information as required in 958 CMR 3.302(2). In the event that the signed authorization is not provided by the insured or the insured's authorized representative, if any, within 30 days of the receipt of the grievance, the carrier or utilization review organization may, in its discretion, issue a resolution of the grievance without review of some or all of the medical records.

3.306: Review of Internal Grievances

(1) Each reviewer assigned by a carrier or utilization review organization to perform review of an internal grievance must meet the following qualifications:

(a) Each reviewer shall not have participated in any of the carrier's prior decisions regarding the treatment or service at issue in the grievance, and shall not be subordinate to or under the supervision of the reviewer who issued the adverse determination.

(b) Each reviewer shall have no conflict of interest, such that decisions by the carrier or utilization review organization regarding the hiring, compensation, termination, promotion, or other similar matters with respect to the reviewer must not be based upon the likelihood that the reviewer will support the denial of benefits.

(2) Where the grievance was the result of an adverse determination, each reviewer shall be an actively practicing health care professional in the same or similar specialty who

typically treats the medical condition, performs the procedure or provides the treatment that is the subject of the grievance.

(3) The carrier shall assemble a reasonably complete medical record for its internal review.

3.307: Form of Written Resolution of the Internal Grievance

(1) Each written resolution of an internal grievance shall include identification of the specific information considered and an explanation of the basis for the decision.

(2) In the case of an internal grievance that involves an adverse determination, the written resolution shall include a substantive clinical justification for the final adverse determination that is consistent with generally accepted principles of professional medical practice, and shall at a minimum:

- (a) include information about the claim including, if applicable, the date(s) of service, the health care provider(s), the claim amount, and any diagnosis, treatment, and denial code(s) and their corresponding meaning(s);
- (b) identify the specific information upon which the adverse determination was based;
- (c) discuss the insured's presenting symptoms or condition, diagnosis and treatment interventions;
- (d) explain in a reasonable level of detail the specific reasons the reviewer found that the medical evidence does not support a finding of medical necessity;
- (e) reference and include a copy of any applicable clinical practice guidelines and medical necessity criteria including any other standard, guidance, policy, or memoranda used in making the decision, or if none were used, a statement that no medical necessity criteria were used in making the determination;
- (f) specify alternative treatment options covered by the carrier, including identification of providers who are accessible by geographic area and language to the insured and currently accepting new patients;
- (g) provide a summary of the reviewer's professional qualifications, and a certification that the reviewer meets the qualifications specified at 958 CMR 3.306(1) and, if applicable, 958 CMR 3.306(2); and
- (h) notify the insured or the insured's authorized representative of any available procedure for reconsideration of the decision by the carrier, pursuant to 958 CMR 3.308, and the procedures for requesting external review, including the procedures to request an expedited external review.

(3) The carrier or utilization review organization must include with every written final adverse determination the following:

- (a) A paper copy of the form prescribed by the Office of Patient Protection for the request for external review, as well as instructions for locating the form on the Office of Patient Protection's website;

- (b) The toll-free number and other contact information for the Massachusetts consumer assistance program, and the consumer assistance toll-free number and other contact information maintained by the Office of Patient Protection; and
- (c) A clear written list of additional documents and information available to the insured from the carrier, including the insured's entire claim file, and other documents and information which may be provided to the insured by the carrier pursuant to Massachusetts or federal law. The carrier shall include instructions for obtaining these documents, including instructions explaining that the insured may request these documents by calling the carrier's toll-free telephone number for assisting insureds in resolving grievances.

3.308: Reconsideration of Carrier Decisions on Internal Grievances

- (1) For members of group health plans, the carrier or utilization review organization may offer to the insured or the insured's authorized representative, if any, the opportunity for reconsideration of a carrier's final adverse determination where relevant medical information:
 - (a) was received too late to review within the 30 day time limit;
 - (b) was not received but is expected to become available within a reasonable time period following the written resolution; or
 - (c) other good cause offered by the insured or insured's authorized representative.
- (2) When an insured or the insured's authorized representative, if any, chooses to request reconsideration, the carrier or utilization review organization must agree in writing to a new time period for review, but in no event greater than 30 days from the agreement to reconsider the grievance. The time period for requesting external review shall begin to run on the date of the resolution of the reconsidered grievance.
- (3) Reconsideration is voluntary for the insured. A carrier or utilization review organization may not compel the insured or the insured's authorized representative to submit a grievance for reconsideration.
- (4) Reconsideration is not available to members of individual health plans.

3.309: Expedited Internal Review of Adverse Determinations

- (1) A carrier or utilization review organization shall provide for expedited internal review of an adverse determination concerning a carrier's coverage or provision of immediate and urgently needed service(s), that meets the minimum requirements of 958 CMR 3.309.
 - (a) For purposes of 958 CMR 3.309, immediate and urgently needed service(s) means, in the opinion of the health care professional responsible for the treatment or proposed treatment :
 - 1. the service is medically necessary;

2. a denial of coverage for such service(s) would create a substantial risk of serious harm to the insured; and
3. such risk of serious harm is so immediate that the provision of such service(s) should not await the outcome of the normal internal grievance process.

- (b) A carrier or utilization review organization shall provide a written resolution of an expedited internal review in compliance with 958 CMR 3.307 as soon as possible and no later than 72 hours after receipt of the request for expedited review, or as otherwise in 958 CMR 3.309.
 - (c) If the expedited internal review process results in a final adverse determination, the written resolution must inform the insured or the insured's authorized representative of the opportunity to request an expedited external review pursuant to 958 CMR 3.401 and, if the review involves the termination of ongoing services, the opportunity to request continuation of services pursuant to 958 CMR 3.414.
 - (d) An insured or insured's authorized representative may file a request for an expedited external review at the same time as the insured or insured's authorized representative files a request for expedited internal review of the grievance pursuant to 958 CMR 3.401(4).
- (2) If the insured or the insured's authorized representative submits a request for expedited internal review while the insured is an inpatient in a hospital, a carrier or utilization review organization shall provide a written resolution of the expedited internal review before the insured's discharge from the hospital. For the purposes of 958 CMR 3.309(2) only, and only while the insured is an inpatient, a health care professional or a representative of the hospital may be the insured's authorized representative without a written authorization by the insured.
 - (3) A carrier or utilization review organization shall provide for automatic reversal of decisions denying coverage for service(s) or durable medical equipment within 48 hours, or earlier, pending written resolution of the expedited internal review process, as follows:
 - (a) A carrier or utilization review organization shall provide for automatic reversal of the decision within 48 hours of receipt of certification by the physician responsible for the treatment or proposed treatment that is the subject of the grievance that, in the physician's opinion:
 1. the service(s) or durable medical equipment is medically necessary;
 2. a denial of coverage for such service(s) or durable medical equipment would create a substantial risk of serious harm to the patient; and
 3. such risk of serious harm is so immediate that the provision of such service(s) or durable medical equipment should not await the outcome of the normal grievance process.

- (b) For durable medical equipment, in the event the certifying physician exercises the option of automatic reversal earlier than 48 hours, the physician must further certify as to the specific, immediate and severe harm that will result to the patient absent action within the 48 hour time period.

3.310: Grievance Process for Insured with Terminal Illness

- (1) When a grievance is submitted by an insured with a terminal illness, or by the insured's authorized representative on behalf of the insured, a resolution shall be provided to the insured or insured's authorized representative within five business days from the receipt of such grievance, except that grievances regarding urgently needed services for such insured shall be resolved within 72 hours.
- (2) If the expedited review process affirms the denial of coverage or treatment to an insured with a terminal illness, the carrier shall provide the insured or the insured's authorized representative, if any, within five business days of the decision:
 - (a) a statement setting forth the specific medical and scientific reasons for denying coverage or treatment and,
 - (b) a description of alternative treatment, services or supplies covered or provided by the carrier, if any.
- (3) If the expedited review process affirms the denial of coverage or treatment to an insured with a terminal illness, the carrier or utilization review organization shall allow the insured or the insured's authorized representative, if any, to request a conference.
 - (a) The conference shall be scheduled within ten days of receiving a request from an insured; provided however that the conference shall be held within five business days of the request if the treating physician determines, after consultation with the carrier's medical director or his designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies covered by the carrier, would be materially reduced if not provided at the earliest possible date.
 - (b) At the conference, the carrier shall permit attendance of the insured, the authorized representatives of the insured, if any, or both.
 - (c) At the conference, the insured and/or the insured's authorized representative, if any, and a representative of the carrier who has authority to determine the disposition of the grievance shall review the information provided to the insured under 958 CMR 3.310(2).
- (4) If the review process set forth in 958 CMR 3.310 results in a final adverse determination, the written resolution must inform the insured or the insured's authorized representative of the opportunity to request an expedited external review pursuant to 958 CMR 3.401 and, if the review involves the termination of ongoing services, the opportunity to request continuation of services pursuant to 958 CMR 3.414.

3.311: Failure of Carrier to Meet Time Limits

A grievance not properly acted on by the carrier within the time limits required by 958 CMR 3.300 through 3.310 shall be deemed resolved in favor of the insured.

3.312: Coverage or Treatment Pending Resolution of Internal Grievance

(1) If a grievance is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment shall remain in effect at the carrier's expense through completion of the internal grievance process regardless of the final internal grievance decision, provided that the grievance is filed on a timely basis, based on the course of treatment.

(2) The carrier's internal grievance process shall include provision for automatic reversal of the carrier's or utilization review organization's adverse determinations denying coverage for services, pending the outcome of the internal grievance process, within 48 hours of receipt by the carrier or utilization review organization of certification by the physician responsible for the insured's treatment or proposed treatment, which states the physician's opinion that the following factors are present:

- (a) the service at issue in the grievance is medically necessary;
- (b) denial of coverage for these services would create a substantial risk of serious harm to the patient; and
- (c) the risk of that harm is so immediate that the provision of such services should not await the outcome of the normal grievance process.

(3) The carrier's internal grievance process shall include provision for automatic reversal of the carrier's or utilization review organization's adverse determinations denying coverage for durable medical equipment, pending the outcome of the internal grievance process, within 48 hours or earlier, of receipt by the carrier or utilization review organization of certification by the physician responsible for the insured's treatment or proposed treatment, which states the physician's opinion that the following factors are present:

- (a) the durable medical equipment at issue in the grievance is medically necessary;
- (b) denial of coverage for the durable medical equipment would create a substantial risk of serious harm to the patient;
- (c) the risk of that harm is so immediate that the provision of such durable medical equipment should not await the outcome of the normal grievance process; and
- (d) if the physician certifies that the coverage decision should be reversed earlier than 48 hours after the carrier's or utilization review organization's adverse determination, a certification as to the specific, immediate and severe harm that will result to the insured absent action within the 48 hour time period.

3.313: Confidentiality

No carrier or utilization review agency shall, except as specifically authorized by an appropriate release signed by an insured or authorized representative, release medical and treatment information or other information obtained as part of the internal inquiry or grievance process unless otherwise required or authorized by law.

3.314: Internal Review Conference

Nothing in 958 CMR 3.000 shall be construed to prohibit an insured or insured's authorized representative from voluntarily participating in a conference or informal meeting with the carrier or utilization review organization to attempt to resolve the subject matter of the grievance.

3.400: External Review

(1) Any insured or authorized representative of an insured who is aggrieved by a final adverse determination issued by a carrier or utilization review organization may request an external review by filing a request in writing with the Office of Patient Protection within four months of the insured's receipt of written notice of the final adverse determination, except that no final adverse determination is required when the insured simultaneously requests an expedited internal review and expedited external review pursuant to 958 CMR 3.401(4), or where a carrier has waived internal review pursuant to 958 CMR 3.300(3).

(2) An insured or insured's authorized representative may file a request for external review for services of any monetary value. There is no minimum financial threshold for filing a request for external review.

3.401: Expedited External Review

(1) An insured or the insured's authorized representative may request to have the request for review processed as an expedited external review.

(2) Each request for an expedited external review shall contain a certification, in writing, from a health care professional responsible for the treatment or proposed treatment that delay in the provision or continuation of health care services that are the subject of a final adverse determination, would pose a serious and immediate threat to the health of the insured.

(3) Upon receiving a properly executed certification that a serious and immediate threat to the insured exists, the Office of Patient Protection shall qualify such request as eligible for an expedited external review.

(4) The insured or insured's authorized representative may file a request for expedited external review concurrently with a request for expedited internal review.

(5) The external review agency shall issue a decision within 72 hours of receiving the request for expedited external review.

3.402: Fees

- (1) An insured seeking an external review shall pay a fee of \$25.00, which shall accompany the request for a review, to the Office of Patient Protection.
 - (a) No insured shall be required to pay more than \$75 in fees for external review requests per plan year, regardless of the number of external review requests submitted.
 - (b) If the \$25 fee has been paid, the Office of Patient Protection shall refund the \$25 fee to the insured if the adverse determination is reversed or overturned in its entirety by the external review agency.
- (2) The Office of Patient Protection shall waive the fee for any insured with a total household income that does not exceed 300% of the federal poverty level or if it determines that the payment of the fee will result in extreme financial hardship to the insured.
- (3) The remainder of the cost for an external review shall be borne by the involved carrier. Upon completion of the external review, the Office of Patient Protection or the external review agency shall bill the involved carrier the amount established pursuant to contract between the Commission and the assigned external review agency minus the \$25 fee when this fee is the insured's responsibility. When the insured is not required to pay the fee pursuant to 958 CMR 3.402(1)(a) or (2) or the insured's fee is refunded pursuant to 958 CMR 3.402(1)(b), the carrier shall be responsible for paying the full cost of review, including the \$25 fee.

3.403: Consent to Release of Medical Information

- (1) Any request for an external review pursuant to 958 CMR 3.400 et seq. shall include the signature of the insured, or the insured's authorized representative authorizing the release and forwarding of medical information and records relevant to the subject matter of the external review, in a manner consistent with state and federal law, to any external review agency assigned to conduct external reviews pursuant to 958 CMR 3.407.
- (2) In connection with any request for an external review, the carrier shall assure that the insured, and where applicable the insured's authorized representative, has access to any medical information and records relating to the insured, in the possession of the carrier or under its control.

3.404: Form and Manner of Request for External Review

Requests for external review submitted by the insured or the insured's authorized representative shall:

- (1) be on a form prescribed by the Office of Patient Protection;
- (2) include the signature of the insured or the insured's authorized representative consenting to the release of medical information;
- (3) include a copy of the written final adverse determination issued by the carrier; and,
- (4) include the \$25.00 fee required by 958 CMR 3.402 unless not required pursuant to 958 CMR 3.402(1)(a) or waived pursuant to 958 CMR 3.402(1)(b).

3.405: Screening of Requests for External Review

- (1) The Office of Patient Protection shall screen all requests for external reviews to determine if they:
 - (a) comply with the requirements of 958 CMR 3.404;
 - (b) do not involve a service or benefit that has been explicitly excluded from coverage by the carrier in its evidence of coverage; and
 - (c) result from a carrier's issuance of a notice of final adverse determination; provided, however, that no final adverse determination is necessary where the carrier has failed to comply with timelines for the internal grievance process, the carrier has waived the internal grievance process in writing pursuant to 958 CMR 3.300(3), or if the insured or his or her authorized representative is requesting an expedited external review at the same time that the insured is requesting an expedited internal review pursuant to 958 CMR 3.401(4).
- (2) Screening of requests for expedited reviews shall begin within 48 hours of receipt. Screening of all other requests shall begin within five business days of receipt.

3.406: Requests Ineligible for External Review – Notification

- (1) Notification of the rejection of a request for external review for failure to meet the requirements of 958 CMR 3.400 et seq. shall be issued by the Office of Patient Protection to the insured, the insured's authorized representative and the carrier within 72 hours of a receipt of a request for an expedited review and within ten business days of receipt of all other requests. The notification shall set forth the specific reason why the request has been determined ineligible for an external review and any submitted fee shall be returned.
- (2) The Office of Patient Protection shall determine that a request for external review is ineligible for review based on the following:
 - (a) Insured or insured's authorized representative filed the request for external review after the time limit provided at 958 CMR 3.400;

- (b) Insured seeks external review of a decision by a self-funded plan not eligible for review under M.G.L. c. 176O;
- (c) Insured seeks external review of a decision by a health benefit plan licensed in a state other than Massachusetts, which is not eligible for review under M.G.L. c. 176O;
- (d) Insured seeks external review of a decision by a plan issued by Medicaid, Medicare, or other health benefit plan not subject to M.G.L. c. 176O;
- (e) Insured's treatment was found to be medically necessary by the carrier, and the insured is attempting to seek external review of an issue related to the amount of copayment, deductible, coinsurance or other out-of-pocket expense; or
- (f) Insured seeks external review of a decision by a carrier which was not a final adverse determination, except that an adverse determination will be sufficient where the insured seeks an expedited external review and has simultaneously filed a request for expedited internal review.

3.407: Assignment of External Reviews

Upon the determination by the Office of Patient Protection that a request for review is eligible for an external review, the external review request shall be assigned promptly to an external review agency by the Office of Patient Protection on a random basis. The Office of Patient Protection shall forward a copy of the insured's request for an external review together with any related documentation filed with the Office by the insured or the carrier to the external review agency.

3.408: Notification of Assignment and Request for Information

Upon the referral of a request to an external review agency, the Office of Patient Protection shall notify the insured, the insured's authorized representative if applicable and the carrier, that the request has been referred and shall identify the selected external review agency, and where applicable, identify that the review is being considered on an expedited basis. A copy of the insured's written authorization for the release of medical records and information shall be included with notification sent to the carrier.

3.409: Medical Records and Information

(1) For non-expedited reviews, the carrier or utilization review organization shall forward the insured's medical and treatment records relevant to the review and created by or in the possession or control of the carrier and a copy of the carrier's evidence of coverage applicable to the insured, to the identified external review agency within three business days of receipt of the notification provided pursuant to 958 CMR 3.408. It is the responsibility of the carrier to assemble a reasonably complete medical record or file. The carrier shall make good faith efforts to obtain records relevant to the review and not in the possession of the carrier from providers, whether the providers are in the carrier's network or outside of the carrier's network. Failure to make such good faith efforts shall be subject to the penalties listed at 958 CMR 3.412(2)(b).

(2) For expedited reviews, the carrier or utilization review organization shall furnish to the identified external review agency the insured's medical and treatment records relevant to the review and created by or in the possession or control of the carrier, and a copy of the carrier's evidence of coverage applicable to the insured, within 24 hours of receipt of notification provided pursuant to 958 CMR 3.408. It is the responsibility of the carrier to assemble a reasonably complete medical record or file. The carrier shall make good faith efforts to obtain records relevant to the review and not in the possession of the carrier from providers, whether the providers are in the carrier's network or outside of the carrier's network. Failure to make such good faith efforts shall be subject to the penalties listed at 958 CMR 3.412(2)(b).

(3) The carrier or utilization review organization or the insured or his or her authorized representative shall have access to all information filed by any party with the external review agency including any information filed pursuant to 958 CMR 3.412.

(4) For the purposes of 958 CMR 3.409(1) and (2), "good faith efforts" shall be defined as no fewer than three reasonable documented attempts by the carrier to obtain the information from an in-network or out-of-network provider or the provider's designee.

3.410: Review Panel

(1) Upon receipt of an external review referral the external review agency shall assign the review to a panel that is comprised of one or more clinical reviewers who did not participate in any of the carrier's prior decisions on the claim or internal grievance. These reviewers shall be actively practicing health care professionals in the same or similar specialty who typically treat the medical condition, perform the procedure or provide the treatment that is the subject of the external review.

(2) Upon receipt of an external review referral involving services or treatment considered by the carrier or utilization review organization to be experimental or investigational, or other services or treatment as determined by the Office of Patient Protection, the external review agency shall assign the review to a panel that is comprised of three clinical reviewers who did not participate in any of the carrier's prior decisions on the claim or internal grievance. These reviewers shall be actively practicing health care professionals in the same or similar specialty who typically treat the medical condition, perform the procedure or provide the treatment that is the subject of the external review.

3.411: Conflict of Interest

(1) External review agencies shall ensure that the external review agency and the clinical reviewers assigned to any external review:

- (a) shall have no material professional, familial or financial affiliation with any party that is the subject of the review;

(b) shall have no material professional, family or financial affiliation with any party that participated in the delivery of health care to the insured who is the subject of the review;

1. shall not have participated as a clinical reviewer in connection with any medical necessity determination with respect to the insured who is the subject of the review; and
2. shall have no material professional, familial or financial conflict of interest with any officer, director, or management employee of the carrier or utilization review organization; the plan administrator, plan fiduciaries, or plan employees; the health care provider, the health care provider's group, or practice association recommending the treatment that is subject to the external review; the facility at which the recommended treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended.

(2) The Office of Patient Protection shall not contract with any external review agency which owns or controls, or is owned or controlled by a carrier or utilization review organization, the sponsor of a group health plan, a trade association of plans or issuers, or a trade association of health care providers.

(3) Decisions by the external review agency regarding the hiring, compensation, termination, promotion, or other similar matters with respect to the reviewer must not be based upon the likelihood that the reviewer will support the denial of benefits.

3.412: Additional Medical or Other Information

(1) The insured or the insured's authorized representative may submit additional medical evidence or other relevant information to the external review agency.

(a) The Office of Patient Protection will notify the insured or insured's authorized representative of the right to submit additional medical evidence or other relevant information in its letter to the insured or insured's authorized representative acknowledging the receipt and assignment of the request for external review. The Office of Patient Protection will include in its letter instructions for submitting any additional medical evidence or other relevant information to the external review agency.

(b) In a non-expedited review, any such additional medical evidence or other relevant information shall be submitted to the external review agency within 10 days from the date of the notice from the Office of Patient Protection, in order to be reviewed by the external review agency.

(c) In an expedited review, any such additional medical evidence or other relevant information shall be submitted to the external review agency within 24 hours of the insured's or insured's authorized representative's filing of the request for expedited external review, in order to be reviewed by the external review agency.

- (d) The external review agency shall forward a copy of any additional medical evidence or other relevant information submitted by the insured or the insured's authorized representative to the carrier within one business day of receipt.
- (2) The assigned external review agency may request the carrier to provide such additional information or documentation as the external review agency deems necessary in order to render a decision. Such additional information shall be provided within 24 hours of the request in expedited review cases and within three business days for all other reviews.
 - (a) Carriers shall make good faith efforts to obtain any such additional information requested by the external review agency that is not in the possession of the carrier.
 - (b) Failure by the carrier to make good faith efforts to supply information requested pursuant to 958 CMR 3.409 or 3.412 may result in penalties to carriers including action by the Division of Insurance pursuant to 211 CMR 52.17. In addition, where a carrier has failed to make good faith efforts to supply information pursuant to 958 CMR 3.409 or 3.412, the external review agency may in its discretion order the grievance in dispute to be resolved in favor of the insured.
 - (c) For the purposes of 958 CMR 3.409 or 3.412, "good faith efforts" shall be defined as no fewer than three reasonable documented attempts by the carrier to obtain the information from a provider or the provider's designee.
- (3) The assigned external review agency may request the insured, or where applicable the insured's authorized representative, to provide such additional information or documentation as the external review agency deems necessary in order to render a decision. Such additional information shall be provided within 24 hours of the request in expedited review cases and within ten business days for all other reviews, on order to be considered by the external review agency.

3.413: Informal Meeting

The external review agency may, in its discretion, conduct an informal meeting with the parties in order to obtain information that it deems relevant to its decision making.

3.414: Continuation of Services

- (1) If the subject matter of the external review involves the termination of ongoing services, the insured or insured's authorized representative may apply to the external review agency to seek the continuation of coverage for the terminated service during the period the review is pending. Any such request to the external review agency must be made before the end of the second business day following receipt of the final adverse determination, or when the internal and external reviews are filed simultaneously, the second business day following receipt of the adverse determination.

The external review agency shall order the continuation of coverage or treatment where it determines that substantial harm to the insured's health may result absent such continuation or for such other good cause as the external review agency shall determine. Continuation of coverage shall be at the carrier's expense regardless of the final external review determination.

- (2) A request for continuation of coverage by an insured or insured's authorized representative shall be included in the external review request, on the external review request form issued by the Office of Patient Protection.
- (3) If continuation of coverage was provided during the internal review process, then any continuation of coverage ordered during the external review shall follow immediately upon the prior coverage so that there is no gap in coverage between the internal review process and external review process.

3.415: Decisions and Notice

- (1) The external review agency shall determine whether the service that is the subject of the review is medically necessary and is a covered benefit as defined in 958 CMR 3.020.
- (2) The final decision of the external review agency shall be in writing and shall contain the following information:
 - (a) the specific medical and scientific reasons for the decision;
 - (b) an analysis of the medical evidence and how the evidence supports the finding of the reviewer;
 - (c) the Massachusetts medical necessity standard as defined at 958 CMR 3.020, and an explanation of why the requested treatment or service was found or was not found to be medically necessary;
 - (d) a list of any medical literature or references relied upon in making the decision;
 - (e) a statement that the decision is final and binding, but may have other legal rights under state or federal law; and
 - (f) a statement prepared by the Office of Patient Protection, which notifies the insured of the availability of translation and interpretation assistance from the carrier.
- (3) The external review agency shall provide a copy of the final decision to the insured, the insured's authorized representative and the carrier. Where the insured is a

minor or a person with a legal guardian, the external review agency shall provide the insured's copy of the final decision to the insured's parent or legal guardian.

- (4) For non-expedited reviews, an external review agency shall issue its final disposition within 45 calendar days from its receipt of the referral from the Office of Patient Protection.
- (5) For expedited reviews, the external review agency shall issue its final disposition within 72 hours of its receipt of the referral from the Office of Patient Protection.
- (6) Each external review agency shall retain records of all external review requests, decisions and notices for three years from the date of the final disposition, and shall make these records available to the Office of Patient Protection upon request.
- (7) The decision of the external review agency shall be binding on the carrier and the insured, except to the extent other remedies are available under Massachusetts or federal law, and except that the requirement that the decision is binding shall not preclude the carrier from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. Nothing in 958 CMR 3.415 shall prohibit the parties from voluntarily proceeding with any informal efforts to resolve the matter under review prior to the issuance of a final decision.
- (8) Upon written request by the insured, the insured's authorized representative or the carrier, and at the sole discretion of the Director of the Office of Patient Protection, an external review agency may be directed to retract and revise a decision only upon a finding of clear procedural or factual error which is evident on the face of the decision. Any such written request must be received by the Office of Patient Protection within seven days of the date of the external review agency's final decision, in order to be considered. For the purposes of this section, "clear procedural or factual error" is defined as including at least one of the following:
 - (a) the decision by the external review agency fails to acknowledge or consider medical records which were submitted to the external review agency within the time limits specified at 958 CMR 3.412;
 - (b) the decision by the external review agency identifies the incorrect insured, provider, carrier, diagnosis or medical treatment in its decision; or
 - (c) the decision by the external review agency fails to cite the correct Massachusetts medical necessity standard as defined at 958 CMR 3.020.
- (9) If the external review agency overturns a carrier's decision in whole or in part, the carrier shall issue a written notice to the insured within five business days of receipt of the written decision from the review agency. Such notice shall:
 - (a) acknowledge the decision of the review agency;

- (b) advise the insured of any additional procedures for obtaining the requested coverage or services;
 - (c) advise the insured of the date by which the payment will be made or the authorization for services will be issued by the carrier or utilization review organization; and
 - (d) advise the insured of the name and phone number of the person at the carrier who will assist the insured with final resolution of the grievance.
- (10) The carrier shall comply with the external review agency's decision and shall make payment, authorize services, or otherwise comply without delay.

3.416: Confidentiality – External Review

No external review agency or reviewer shall, except as specifically authorized by an appropriate release signed by an insured or representative authorized by law, release medical and treatment information or other information obtained as part of an external review, except to the Office of Patient Protection and as otherwise authorized or required by law.

3.417: External Review Conference

Nothing in 958 CMR 3.000 shall be construed to prohibit an insured or insured's authorized representative from voluntarily participating in a conference or informal meeting with the external review agency regarding the external review request, or with the carrier or utilization review organization to resolve the matter which is the subject of the external review request.

3.500: Disenrollment of Primary Care Provider

Where a carrier allows or requires the designation of a primary care provider, the carrier shall in the event of disenrollment of a primary care provider for reasons other than those related to quality or fraud:

- (1) provide to any insured written notice of the disenrollment of the insured's primary care provider at least 30 days prior to any such disenrollment;
- (2) include in said notice a description of the procedure for choosing an alternate primary care provider; and,
- (3) permit the insured to be covered for health services, consistent with the terms of the carrier's evidence of coverage, provided by such primary care provider for at least 30 days after the provider is disenrolled.

3.501: Disenrollment of Providers of Care to Pregnant Women

Carriers shall allow any female insured who is in her second or third trimester of pregnancy and whose provider in connection with said pregnancy is involuntarily disenrolled for reasons other than those related to quality or fraud, to continue treatment

with her provider, consistent with the carrier's evidence of coverage, for a period up to and including the insured's first postpartum visit.

3.502: Disenrollment of Providers of Care to the Terminally Ill

Carriers shall allow any insured who is terminally ill, and whose provider in connection with the treatment of the insured's terminal illness is involuntarily disenrolled for reasons other than those related to quality or fraud, to continue treatment with the provider, consistent with the terms of the carrier's evidence of coverage, until the insured's death.

3.503: Coverage for the Newly Insured

- (1) A carrier shall provide coverage for health services to a newly insured provided by a provider who is not a participating provider in the carrier's network for up to 30 days from the effective date of coverage if:
 - (a) the insured's employer only offers the insured a choice of carriers in which said provider is not a participating provider; and
 - (b) said provider is providing the insured with an ongoing course of treatment or is the insured's primary care provider.
- (2) With respect to an insured pregnant woman who is in her second or third trimester, coverage pursuant to 958 CMR 3.503(1) shall apply to services rendered through the insured's first postpartum visit.
- (3) With respect to an insured with a terminal illness, coverage pursuant to 958 CMR 3.503(1) shall apply to services rendered until the insured's death.

3.504: Carrier's Coverage Conditions

- (1) A carrier may condition coverage of continued treatment by a provider under 958 CMR 3.500 through 3.503, upon the provider's agreeing:
 - (a) to accept reimbursement from the carrier at the rates applicable prior to the notice of disenrollment as payment in full;
 - (b) to not impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled;
 - (c) to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and,
 - (d) to adhere to such carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing treatment pursuant to a treatment plan, if any, approved by the carrier.
- (2) A carrier may condition coverage of treatment by a physician or nurse practitioner under 958 CMR 3.503 upon the provider's agreeing:
 - (a) to accept reimbursement from the carrier at the rates applicable to participating providers as payment in full;

- (b) to not impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider participated in the carrier’s network;
 - (c) to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and
 - (d) to adhere to the carrier’s policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing treatment pursuant to a treatment plan, if any, approved by the carrier.
- (3) Nothing in 958 CMR 3.500 through 3.502 or 3.504 shall be construed to require the coverage of benefits that would not have been covered if the provider involved had remained a participating provider. Nothing in 958 CMR 3.503 shall be construed to require coverage of benefits that would not have been covered if the provider involved was a participating provider.

3.505: Standing Referrals

- (1) A carrier that requires an insured to designate a primary care provider shall allow such a primary care provider to authorize a standing referral for specialty health care, including mental health care, provided by a health care provider participating in such carrier’s network when:
- (a) the primary care provider determines that such referrals are appropriate;
 - (b) the provider of specialty health care agrees to a treatment plan for the insured and provides the primary care provider with all necessary clinical and administrative information on a regular basis; and
 - (c) the health care services to be provided are consistent with the terms of the carrier’s evidence of coverage.
- (2) Nothing in 958 CMR 3.505 shall be construed to permit a provider of specialty health care who is the subject of a referral to authorize any further referral of an insured to any other provider without the approval of the insured’s carrier.
- (3) For the purposes of 958 CMR 3.505, “specialty health care” means health care services rendered by a provider other than a primary care provider.

3.506: Specialty Care Not Requiring Prior Authorization

- (1) No carrier that requires an insured to obtain referrals or prior authorizations from a primary care provider for specialty care shall require an insured to obtain a referral or prior authorization from a primary care provider for the following specialty care provided by an obstetrician, gynecologist, certified nurse-midwife or family practitioner participating in such carrier’s health care provider network:
- (a) annual preventive gynecologic health examinations, including any subsequent obstetric or gynecological services determined by such obstetrician, gynecologist, certified nurse-midwife or family practitioner to be medically necessary as a result of such examination;

- (b) maternity care; and
 - (c) medically necessary evaluations and resultant health care services for acute or emergency gynecological conditions.
- (2) No carrier shall require higher copayments, coinsurance, deductibles or additional cost sharing arrangements for such services provided to such insureds in the absence of a referral from a primary care provider.
- (3) Carriers may establish reasonable requirements for participating obstetricians, gynecologists, certified nurse-midwives or family practitioners to communicate with an insured's primary care provider regarding the insured's condition, treatment and need for follow-up care.
- (4) Nothing in 958 CMR 3.506 shall be construed to permit an obstetrician, gynecologist, certified nurse-midwife or family practitioner to authorize any further referral of an insured to any other provider without the approval of the insured's carrier.
- (5) For the purposes of 958 CMR 3.506, the term "specialty care" is limited to those services that are medically necessary and consistent with the terms of the carrier's evidence of coverage.
- (6) Nothing in 958 CMR 3.506 shall be construed to prohibit a carrier from applying all other applicable health plan requirements for preauthorization or other prior approval for admission to a facility or specific procedures for specialty care provided by an obstetrician, gynecologist, certified nurse-midwife or family practitioner.

3.507: Coverage of Pediatric Specialty Care

Carriers shall provide coverage of pediatric specialty care, including mental health care, by persons with recognized expertise in providing specialty pediatric care to insureds requiring such services.

3.508: Denial of Provider Application

Carriers shall provide health care providers who are applying to be participating providers and who are denied such status with a written reason or reasons for the denial of such application.

3.509: Provider Termination Without Cause Provisions

- (1) Contracts between carriers and health care providers shall state that neither the carrier nor the provider has the right to terminate the contract without cause.
- (2) Carriers shall provide a written statement to a provider of the reason or reasons for such provider's involuntary disenrollment.

3.600: Reporting Requirements

(1) Using a template or form developed by the Office of Patient Protection, carriers shall provide the following information to the Office of Patient Protection no later than April 1 of each year, with the exception of the materials required under 958 CMR 3.600(A)(5), which shall be submitted concurrent with their submission to the Division of Insurance.

- (a) a list of sources of independently published information assessing insureds' satisfaction and evaluating the quality of health care services offered by the carrier;
- (b) the percentage of physicians and nurse practitioners who voluntarily and involuntarily terminated participation contracts with the carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary provider disenrollment;
- (c) the medical loss ratio, which is percentage of premium revenue expended by the carrier for health care services provided to insureds for the most recent year for which information is available;
- (d) a report detailing, for the previous calendar year:
 - 1. the total number of filed grievances, the type of medical or behavioral health treatment at issue where applicable, the number of grievances that were approved internally, the number of grievances that were denied internally, and the number of grievances that were withdrawn before resolution;
 - 2. the number of grievances which resulted from an adverse determination, the type of medical or behavioral health treatment at issue, and the outcomes of those grievances; or if this information is also being reported to the Commissioner of Insurance on or prior to July 1, a statement to that effect;
 - 3. the percentage of insureds who filed internal grievances with the carrier;
 - 4. the total number of internal grievances that were reconsidered pursuant to 958 CMR 3.308, the number of reconsidered grievances that were approved internally, the number of reconsidered grievances that were denied internally, and the number of reconsidered grievances that were withdrawn before resolution;
 - 5. the total number of external reviews pursued after exhausting the internal grievance process, and the resolution of all such external reviews.

The report shall identify, for each such category, to the extent such information is available, the demographics of such insureds, which shall include, but need not be limited to, race, gender and age.

- (e) An electronic copy of the following, which are required to be provided upon enrollment to at least one adult insured in each household residing in Massachusetts pursuant to M.G.L. c.176O, §§ 6 and 7(a):
 - 1. Evidence of coverage and any amendments thereto;
 - 2. A list of health care providers in the carrier's network, organized by specialty and by location and summarizing for each such provider the method used to compensate or reimburse such provider, provided, however, that disclosure of the specific details of any financial arrangements between a carrier and a provider is not required;

3. A statement that physician profiling information, so-called, may be available from the board of registration in medicine;
 4. A summary description of the process by which clinical guidelines and utilization review criteria are developed;
 5. The voluntary and involuntary disenrollment rate among insureds of the carrier;
 6. A statement that insureds have the opportunity to obtain health care services for an emergency medical condition, including the option of calling the local pre-hospital emergency medical service system, whenever the insured is confronted with an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency services; and
 7. A statement that the information specified in 958 CMR 3.600(1)(a) through (d) is available to the insured or prospective insured from the Office of Patient Protection.
- (2) Carriers shall provide to the Office of Patient Protection, concurrent with the submission to the Center for Health Information and Analysis pursuant to M.G.L. c. 111, § 217, a copy of the health plan data and information set compiled for the National Committee on Quality Assurance or other information collected by the carrier and deemed to be similar or equivalent thereto. At the carrier's option, proprietary financial data may be excluded from this submission.
- (3) Each carrier shall provide to the Office of Patient Protection no later than April 1 of each year, information to assist the Office of Patient Protection in resolving appeals.
- (a) Each carrier shall provide the name, telephone number and e-mail address of the person or persons within its organization who will serve as the general contact for the Office of Patient Protection for appeals and grievances.
 - (b) Each carrier shall provide the name, telephone number and e-mail address of the person or persons who have the authority to approve appeals and approve the payment of claims for all products and for all types of services.
 - (c) If any of this contact information changes, the carrier shall provide the new information in writing to the Office of Patient Protection within ten business days following the change.
- (4) The confidentiality of any information about a carrier or utilization organization which, in the opinion of the Office of Patient Protection in consultation with the Division of Insurance, is proprietary in nature shall be protected, except where disclosure is otherwise required by law.
- (5) The Office of Patient Protection shall establish a site on the internet and through other communication media, make managed care information collected by the Office of Patient Protection readily accessible to consumers. The internet site shall, at a minimum, include:

- (a) a chart comparing the information obtained on premium revenue expended for health care services as provided pursuant to 958 CMR 3.600 (1)(c) for the most recent year for which information is available; and
- (b) data collected pursuant to 958 CMR 3.600(2).

3.700: Required Oral Interpretation and Written Translation Services

- (1) Each carrier shall provide to the insured or the insured's authorized representative, upon request, oral interpretation and written translation services related to all procedures required by 958 CMR 3.000, as required by M.G.L. 176O, § 15(k).
- (2) A carrier must include in the English version of all notices required by 958 CMR 3.000 and provided to the insured or the insured's authorized representative, a statement describing how the insured or the insured's authorized representative can request oral interpretation and written translation services from the carrier. At a minimum the statement must be prominently displayed in English, Arabic, Khmer (Cambodian), Chinese, French, Greek, Haitian-Creole, Italian, Lao, Portuguese, Russian and Spanish, and in any non-English language in which ten (10) percent or more of the population residing in any Massachusetts county served by the carrier is only literate in the same non-English language, as determined by the Office of Patient Protection.
- (3) For written translation services, upon request by the insured or the insured's authorized representative, the carrier must provide all subsequent written notices required by 958 CMR 3.000 to the insured or the insured's authorized representative in the requested non-English language, along with the English version.
- (4) For oral interpretation services, upon request by the insured or the insured's authorized representative, the carrier must provide oral interpretation services related to all procedures required by 958 CMR 3.000, including but not limited to answering questions and providing information and assistance with filing grievances or external review requests.

REGULATORY AUTHORITY

958 CMR 3.000: M.G.L. c. 6D, § 16 and c.176O.