The Commonwealth of Massachusetts
HEALTH POLICY COMMISSION
50 MILK STREET, 8TH FLOOR
BOSTON, MASSACHUSETTS 02109
(617) 979-1400

DEBORAH DEVAUX
CHAIR

DAVID M. SELTZ
EXECUTIVE DIRECTOR

OFFICE OF PATIENT PROTECTION
(800) 436-7757 (PHONE)
(617) 624-5046 (FAX)

REQUEST FOR AN EXTERNAL REVIEW OF AN ACO OR RBPO APPEAL DECISION

Certain patients in Massachusetts receive health care from providers who participate in an Accountable Care Organization (ACO) or Risk-bearing Provider Organization (RBPO). An ACO or RBPO is a group of health care providers that works together to coordinate health care and enters into financial agreements with insurance companies to do so. Under Massachusetts law, as a patient of an ACO or RPBO you may have the right to appeal a decision made by your health care provider relating to referrals, timely access to care, limitations on the type or intensity of care, and other concerns. This process does not apply to patients covered by Medicare, Medicare Advantage, Medicaid, or any MassHealth plans.

If you submitted an internal appeal to your ACO or RBPO and it was denied, you may be able to request that the Office of Patient Protection (OPP) assign an independent medical expert to review the ACO or RBPO's decision. This process is called an external review. If your condition needs urgent medical attention, you may request an expedited (fast) external review.

- **Standard External Review** - Before an external review, you must first ask your ACO or RBPO for an internal appeal of the decision. If your internal appeal is denied, you may request an external review within 30 calendar days of receiving a written resolution from the ACO or RBPO. A written resolution is a letter that includes the clinical justification for the decision to deny your appeal.

  Next Steps : Complete pages 2-7 of this form or complete the online form available at:
  https://masshpc.gov/opp/external-review-rbpo-aco#Forms
  Attach written resolution letter and other documentation
  Send form and documents to OPP (see checklist on page 2)

- **Expedited External Review** – If you believe there is an urgent medical need, you may request an expedited external review. You can request an expedited external review within 30 calendar days of receiving a written resolution letter from your provider.

  Next Steps : Complete pages 2-8 of this form or complete the online form available at:
  https://masshpc.gov/opp/external-review-rbpo-aco#Forms
  Attach written resolution letter and other documents
  Send form and documents to OPP (see checklist on page 2)

EXTERNAL REVIEW CHECKLIST – WHAT TO SEND AND WHERE TO SEND IT

If you wish to submit your request electronically, please use our online form with secure submission of documents at: https://masshpc.gov/opp/external-review-rbpo-aco#Forms

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Please be sure to complete all applicable sections of the form, and include **all** of the following. Incomplete external review requests cannot be deemed eligible. Please include:

- ☐ Complete application form (pages 2-7 for standard external review).
- ☐ If you are requesting an **expedited external review**, complete page 8 also.
- ☐ A copy of the written resolution letter from your ACO/RBPO
- ☐ A copy of your insurance card and/or your insurance company and insurance ID number
- ☐ Any other information that you would like the external review agency to consider in reviewing your case (the ACO/RBPO will be asked to send the external review agency records relevant to the review).
- ☐ Send the completed application form and other documents to OPP by fax, mail, or online form. If you are requesting an **expedited external review**, fax your application to OPP, then call 800-436-7757 to advise OPP that you faxed the request. OPP does **not** recommend sending this form or any personal health information by email because communications via email are not secure.

Fax: 617-624-5046

Mail: Office of Patient Protection
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Email: HPC-OPP@state.ma.us

Questions? Call OPP at 800-436-7757

PATIENT INFORMATION

1. Patient's Name:	
2. Mailing Address:	
3. Phone:	
4. Email:	
5. Patient's Date of Birth:	

INFORMATION ABOUT THE PATIENT'S ACO/RBPO AND PROVIDER

6. Name of ACO or RBPO:	
7. Name of health care provider who denied requested referral, treatment or service:	
8. Type of Provider:	☐ Primary Care Provider ☐ Other (please specify):_____
9. Provider's Address (Office location where you sought care):	
10. Provider Phone Number and E-Mail address:	

11. Describe the disagreement with your ACO/RBPO. • If possible, please provide details on the referral, treatment, or service that was denied • Attach additional pages if needed • Attach the written resolution letter (the final denial letter from the ACO/RBPO) • Attach any other information from your health care providers that you want the external reviewer to consider

INFORMATION ABOUT YOUR HEALTH HISTORY

If you are submitting medical or clinical records from another provider or facility not previously listed, please list the provider(s) and dates of service here. Attach additional sheets if needed.

Provider Name: _____
Provider Mailing Address:
_____
_____
Provider Phone Number: _____
Date(s) of treatment or service: _____

INFORMATION ABOUT THE PATIENT'S HEALTH INSURANCE COVERAGE

Policyholder's Name:	
Patient's Insurance ID Number:	
Name of Health Insurance Company:	
How did the patient get this insurance? (Check all that apply.)	☐ Employer ☐ Parent ☐ Health Connector ☐ Spouse or former spouse ☐ Insurance company ☐ Other: _____

AUTHORIZED REPRESENTATIVE FORM

Fill out this section only if someone else will represent you in this review.
You can represent yourself, or may ask another person, including a health care provider, to act as your personal representative. You may revoke this authorization in writing at any time.

I hereby authorize _____ to pursue my external review on my behalf.

_____ _____
Signature of Patient or Legal Guardian* Date

* Specify if signed by parent, guardian, conservator or other: _____
Please note: If the patient is 18 or older, he or she is usually a legal adult and must sign. Parents or other family members cannot authorize the release of another adult's records.

Address of Authorized Representative:
_____
_____
_____

Phone number: _____ E-Mail Address: _____

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EXECUTIVE DIRECTOR

REQUEST FOR EXTERNAL REVIEW AND RELEASE OF MEDICAL RECORDS

The Office of Patient Protection (OPP) will randomly assign your case to one of the four agencies with which it has contracts for external review: Independent Medical Expert Consulting Services, Inc. (IMEDECS), the Island Peer Review Organization (IPRO), Maximus Federal Services, Inc. (Maximus), or ProPeer Resources, Inc. (ProPeer). This form will authorize the release of medical records to the agency that will conduct the review. This authorization may be revoked at any time by writing to OPP, but information previously released in reliance upon the authorization will not be affected by the revocation.

I, _____, hereby request an external review of the matter described on page 3 of this application. I attest that the information provided in this application is true and accurate to the best of my knowledge.

I authorize my health care providers to release all relevant medical or treatment records related to the matter described in this request to the external review agency named by OPP to review my request. I understand that the external review agency will review my medical records to make its decision, and that without my authorization, the agency will be unable to review my request.

This release is valid for six months from _____ (today's date).

According to 958 CMR 11.22, an external review agency shall not release medical and treatment information or other information obtained as part of an external review, except to OPP or as otherwise authorized or required by law. I understand that the external review agency may not be covered by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the Massachusetts Fair Information Practices Act.

I understand that OPP may not be covered by federal privacy laws, and that OPP may be able to further share the information that is given to it. Note, however, that medical records are exempt from disclosure under the Massachusetts public records law (M.G.L. c. 4, § 7(26)(c)), and that OPP will not share your medical records with anyone without your written permission or unless otherwise required by law.

_____ _____

Signature of Patient or Legal Guardian* Date

* Specify if signed by parent, guardian, conservator or other: _____

Please note: If the patient is 18 or older, he or she is usually a legal adult and must sign. Parents or other family members cannot authorize the release of another adult's records.

PERMISSION ABOUT SPECIFIC HEALTH INFORMATION

Please write your initials and sign below to authorize the release of any of the following information:

_____I specifically give permission, as required by M.G.L. c. 111, § 70F, to release information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment, to the external review agency.
____I specifically give permission, as required by M.G.L. c. 111, §70G, to release information in my record about my genetic information to the external review agency.
____I specifically give permission to release information in my record about alcohol or drug treatment to the external review agency. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the re-disclosure of this confidential information.

_____ _____
Signature of Patient or Legal Guardian* Date

* Specify if signed by parent, guardian, conservator or other: _____
Please note: If the patient is 18 or older, he or she is usually a legal adult and must sign. Parents or other family members cannot authorize the release of another adult's records.

AUTHORIZATION TO REFER CASE TO ANOTHER STATE AGENCY

With your permission, OPP may refer this case, including medical records and medical information released by this authorization, to another relevant government agency as appropriate.

I understand that other state agencies may not be covered by federal privacy laws, and that they may be able to further share the information that is given to them. Note that medical records and medical information are exempt from disclosure under the Massachusetts public records law (M.G.L. c. 4, § 7(26)(c)).

Please check one of the following:
☐ YES, I give my permission to OPP to refer my case to another relevant government agency.
☐ NO, I do not give my permission to OPP to refer my case to another government agency.

_____ _____
Signature of Patient or Legal Guardian* Date

* Specify if signed by parent, guardian, conservator or other: _____
Please note: If the patient is 18 or older, he or she is usually a legal adult and must sign. Parents or other family members cannot authorize the release of another adult's records.

Complete this form only if you are requesting review of a claim for behavioral health services (includes mental health or substance use disorder treatment)

REQUEST FOR EXTERNAL REVIEW AND RELEASE OF PSYCHOTHERAPY NOTES

The Office of Patient Protection (OPP) will assign your case to one of four external review agencies: Independent Medical Expert Consulting Services, Inc. (IMEDECS), the Island Peer Review Organization (IPRO), Maximus Federal Services, Inc. (Maximus), or ProPeer Resources, Inc. (ProPeer). This form will authorize the release of psychotherapy notes to the agency that conducts the review. This authorization may be revoked at any time by writing to OPP, but information previously released in reliance upon the authorization will not be affected by the revocation.

I _____, hereby request an external review of the matter described on page 3 of this application.

I authorize my ACO/RBPO to release all relevant psychotherapy notes related to the matter described in this request to the external review agency named by OPP to review my request. I understand that the external review agency will review my medical records to make its decision, and that without my authorization, the agency will be unable to review my request.

This release is valid for six months from _____ (today's date).

I understand that the external review agency may not be covered by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the state Fair Information Practices Act. Note that according to 958 CMR 11.22, no external review agency or reviewer shall, except as specifically authorized by an appropriate release signed by a patient or representative authorized by law, release medical and treatment information or other information obtained as part of an external review, except to OPP and as otherwise authorized or required by law.

I understand that OPP may not be covered by federal privacy laws, and that OPP may be able to further share the information that is given to it. Medical records and information are exempt from disclosure under the Massachusetts public records law (M.G.L. c. 4, § 7(26)(c)), and OPP will not share your records with anyone without your written permission or unless otherwise required by law.

_____ _____

Signature of Patient or Legal Guardian* Date

* Specify if signed by parent, guardian, conservator or other: _____

Please note: If the patient is 18 or older, he or she is usually a legal adult and must sign. Parents or other family members cannot authorize the release of another adult's records

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CHAIR

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REQUESTS FOR EXPEDITED REVIEW

A patient may request an expedited external review where the patient believes there is an urgent medical need. The external review agency will decide whether there is a serious and immediate threat to the patient's health that necessitates an expedited review. If expedited, the external review agency will issue a final decision within 72 hours of receipt of the assignment from the Office of Patient Protection.

☐ I am requesting an expedited external review due to an urgent medical need.

If you checked the previous box, please explain the nature of the urgent medical need. Please describe the risk of serious harm to the patient (attach additional documents if needed):

_____

_____

_____

_____

_____

_____

_____

_____

_____

You may attach medical records to assist the External Review Agency in determining if the patient qualifies for an expedited external review.

☐ I am attaching medical records to this form.

[redacted]

Fax this completed form (Pages 2- 8) to 617-624-5046.