ALFRED W. GROSS
COMMISSIONER OF INSURANCE

P.O. BOX 1157
RICHMOND, VIRGINIA 23218
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206
http://www.scc.virginia.gov

STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

September 29, 2006

Administrative Letter 2006 - 14

TO: All Companies Operating One or More Managed Care Health Insurance Plans in Virginia and Interested Parties

RE: § 38.2-5900 of the Code of Virginia
***Rules Governing Independent External Review Of Final Adverse Utilization Review Decisions, 14 VAC 5-215-10*, et seq.**
Final Adverse Decision Letters

The purpose of this letter is to provide general guidance to companies operating Managed Care Health Insurance Plans (MCHIPs) in Virginia in the preparation of final adverse decision* letters. Through various regulatory oversight and consumer assistance functions, Bureau staff has reviewed many of these letters, and has received feedback from individuals impacted by final adverse decisions. While many of the letters are clear and straightforward in their presentation of information, some lack clarity or prominence in identifying important information.

While final adverse decision letters are not subject to prior approval by the Bureau, they are reviewed during market conduct examinations, during investigations of consumer complaints, and in connection with consumer assistance functions through the Offices of the Managed Care Ombudsman and External Appeals. We recognize that a standard form letter cannot be used to communicate effectively final adverse decisions. To the extent, however, that certain information can be standardized, made prominent and presented in a certain sequence, the Bureau is prepared to provide language for final adverse decision letters addressing these concerns. Companies that choose to adopt the format of presentation and *italicized* text described below can be assured that those portions of their final adverse decision letters that are consistent with this letter will be considered compliant by the Bureau. Final adverse decision letters may also include information beyond that which is addressed in this letter.

1. **All** final adverse decision letters must include the following information:

- A clear and concise identification of the decision and a statement that this is a final adverse decision.
- The criteria used to make the decision.
- The clinical reason for the decision.

- The following information concerning the Office of the Managed Care Ombudsman:

  If you have problems with or questions about your appeal rights, you may contact the Office of the Managed Care Ombudsman:

  Office of the Managed Care Ombudsman
  Bureau of Insurance
  P.O. Box 1157
  Richmond, VA 23218
  Telephone: 1-877-310-6560 (toll free)
  804-371-9032 (Richmond Metropolitan Area)
  E-Mail: Ombudsman@scc.virginia.gov

2. Final adverse decision letters that address decisions which qualify for an independent external review* must include information concerning the covered person's independent external review rights, in addition to the information identified in #1, above. Note, however, that information concerning a covered person's independent external review rights should NOT be included when a final determination is made which does not qualify for an independent external review. *

   The following suggested wording identifies specific required information for those decisions which qualify for an independent external review.

   As a covered person under a Managed Care Health Insurance Plan (MCHIP), issued in Virginia, you may submit a formal appeal of this decision to the State Corporation Commission's Bureau of Insurance, which administers an External Appeal Program to provide a fair and impartial review of appeals. To be eligible to file the appeal to the Bureau of Insurance, the actual cost to you of the service involved must exceed $300, and you must be covered under a fully-insured plan issued in Virginia. ***NOTE****: The appeal must be filed with the Bureau of Insurance within 30 days of the date of this letter, regardless of whether or not you intend to communicate or appeal further with [company] concerning the adverse decision.*

   Forms and related instructions for submitting an appeal request to the Bureau of Insurance are enclosed. A $50 filing fee should accompany your appeal request, however this fee may be waived or refunded if the payment of the fee will cause you undue financial hardship. If you would like to request a waiver of the fee, there is a designated space to provide the reason(s) for the fee waiver request in the attached appeal form.

   The ruling provided by the Commissioner of Insurance on your appeal will be in writing and will be final and binding on you and

> *[company] to the same extent that each would have been bound by a judgment entered in an action at law or in equity, and, except in the instance of fraud, may preclude your exercising any other right or remedy relating to the adverse decision.*

While this letter addresses requirements specifically applicable to final adverse decision letters, other communications from the MCHIP to the covered person must adhere to certain statutory requirements as well. We encourage all MCHIPs to review the Bureau's website regularly for more detailed compliance information relating to MCHIPs, or to contact the Bureau at the number below.

We appreciate your attention to this matter. Questions concerning this letter may be addressed to:

Julie Blauvelt
Senior Insurance Examiner
Bureau of Insurance
Life and Health Division
P.O. Box 1157
Richmond, VA 23218
Phone: 804-371-9865

Cordially,

Alfred W. Gross
Commissioner of Insurance

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* Final adverse decisions involving utilization review determinations, including those denials based on findings that care is not medically necessary or is experimental or investigational qualify for an independent external review and therefore should include the information in number 2, above. A final adverse decision includes any adverse utilization review determination resulting from an expedited appeal, or a decision to decline an expedited review in an alleged medical emergency situation, as well as a final adverse utilization review determination following completion of the internal appeal process. Decisions based upon clear contractual restrictions or exclusions <u>do not</u> qualify for an independent external appeal. Refer to Virginia Code § 38.2-5900 and 14 VAC 5-215-30, definitions of "covered person", "final adverse decision", and "utilization review" for more specific information.