

# STATE OF CONNECTICUT

## INSURANCE DEPARTMENT

Bulletin HC-89-13  
January 8, 2013

**TO: ALL HEALTH CARRIERS ISSUING HEALTH BENEFIT PLANS IN CONNECTICUT**

**RE: ANNUAL FILING REQUIREMENTS PURSUANT TO SECTION 38a-591b(e) OF THE CONNECTICUT GENERAL STATUTES**

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Section 38a-591b(e) of the Connecticut General Statutes requires that each health carrier offering a health benefit plan in Connecticut file, on or before March 1 annually, various information concerning its utilization review programs and grievance procedures in Connecticut. The purpose of this Bulletin is to outline what is to be filed and provide the format to be used in reporting all required information.

A health benefit plan is defined in Section 38a-591a(21) of the Connecticut General Statutes as an insurance policy or contract, certificate or agreement offered, delivered, issued for delivery, renewed, amended or continued in this state to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. The information requested is limited to fully insured plans issued or delivered in Connecticut that provide coverage of the type specified in subdivisions (1), (2), (4), (10), (11), (12) and (16) of Connecticut General Statute §38a-469, not specifically excluded by the Act.

1. For each **type** of health benefit plan offered in Connecticut, the carrier must provide data regarding the number and resolution of all grievances (medically necessary and not-medical information must be submitted in the format found in Attachment A. Please note, this information is now being asked of the carrier and not of any "carve out" company utilized by the carrier. The utilization review and grievance data submitted by the carrier must include data from all subcontracted entities. (For purposes of reporting, a "type" is considered one of the categories listed above Section 38a-469 of the Connecticut General Statutes.)

Pursuant to Section 38a-591a(20) ) of the Connecticut General Statutes, "Grievance" means a written complaint or, if the complaint involves an urgent care request, an oral complaint, submitted by or on behalf of a covered person regarding"

(A) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(B) Claims payment, handling or reimbursement for health care services; or

(C) Any matter pertaining to the contractual relationship between a covered person and a health carrier.

2. In addition, each carrier must file a certificate of compliance certifying that the utilization review program of the health carrier or its designee(s) complies with all applicable state and federal laws concerning confidentiality and reporting requirements.

Please reference Attachment B.

3. Finally, each carrier must provide 3 reports of its utilization review activities on a nationwide and Connecticut-only basis. The information must be submitted in the format found in Attachment C.

Please return the completed reports to the Connecticut Insurance Department, Life and Health Division at the following address:

Mailing address: P.O. Box 816  
Hartford, CT 06142-0816

Office address: 153 Market Street, 7<sup>th</sup> Floor  
Hartford, CT 06103

Electronic submissions: [cid.lh@ct.gov](mailto:cid.lh@ct.gov)

The office address must be used for all express or special delivery mail or for hand delivery of any documents.

Please contact the Life & Health Division at [cid.lh@ct.gov](mailto:cid.lh@ct.gov) with any questions.



Thomas B. Leonardi  
Insurance Commissioner

TBL:pl

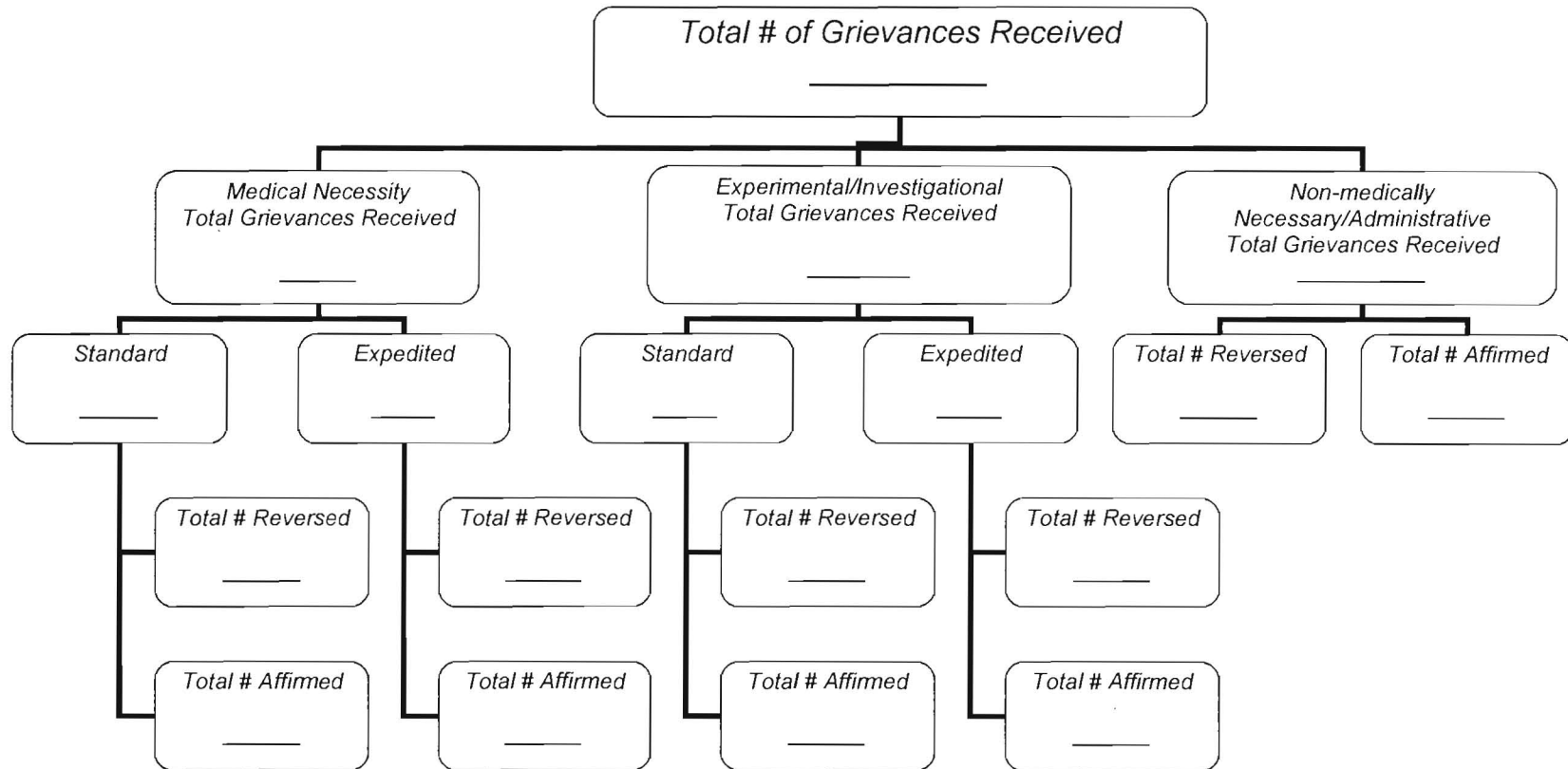
**Attachment A**

Company Name: \_\_\_\_\_

**2013 Report** (business of 2012) – Use separate sheet for each type of plan

Type of Plan:     Basic Hospital Expense             Basic Medical-Surgical Expense             Major Medical  
                          Limited Benefit                             Hospital or Medical Service Plan             HMO  
                          Single Service Ancillary Health Coverage

# of Covered Lives: \_\_\_\_\_



Company Name: \_\_\_\_\_

Type of Plan:     Basic Hospital Expense             Basic Medical-Surgical Expense             Major Medical  
                          Limited Benefit                             Hospital or Medical Service Plan             HMO  
                          Single Service Ancillary Health Coverage

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Number of Grievances appealed to the Commissioner: \_\_\_\_\_

Number of grievances referred to alternative dispute resolution procedures or resulting in litigation: \_\_\_\_\_

Actions being taken to correct any problems identified regarding grievances (attach separate sheet if necessary):  
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Person Completing Form \_\_\_\_\_

Telephone #: \_\_\_\_\_ e-mail address: \_\_\_\_\_

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**Attachment B**

**Certificate of Compliance**  
(To be signed by an officer of the company)

I, \_\_\_\_\_, \_\_\_\_\_  
(Printed Name) (Title)

hereby certify that the utilization review program conducted by \_\_\_\_\_ or its  
(Health Carrier)  
designee(s) is in compliance)with all applicable state and federal laws concerning confidentiality and reporting requirements.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

Subscribed and sworn to before me on this \_\_\_\_\_ day of \_\_\_\_\_, 2013.

\_\_\_\_\_  
Commissioner of Superior Court or Notary

\_\_\_\_\_  
Commission Expiration Date

## Attachment C

### Utilization Review Statistics Filing Instructions

Three statistical reports must be completed and returned to the Insurance Department **on or before March 1, 2013**. **PLEASE READ THESE INSTRUCTIONS CAREFULLY**, as significant changes have been made from prior years requirements. Failure to file in a complete, accurate or timely manner may result in regulatory action.

Reporting requirements are to be filed by the health carrier; filings by separate utilization review companies are no longer required. The statistics filed, therefore, must be a compilation of all utilization review activities conducted by, or on behalf of, the health carrier. In addition, please note that the definition of utilization review includes retrospective reviews.

One report requires the health carrier to report on the company's 2012 utilization review activities on both a nationwide (including Connecticut) and Connecticut only basis. This report should include all utilization review activities (including mental and nervous conditions) conducted. If the company conducts UR in Connecticut only, the same numbers should appear in both columns. The second report requires you to report utilization review activities for mental and nervous conditions only. The third and fourth reports require a breakdown of the mental/nervous statistics by type of services. If your company does not conduct utilization review for mental or nervous conditions, please enter "0" in each column. **Do not leave any column or box blank**. All forms must be completed and returned.

#### General

All statistics should be reported based upon the actual number of prospective, concurrent or retrospective requests for review. Please do not report cases based upon the number of treatments, hospital days or other activity measures.

Reported statistics are subject to on-site verification by the Insurance Department. Please report accurately and retain an audit trail of the records and sources used for preparing the report until further notice.

The Reports are due in the Insurance Department **no later than March 1, 2013**. Filing extensions cannot be granted. Failure to file in a complete or timely manner may result in regulatory action.

***All numbers should reflect utilization review activities conducted for enrollees of fully funded health benefit plans under the jurisdiction of the Insurance Commissioner.***

#### I. Total Number of Utilization Review Determinations Performed

This number is the total of requests received for medical necessity determinations i.e., each evaluation conducted for medical necessity, appropriateness, health care setting, level of care, effectiveness or experimental or investigational requests of the medical need for and the appropriateness of an admission, service, procedure or the extension of a stay or treatment.

## **II. Total Number of Adverse Determinations (denials)**

Determinations not to certify or approve are any denials of requests for admissions, services, procedures or the extension of a stay or treatment, based upon the failure of the requests to meet medical necessity requirements including denials on the basis that they involve treatments or procedures of an investigational or experimental nature should be reported in this statistic.

**Additionally, report in this number all revised certifications of providers' or enrollees' original requests for a determination, where the resulting revised certifications reduced the level or extent of care.** For example, approvals of reduced numbers of treatment days requested or approvals of outpatient treatment rather than requested hospitalization, should be reported as denials.

## **III. Total Number of Grievances (Appeals of Adverse Determinations Requested)**

Report all appeals requested of initial determinations not to certify.

## **IV. Total Number of Determinations Not To Certify Reversed after Grievance (Appeal)**

Report all grievances where the ultimate outcomes of such grievance were to reverse the original denial and approve certification of the original requests.

**State of Connecticut  
Insurance Department  
Report of Health Carrier Utilization Review Statistics  
Calendar Year 2012**

NAME OF COMPANY: \_\_\_\_\_

CONNECTICUT UR LICENSE #: \_\_\_\_\_

PREPARED BY: \_\_\_\_\_ TEL #: \_\_\_\_\_

e-mail address: \_\_\_\_\_

<b>Utilization review data must include utilization review performed by <u>all</u> companies that are sub-contracted, including carve-out services under contract with the Health Carrier for its enrollees.</b>	<b>Nationwide (including Connecticut)</b>	<b>Connecticut Only</b>
<i>Total Number of Utilization Review Determinations Performed</i>		
<i>Total Number of Adverse Determinations (denials)</i>		
<i>Total Number of Grievances (Appeals) of Adverse Determinations Requested</i>		
<i>Total Number of Determinations not to Certify <u>Reversed</u> on Appeal</i>		

List all companies and CT Utilization Review License numbers of all companies that are sub-contracted to perform any utilization review services for above named health carrier:

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**State of Connecticut  
Insurance Department  
Report of Health Carrier Utilization Review Statistics  
MENTAL/NERVOUS CONDITIONS ONLY  
Calendar Year 2012**

NAME OF COMPANY: \_\_\_\_\_

CONNECTICUT UR LICENSE #: \_\_\_\_\_

PREPARED BY: \_\_\_\_\_ TEL #: \_\_\_\_\_

e-mail address: \_\_\_\_\_

<b>Utilization review data must include utilization review performed by <u>all</u> companies that are sub-contracted, including carve-out services under contract with the Health Carrier for its enrollees.</b>	<b>Nationwide (including Connecticut)</b>	<b>Connecticut Only</b>
<i>Total Number of Utilization Review Determinations Performed</i>		
<i>Total Number of Adverse Determinations (denials)</i>		
<i>Total Number of Grievances (Appeals) of Adverse Determinations Requested</i>		
<i>Total Number of Determinations not to Certify <u>Reversed</u> on Appeal</i>		

