



STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Bulletin HC-89-14
January 13, 2014

TO: ALL HEALTH CARRIERS ISSUING HEALTH BENEFIT PLANS IN CONNECTICUT

RE: ANNUAL FILING REQUIREMENTS PURSUANT TO C.G.S. §38a-591b(e) and Connecticut Agencies Regulations §38a-591-5

C.G.S. §38a-591b(e) and Connecticut Agencies Regulations §38a-591-5 require 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 C.G.S. §38a-591a(21) 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 C.G.S. §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 in C.G.S. §38a-469.)

Pursuant to C.G.S. §38a-591a(20), "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:

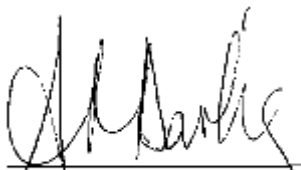
Mailing address: P.O. Box 816
Hartford, CT 06142-0816

Office address: 153 Market Street, 7th Floor
Hartford, CT 06103

Electronic submissions: 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 with any questions.



Anne Melissa Dowling
Deputy Commissioner

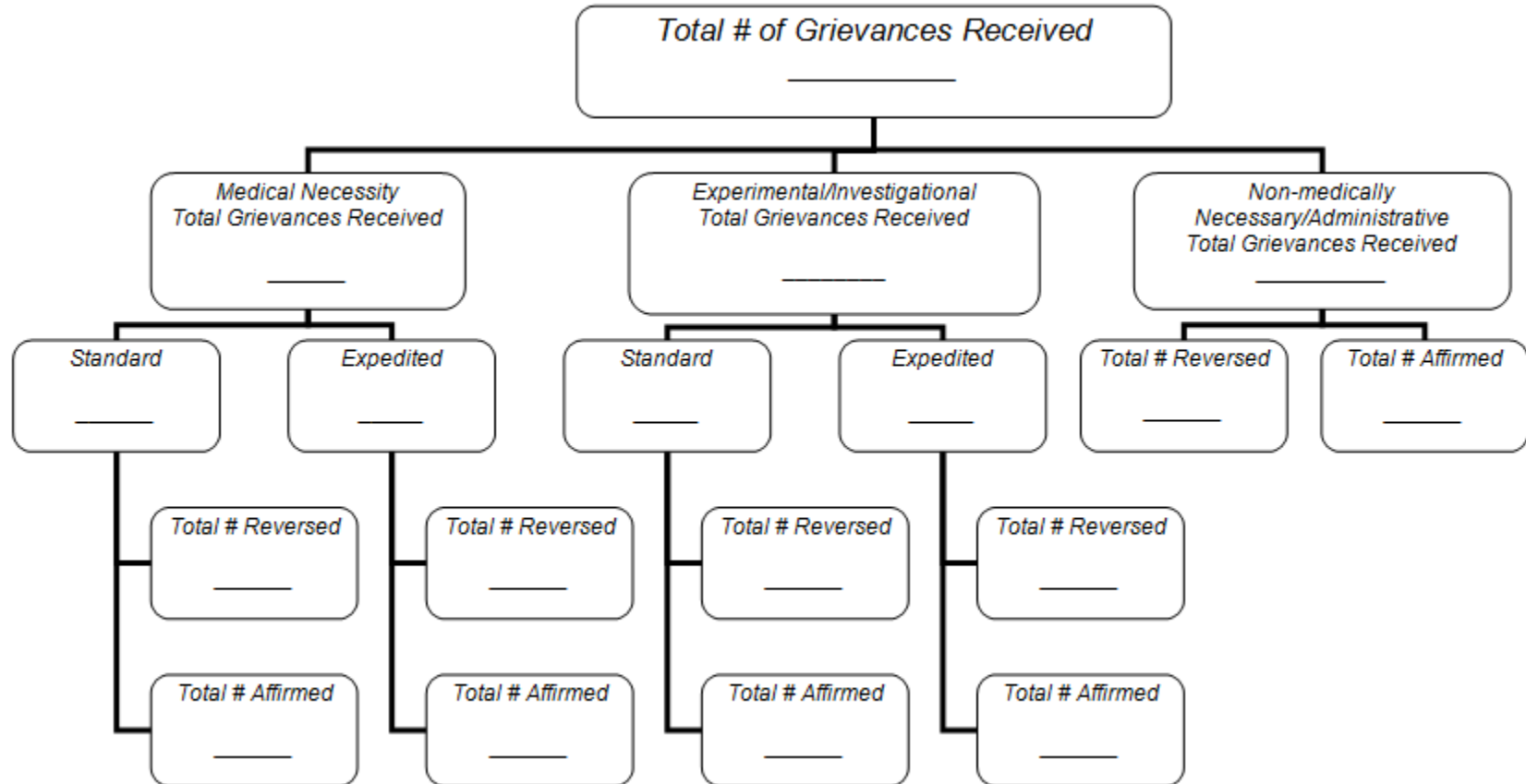
Attachment A

Company Name: _____

_____ **Report** (for business as of _____) – Use separate sheet for each type of plan
(current year) (prior calendar year)

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

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):

Person Completing Form _____

Telephone #: _____ e-mail address: _____

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 _____.

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 of each year**. **PLEASE READ THESE INSTRUCTIONS CAREFULLY.** 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 utilization review activities from the prior calendar year 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 report requires 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 of each year**. 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 XXXX**

NAME OF COMPANY: _____

CONNECTICUT UR LICENSE #: _____

PREPARED BY: _____ TEL #: _____

e-mail address: _____

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.	Nationwide (including Connecticut)	Connecticut Only
<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:

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

NAME OF COMPANY: _____

CONNECTICUT UR LICENSE #: _____

PREPARED BY: _____ TEL #: _____

e-mail address: _____

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.	Nationwide (including Connecticut)	Connecticut Only
<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>		

