



Michael D. Maves, MD, MBA, Executive Vice President, CEO

January 31, 2011

Kathleen Sebelius
Secretary
Department of Health and Human Services
Attention: OCH0-9998- IFC
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule

Dear Secretary Sebelius:

On behalf of the physician and medical student members of the American Medical Association (AMA), thank you for this opportunity to provide the Department of Health and Human Services (HHS) with comments and recommendations in response to the Interim Final Rule implementing medical loss ratio requirements for health insurance issuers under the Patient Protection and Affordable Care Act (ACA). During the health system reform debate, the AMA repeatedly expressed support for establishing greater transparency in the health insurance market. Premium transparency and medical loss ratio information are extremely valuable for patients. The AMA supports patients receiving the maximum value for the premiums they pay.

Support NAIC Recommendations

We applaud HHS for adopting the National Association of Insurance Commissioners' (NAIC) recommendations and for maintaining a strong medical loss ratio standard. The AMA worked closely with the NAIC, consumers, health insurers, and others during the task force process to ensure that the final recommendations meet the needs of consumers, physicians, and other key stakeholders. The final recommendations, which the NAIC Executive Committee adopted on October, 14, 2010, reflect an acceptable compromise. In particular, we applaud HHS for supporting NAIC's rigorous criteria for what may be defined, and therefore included in the numerator of the medical loss ratio, as "quality improvement" activities. The NAIC-adopted standards ensure that there is a strong nexus between patient benefit and what is defined as "quality," and that "administrative expenses" cannot be categorized as "quality." We urge HHS to retain this strong standard and to avoid broadening the standard to allow health insurers to include cost containment or other administrative expenses in this standard.

Quality Improvement Definitions

We commend HHS for including rigorous standards for how “quality improvement” and “administrative expenses” are defined. Without these criteria, there would be significant latitude for insurers to creatively categorize cost containment, contracting, marketing, and other administrative expenses as “quality improvement activities.” We support a strict interpretation of Section 2717 of ACA, which narrowly defines the criteria for what types of activities may be considered “quality improvement.”

We strongly support the Interim Final Rule’s requirement to exclude concurrent and retrospective utilization review from being considered “quality improvement.” We note that the Interim Final Rule allows for the portion of prospective utilization review that directly improves quality to be considered “quality improvement.” Specifically, the Preamble of the Interim Final Rule at page 7486 supports this inclusion “because it is rendered before care is given and can help ensure that the most appropriate medical treatment is given in the most appropriate setting.”

While we recognize the final language is a compromise, the AMA strongly believes that all utilization review activities, including prospective utilization review, should be excluded from any “quality improvement” category in the medical loss ratio. Prior authorization and other prospective utilization review programs are quintessential cost containment activities. Legislators and regulators throughout the country have felt it necessary to enact numerous protections for patients and physicians to reduce the likelihood that these programs cause serious harm. Attached is a summary of the strongest laws in this area, as well as a compendium of the full text of all relevant laws for your review (see Attachment A). The notion that these types of activities constitute “quality improvement” is belied by this mass of regulation.

If the narrowly defined category of prospective utilization review aimed at improving quality is to be included, then we strongly urge HHS to strictly regulate how insurers comply with this section. We urge HHS to rigorously monitor and regulate how insurers categorize these activities when reporting their medical loss ratios and set extremely strict enforcement standards against any insurers who attempt to exaggerate or miscategorize any expenses that do not directly improve quality, as defined under section 2717 of the ACA.

Agent and Broker Fees Commissions

We urge HHS to remain vigilant about excluding agent and broker fees and commissions from the medical loss ratio. We recognize that there is significant pressure from the agent and broker industry to include these in the medical loss ratio’s numerator, but broker fees and commissions are quintessential administrative costs; they do not constitute the provision of medical services or the provision of services to improve the quality of those medical services. Rather, broker fees and commissions are related to efforts to sell health insurance and assist purchasers of that insurance in their dealings with the health insurance company. Agent and broker fees and commissions do not meet the definitions for improving quality as listed under section 2717 of ACA. We support maintaining these fees and commissions as currently defined in section 158.160(b)(2) of the Interim Final Rule as non-claims expenses.

We also understand that some insurers may attempt to find creative ways to collect these fees and commissions from enrollees by not counting these expenses as premium revenue or administrative expenses. Insurers should not be allowed to use this end-run to earn more profits. Congress intended that commissions be included in the premiums. Premiums must include the amounts applied towards the commission. Failure to meet this standard should be considered a violation of the definition of “premium revenue” as found in section 158.130 and the definition of “non-claims costs” found in section 158.160.

State Level Aggregation

Near the end of the NAIC’s medical loss ratio deliberations, members of the insurance industry exerted significant pressure to allow national aggregation and reporting of health insurers’ medical loss ratios. We support the Interim Final Rule language rejecting national aggregation, and strongly support NAIC’s final recommendation for state-level aggregation. State level aggregation will ensure that insurers are regulated by the same state insurance commissioners that oversee their conduct and review their rate filings. Moreover, consumers of health insurance deserve to have meaningful and accessible medical loss ratio information when they compare health plans. While we would have preferred a requirement that medical loss information be reported by product line, state level reporting provides at least some level of transparency of this critical metric for consumers.

Flexibility for Individual Market Insurers

While we believe that all insurers should be held to the rigorous standards of the medical loss ratio, we understand that there may need to be flexibility for health insurers offering coverage in the individual market in order to protect market competition and affordability. For these reasons, we understand why sections 158.301–158.350 of the Interim Final Rule, dealing with states that request interim adjustments to the minimum medical loss ratio, were included. While we support a standard that maintains market competition, we urge HHS to strictly monitor and regulate this standard. HHS should mandate that any states that request flexibility support their requests with evidence that implementation of the statute as written would result in destabilization of the market, including information on whether any new entrants have applied for an insurance license and the status of those applications. We agree that if a state wants an exception, it must complete the process established by sections 158.340-158.345 for evaluating those requests. We also support a standard that requires public disclosure of a state’s adjustment request on the HHS website, and the opportunity for public response and a public hearing. We commend HHS for considering the effect of an adjustment on consumers when evaluating state adjustment requests (section 158.330).

Capitation

Section 158.140 addresses how the calculation of capitated payments is included in the medical loss ratio. The Interim Final Rule requires a report that must include direct claims paid to or

received by physicians and other health care providers, including under capitation contracts with physicians, whose services are covered by the policy for clinical services or supplies covered by the policy. As a general matter, the AMA recommends that capitated payments should be classified as provider payments, and thus inferred as medical expenses. All medical groups incur administrative costs and costs associated with quality improvement activities, which are necessary for them to provide medical care. The purpose of the medical loss ratio calculation is to measure how efficient a health insurer is in providing health insurance, not how efficient individual physician or other medical professional groups are in providing health care. Moreover, it should make no difference how the physician or other professional group is compensated by the health insurer for the services they provide. Payments to health care professionals for providing medical care to enrollees is a quintessential “medical loss.”

The only caveat to this conclusion involves those circumstances where the health insurer has delegated responsibility to a medical group for the processing and payment of claims. In such circumstances, the medical group is incurring administrative costs above and beyond the administrative costs ordinarily associated with the provision of medical care, but which are rather ordinarily associated with health insurers. In such cases, we believe that health insurers should be required to allocate a portion of the capitation payment which is equal to the claim’s adjudication expenses that the health insurer would have incurred had it not delegated the responsibility. This allocation should be both easily calculated and ensure that health insurers are neither encouraged nor discouraged from delegating claims processing responsibilities to medical groups based on medical loss ratio considerations.

Confidence Interval Ratio and Credibility Adjustment

The AMA applauds HHS for adopting the NAIC-recommended credibility adjustment requirements. Near the end of the NAIC deliberations, there was significant insurance industry pressure to increase the confidence interval ratio to 80 percent from the previously approved 50 percent. The AMA urged NAIC to retain the accepted industry standard of 50 percent to retain fair and consistent health insurance pricing. If this ratio had been increased, the incentive for health insurers to price at fair and reasonable levels would have been reduced. This would result in higher premiums because the rebate would have been reduced. Insurers are well aware of the fluctuation in results within their markets each year. As a result, insurers rarely set their rates to a level where they are 90 percent confident that they will not incur loss. Insurers are more likely to price to the 50 percent confidence level because it is reasonable and does not result in excessive adjustments to the calculated medical loss ratio with the credibility adjustment.

The 50 percent ratio fairly ensures that insurers and consumers are both treated fairly, insurers’ loss calculations are as accurate as possible, and rebates are provided when appropriate. The medical loss ratio with the 50 percent confidence interval ratio will force insurers to change the way they do business, including becoming more efficient and using a fair and more limited amount of premium for administrative expenses.

ICD-10

The AMA applauds HHS for not including ICD-10 expenses in the definition of “quality improvement.” ICD-10 related expenses are administrative and do not have a clear nexus to direct patient benefit. We note that on page 74877 of the Interim Final Rule, HHS has requested further input on how ICD-10 expenses should be allocated. The AMA welcomes the opportunity to work with HHS in developing solutions for updating current clinical quality measure specifications to incorporate ICD-10, as well as re-tool these measures for electronic health record capture. It is important to point out that quality measure maintenance is the responsibility of quality measure stewards, e.g., the AMA-convened Physician Consortium for Performance Improvement (PCPI)®, and the National Committee for Quality Assurance, not health insurance companies. Therefore, we urge HHS to be clear that insurers are not allowed to include, retrospectively or prospectively, the costs of updating quality measure specifications under their “quality improving activities.” As a whole, costs will be incurred by the entire health care system to smoothly transition to ICD-10. However, the staff and financial resources necessary to update current quality measure specifications will remain the primary responsibility of measure stewards.

Enforcement

The AMA urges HHS to strengthen the enforcement provisions of the Interim Final Rule. In order to ensure that insurers comply with medical loss ratio and transparency of premium information regulations, we recommend more vigorous enforcement provisions. The AMA recommends the following provisions:

- State Insurance Commissioners should require that each insurer is audited annually. If the audit shows that the insurer violated any part of the law, it will be subject to penalties and fines;
- If an insurer fails to comply with the reporting requirements of this law, or of any rules promulgated pursuant to the law, it will be subject to a fine of no less than \$1,000, and no more than \$10,000, per day of violation; and
- Any consumer, employer, or their representatives, shall be entitled to seek an injunction to enforce any obligation established by the law or any regulation promulgated under the law.

Conclusion

The AMA appreciates the opportunity to comment on the “Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and

Kathleen Sebelius

January 31, 2011

Page 6

Affordable Care Act; Interim Final Rule.” We look forward to working further with HHS on this important matter. Please contact Elizabeth Schumacher, Legislative Attorney, at elizabeth.schumacher@ama-assn.org or (312) 464-4783, for more information.

Sincerely,

A handwritten signature in black ink that reads "Mike Maves". The signature is written in a cursive style. To the right of the signature, there is a vertical red line.

Michael D. Maves, MD MBA

Attachment



This document is an excerpt from the AMA's National Managed Care Contract. The National Managed Care Contract represents the AMA's attempt to develop a managed care agreement provisions that comply with the legal requirements of all fifty states. The National Managed Care Contract, and the attached excerpt from that contract, have been copyrighted by the American Medical Association, 2009-2011.

Article XIII. Utilization review

13.1 Definitions. For the purpose of this Article XIII, the terms below are defined as follows.

13.1.1 "Adverse determination" means a determination by the MCO or an Authorized Payer that the health care services furnished, or proposed to be furnished, to a Subscriber by an MPP are not medically necessary or appropriate and therefore that the MCO or the Authorized Payer will deny, reduce, or terminate payer for those services.¹

13.1.2 "Appeal" means a request by an MPP to the MCO or an Authorized Payer that the MCO or Authorized Payer will reconsider an adverse determination.²

13.1.4 "Expedited appeal" means an accelerated appeal of an adverse determination involving urgent health care services.³

13.1.5 "Health care service" means a health care procedure, treatment, or service

(i) provided by a facility licensed in (indicate the name of the state); or

(ii) provided by doctor of medicine, doctor or osteopathy, or health care professional licensed in (indicate the name of the state).

The term "health care service" also includes the provision of pharmaceutical products or services or durable medical equipment.⁴

13.1.6 "Preauthorization" or "preauthorizes" means a determination by the MCO or an Authorized Payer that proposed health care services are medically necessary and appropriate and that the MCO or Authorized Payer will pay the MP Professional for providing those health care services.⁵

"Preauthorization" or "preauthorizes" includes circumstances in which the MCO or an Authorized Payer requires an MP Professional to notify the MCO or Authorized Payer prior to the MP Professional's provision of a health care service to a Subscriber.⁶

¹ KRS § 304.17A-600(1)(a)

² Miss. Admin. Code 15-6-30:102

³ MT ARM 37.108.301(1)

⁴ McKinney's Insurance Law § 4900(e)(1)(A)

⁵ O.R.S. § 743.801(12); Or. Admin. r. 836-053-1200(1); V.T.C.A., Insurance Code § 843.347(a); 28 TAC § 19.1703(39); OR ST § 743.837(1) and (2); 28 TAC § 19.1703(29); V.T.C.A., Insurance Code § 1301.133(a)

⁶ V.T.C.A., Insurance Code § 843.347(a); 28 TAC § 19.1703(39); OR ST § 743.837(1) and (2)

13.1.7 "Preauthorization review" means a review, for payment purposes, of the medical necessity and appropriateness of a proposed health care service.⁷

13.1.8 "Retrospective review" means a review, for payment purposes, of the medical necessity and appropriateness of a health care service provided to a Subscriber that is performed for the first time subsequent to the completion of such health care service.⁸

13.1.9 "Urgent health care service" means a health care service with respect to which the application of the time periods in this Article for making preauthorizations or adverse determinations concerning nonurgent health care services:

- (1) could seriously jeopardize the life or health of the Subscriber or the ability of the Subscriber to regain maximum function; or
- (2) would, in the opinion of an MP Professional with knowledge of the Subscriber's medical condition, subject the Subscriber to severe pain that cannot be adequately managed without the health care service that is the subject of the utilization review.

"Urgent health care service" includes all requests for hospitalization and outpatient surgery.⁹

13.1.10 "Utilization review" means the evaluation of the medical necessity and appropriateness of a health care service, and includes both preauthorization review and retrospective review.¹⁰

13.1.11 "Written clinical criteria" means the written policies, written screening procedures, drug formularies or lists of covered drugs, decision rules, decision abstracts, clinical protocols, and practice guidelines, used by the MCO or an Authorized Payer to determine the medical necessity and appropriateness of a health care service, including those used to determine if a health care service is experimental or investigational.¹¹

13.2 MCO's and Authorized Payers' disclosure obligations

13.2.1 Obligation to disclose written clinical criteria. On the written request of an MP Professional, the MCO or an Authorized Payer will provide one (1) copy of the specific written clinical criteria to be used in conducting utilization review and any subsequent revisions, modifications, or additions to the specific written clinical criteria, to the MP Professional.¹²

13.2.2 Obligation to disclose list of health care services requiring preauthorization. If an MCO or Authorized Payer requires preauthorization for health care services, the MCO or Authorized Payer must provide to a requesting MPP a list of all health care services for which the MCO or Authorized Payer requires preauthorization and information concerning the preauthorization process. The MCO or Authorized Payer must provide this information no later than the 10th business day after the date the MPP's request is received.¹³

13.3 Available personnel. A registered professional nurse or physician shall be immediately available by phone seven days a week, 24 hours a day, to render utilization review determinations for MP Professionals.¹⁴

⁷ O.R.S. § 743.801(12); Or. Admin. r. 836-053-1200(1)

⁸ F.S.A. § 641.47(15); Tex. Admin. Code tit. 28, § 19.1703

⁹ KRS § 304.17A-600(17)(a) and (b)

¹⁰ 215 ILCS 134/10; 50 Ill. Adm. Code 5420.30

¹¹ M.S.A. § 62M.02(8); (MO 376.1350(6); Miss. Admin. Code 15-6-30:102.18; NC 58-50-61(2); CT § 38a-478e(a); FL § 641.47(4); MA M.G.L.A. 1760 § 1; 105 CMR 128.020; 211 CMR 52.03; LSA-R.S. 22:1122(8)

¹² MD Code, Insurance, § 15-10B-05(c); NJ:24A-4.14(c); OR 743.807(2)(a); Cal Health & Saf Code § 1363.5(a)

¹³ 28 TAC § 19.1723(b)

¹⁴ N.J.A.C. § 11:24-8.2(a); N.M.A.C. § 13.10.22.9(C)(1).

13.4 Requirements applicable to MCO's or an Authorized Payer's request for information from an MP Professional for the purposes of performing utilization review.

13.4.1 Limitations on information requests generally. When performing utilization review, MCO and Authorized Payers may request from an MP Professional only information that is necessary to make the determination.¹⁵

13.4.2 Limitations on requests for medical records generally. When performing utilization review, MCO and Authorized Payers shall not routinely request copies of medical records of all patients reviewed.¹⁶

13.4.3 Additional limitations on requests for medical records. When performing utilization review, the MCO or Authorized Payer may only request only those portions of medical records that are relevant and necessary to perform the utilization review.¹⁷

13.4.4 Reasonable reimbursement for medical records. The MCO and Authorized Payers will reimburse MP Professional for the reasonable costs of MP Professional providing medical records to MCO and Authorized Payers for the purposes of utilization review.¹⁸

13.5. Deadlines applicable to preauthorization requests concerning nonurgent health care services.

13.5.1 Preauthorizations and adverse determinations must be made within two days of receipt of all necessary information. If the MCO or an Authorized Payer requires preauthorization of a health care service, and the health care service is not an urgent health care service, MCO or the Authorized Payer must preauthorize, or make an adverse determination concerning, the health care service within two (2) working days of obtaining all necessary information regarding the health care service from the MP Professional.

13.5.2 Deadline within which the MCO or an Authorized Payer must notify the MP Professional of a preauthorization or adverse determination concerning a nonurgent health care service. The MCO or an Authorized Payer must notify the MP Professional of a preauthorization, or adverse determination concerning, a nonurgent health care service by telephone, and provide the MP Professional with written or electronic confirmation of the telephonic notification, within two (2) days from the date on which the MCO or Authorized Payer preauthorized, or made an adverse determination concerning, the health care service.¹⁹

13.6 Deadlines applicable to preauthorization requests concerning urgent health care services.

13.6.1 Deadline within which the MCO or an Authorized Payer must notify an MP Professional of a decision to preauthorize, or make an adverse determination concerning, an urgent health care service relating to the extension of an ongoing course of treatment. The MCO or an Authorized Payer must preauthorize, or make an adverse determination concerning, an urgent health care service relating to the extension of an ongoing course of treatment, including but not limited to a Subscriber's continued hospitalization, and notify the MP Professional of the preauthorization or adverse determination, within 24 hours of receiving a preauthorization request from an MP Professional concerning such health care service.²⁰

¹⁵ 215 ILCS 134/85(e)(4); McKinney's Public Health Law § 4905(7); Cal Ins Code § 10123.135(g); Cal Health & Saf Code § 1367.01(g); 28 TAC § 19.1708(c);

¹⁶ McKinney's Public Health Law § 4905(7); (MN) M.S.A. § 62M.04(2)(b); Miss. Admin. Code 15-6-30:106.02(3); Wash. Admin. Code 284-43-410(3)(d); 28 TAC § 19.1708(c)(2)

¹⁷ 215 ILCS 134/85(e)(4); McKinney's Insurance Law § 4905(g); McKinney's Public Health Law § 4905(7); Wash. Admin. Code 284-43-410(3)(e)

¹⁸ WAC 284-43-410(4)

¹⁹ ME ADC 02-031 Ch. 850, § 8(E)(2); MO 376.1363(2); OR 743.807(d)

²⁰ KY KRS § 304.17A-607(1)(i); NH Rev. Stat 420-E:4(IV)(b); 28 TAC § 19.1723(d)(2)

13.6.2 Deadline within which the MCO or an Authorized Payer must notify an MP Professional of a decision to preauthorize, or an adverse determination concerning, urgent care services other than those described in section 13.6.1. For urgent health care services not described in section 13.6.1, the MCO or an Authorized Payer must notify the MP Professional of a preauthorization or adverse determination within seventy-two (72) hours of receiving all necessary information from the MP Professional.²¹

13.7 MCO's and Authorized Payers' obligations specific to authorization notifications.

13.7.1 Obligation to provide a confirmation number. If the MCO or an Authorized Payer authorizes a health care service, the MCO or the Authorized Payer must issue a confirmation number to the MP Professional as part of the notification to the MP Professional.²²

13.7.2 Requirements applicable to notifications of authorizations concerning extended stays in a health care facility. If the MCO or an Authorized Payer preauthorizes a Subscriber' extended stay in a health care facility, the written notification of the preauthorization must include the total number of extended days that are authorized, the date on which the next preauthorization must be requested, if applicable, and the date of admission.²³

13.7.3 Specification of authorized services. If an MCO or an Authorized Payer authorizes health care services, the authorization must specify the health care services that are authorized.²⁴

13.8 MCO's and Authorized Payers' obligations with respect to the validity and effect of preauthorizations.

13.8.1 Validity of preauthorizations. Preauthorizations must be valid for thirty (30) days, or such longer time as specified in the preauthorization.²⁵

13.8.2 Preauthorizations are binding. If the MCO or an Authorized Payer preauthorize a health care service, the MCO or Authorized Payer may not deny or reduce payment to the MP Professional, or rescind or modify the preauthorization, if the MP Professional provides the preauthorized health care service to a Subscriber on or before the 30th day after the date on which the MCO or the Authorized Payer issued the preauthorization. The binding effect of a preauthorization is unaffected by any subsequent rescission, cancellation, or modification of the Subscriber's Benefit Plan or insurance policy.²⁶

13.9 MCO's and Authorized Payers' obligations with respect to emergency health care services.

13.9.1 Payment for emergency health care services. The MCO or an Authorized Payer will pay the MP Professional for the MP Professional's provision of emergency health care services that are necessary to screen and stabilize a Subscriber as required by applicable state and federal legal requirements.²⁷

13.9.2 Prohibition against requiring preauthorization for emergency services. The MCO and Authorized Payers will not require preauthorization for emergency health care services.²⁸

²¹ RI Statutes 23-17.12-9(a)(1)(ii)

²² MO 20 CSR 700-4.100(6)(F); MO 376.1361(12)

²³ M.G.L.A. 1760 § 12(c); 211 CMR § 52.08(5)(a); ME 02-031 CMR Ch. 850, § 8(E)(3)(a); MO V.A.M.S. 376.1363(3)(1); Wash. Admin. Code § 284-43-410(5)(d); Miss. Admin. Code § 15-6-30:106.05(4)(b)

²⁴ Cal Ins Code § 10123.135(h)(4); Cal Health & Saf Code § 1367.01(h)(4)

²⁵ V.T.C.A., Insurance Code § 843.347(e); V.T.C.A., Insurance Code § 1301.133(e)

²⁶ Cal Health & Saf Code § 1371.8; Cal Ins Code § 796.04

²⁷ ND Statute 26.1-26.4-04(9)(a); MO 376.1367(1); 28 CCR 1300.71.4(a) and (b)(3); Cal Health & Saf Code § 1371.4(b)

²⁸ ND Statute 26.1-26.4-04(9)(a); MO 376.1367(1)

13.9.3 Certification by MP Professional constitutes prima facie evidence of the medical necessity and appropriateness of emergency health care services. If an MP Professional certifies in writing to the MCO or an Authorized Payer within seventy-two (72) hours of a Subscriber's emergency admission to a hospital that the admission was medically necessary and appropriate, that certification will constitute prima facie evidence of the medical necessity and appropriateness of that admission. In order to overcome this prima facie evidence, the MCO or Authorized Payer must establish by clear and convincing evidence that the Subscriber's admission was not medically appropriate and necessary.²⁹

13.10 MCO's and Authorized Payers' obligations with respect to retrospective review.

13.10.1 Deadlines applicable to retrospective reviews. For retrospective review determinations, the MCO or an Authorized Payer must make a determination concerning whether or not the MCO or Authorized Payer will pay or render an adverse determination with respect to, the health care services under review within 30 days of receiving all information from the MPP necessary to perform the retrospective review.³⁰

13.10.2 Scope of retrospective review limited. If the MCO or an Authorized Payer undertakes retrospective review of a health care service, the review must be based solely on the medical information available to the MP at the time the MP provided the health care service.³¹

13.11 MCO's and Authorized Payers' obligations concerning adverse determinations generally.

13.11.1 Good faith obligation to obtain information. The MCO and Authorized Payers will not make an adverse determination unless the MCO or Authorized Payer has made a good faith attempt to obtain all necessary information from the MP Professional.³²

13.11.2 Consultation prior to issuing an adverse determination. Prior to issuing an adverse determination, if the MCO or an Authorized Payer is questioning the medical necessity or appropriateness of a health care service, the physician performing the utilization review must, if requested by the attending MP Professional, discuss by telephone the medical necessity or appropriateness of the health care service with the attending MP Professional prior to rendering an adverse determination.³³

13.12 Requirements applicable to the personnel making adverse determinations.

13.12.1 Only a state-licensed physician may make an adverse determination. Only a physician possessing a current and valid non-restricted license to practice medicine in the state in which the health care service has been, or is proposed to be, provided, may make an adverse determination concerning the health care service.³⁴

13.12.2 Board certification/eligibility required. Only a physician who is board certified or eligible in the same or similar specialty as the health care provider who typically manages the Subscriber's medical condition or disease or provides the health care service under review may make an adverse determination

²⁹ Miss. Admin. Code 15-6-30:106.06 and 106.107

³⁰ Code Me. R. 02-031 Ch. 850, § 8(E)(b); R.C. § 1751.81(E); N.C.G.S.A. § 58-50-61(g); McKinney's Insurance Law § 4903(d); McKinney's Public Health Law § 4903(4)

³¹ 215 ILCS 134/85(e)(3); Wash. Admin. Code 284-43-410(3)(g)

³² VA § 32.1-137.13(B)

³³ Miss. Admin. Code 15-6-30:112.03 and 112.04; Ga Comp. R. & Regs. 120-2-58-.05(6)(a); NJAC § 11:24-8.3(b); 28 TAC § 19.1711

³⁴ NY 4900(b)(1)(A); West's F.S.A. § 641.51(4); Miss. Code Ann. § 41-83-31(a); Ala.Code 1975 § 27-3A-5(a)(4)(

concerning that health care service.³⁵

13.13 Requirements applicable to written or electronic notifications of adverse determinations. Written or electronic notifications of adverse determinations must:

(1) include a substantive clinical justification for the adverse determination that is consistent with generally accepted principals of professional medical practice and the written clinical criteria;³⁶

(2) discuss the Subscriber's presenting symptoms or condition, diagnosis, treatment interventions, and the specific reasons such medical evidence fails to establish that the health care service subject to utilization review is medically necessary and appropriate under the relevant written clinical criteria;³⁷

(3) specify any alternative treatment option offered by the MCO or Authorized Payer;³⁸

(4) if the MCO or Authorized Payer relied on an internal rule, guideline, protocol, clinical practice guideline, other written clinical criteria, or policy or plan provision, in making the adverse determination:

(i) include a statement that such internal rule, guideline, protocol, clinical practice guideline, other written clinical criteria, or policy or plan provision was relied on in making the adverse determination; and

(ii) recite the terms of the internal rule, guideline, protocol, clinical practice guideline, other written clinical criteria, or policy or plan provision;

(iii) include a copy of the internal rule, guideline, protocol, clinical practice guideline, other written clinical criteria, or policy or plan provision free of charge to the MP or MP Professional;

(iv) describe how the internal rule, guideline, protocol, clinical practice guideline, other written clinical criteria, or policy or plan provision applies to the Subscriber's specific medical circumstances;³⁹

(5) inform the MP Professional that the MP Professional may request a copy of any report developed by personnel performing the utilization review that led to the adverse determination, and, if requested, the MCO or Authorized Payer must ensure that a copy of that report is mailed to the MP Professional within fifteen (15) days after receipt of the request for the report;⁴⁰

(6) notify the MP Professional of the MP Professional's right to apply for internal and external review (where appropriate under applicable state legal requirements) of the adverse determination, and describe the MCO's or Authorized Payer's appeal procedures, the time limits applicable to such procedures, and to appeal an adverse determination;⁴¹

³⁵ Md. INSURANCE Code Ann. § 15-10B-07(a)(1); Ala.Code 1975 § 27-3A-5(a)(4)(a)

³⁶ M.G.L.A. 176O § 12(d); 211 CMR 52.08(6)

³⁷ M.G.L.A. 176O § 12(d); 211 CMR 52.08(6)(b)

³⁸ M.G.L.A. 176O § 12(d); 211 CMR 52.08(6)(c)

³⁹ M.G.L.A. 176O § 12(d); 211 CMR 52.08(6)(d); N.H. Rev. Stat. § 415-A:4-a(I)(c)(3)(B); N.H. Rev. Stat. § 420-E:4(V)(b)(3)(B); N.H. Rev. Stat. § 420-E:4(V)(b)(1); N.H. Rev. Stat. § 415-A:4-b(V)(a)(1); N.H. Rev. Stat. § 415-A:4-a(c)(1); 29 C.F.R. § 2560.503-1(g)(1)(v)(A); 28 CCR 1300.68(d)(4); Cal Ins Code § 10123.135(f)(2)(D); Cal Health & Saf Code § 1363.5(b)(4)

⁴⁰ 36 Okl. St. § 6558(9)

⁴¹ N.H. Rev. Stat. § 415-A:4-a(I)(c)(2); N.H. Rev. Stat. § 420-E:4(V)(b)(2); Ark. Admin. Code 007.05.5-4(J); Code Me. R. 02-031 Ch. 850, § 8(E)(5); 29 C.F.R. § 2560.503-1(g)(1)(iv)

(7) contain a statement that the MPP has a right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act to challenge an adverse determination that is upheld on appeal;⁴²

(8) include the contact name, address, and telephone number of the person or entity responsible for coordinating an appeal of the adverse determination;⁴³

(9) contain the contact name, address, and telephone number of the physician responsible for making the adverse determination, and, if the adverse determination was made by a medical director, specify the medical director's board status, if any, and indicate all states in which the medical director is currently licensed;⁴⁴ and

(10) be signed by the medical director of the MCO or Authorized Payer that made or oversaw the adverse determination, and the signature must contain the name, title, state of licensure and license number of the medical director.⁴⁵

13.14 Requesting an appeal of an adverse determination

13.14.1 Appealing an adverse determination. MP Professional may request an appeal of an adverse determination.

13.14.2 Requirements applicable to expedited appeals

13.14.2.1 Telephonic basis. An MP Professional may request an expedited appeal of an adverse determination orally.⁴⁶

13.14.2.2 Basis for expedited appeal. An MP Professional may request an expedited appeal of an adverse determination involving: (1) continued or extended health care services for a Subscriber undergoing a course of treatment prescribed by the MP Professional; or (2) an adverse determination in which the MP Professional believes an expedited appeal is warranted.⁴⁷

13.14.2.3 Non-challengability of MP Professional's request for expedited review. If the MP Professional determines that an expedited review of an adverse determination is warranted pursuant to section 13.14.2.2, neither the MCO nor an Authorized Payer may challenge the MP Professional's determination concerning the need for the expedited review.⁴⁸

13.14.2.4 Expeditious transmission of information. To effectuate the expedited appeal, all necessary information, including the appeal decision described in section 13.16.1, must be transmitted between the MCO or Authorized Payer and the MP Professional by telephone, facsimile, or other available similarly expeditious method.⁴⁹

13.15 Requirements applicable to personnel who may review appeals of adverse determinations.

⁴² 29 C.F.R. § 2560.503-1(g)(1)(iv)

⁴³ Va Code Ann. 32.1-137.13(A)

⁴⁴ Va. Code Ann. § 32.1-137.13(A); West's F.S.A. § 641.51(4)

⁴⁵ 806 Ky. Admin. Regs. 17:230(8); 806 Ky. Admin. Regs. 17:230(4)(2)(a); 806 Ky. Admin. Regs. 17:230(5)

⁴⁶ Ark. Admin. Code 007.05.5-4(E); Miss. Admin. Code 15-6-30:108.01; 29 C.F.R. § 2560.503-1(h)(3)(vi)(A); 28 CCR 1300.68.01(a)(1)

⁴⁷ NY CLS Ins § 4904(b); NY CLS Pub Health § 4904 (2)(b)

⁴⁸ A.R.S. § 20-2534(A); 29 C.F.R. § 2560.503-1(m)(iii)

⁴⁹ 29 C.F.R. § 2560.503-1(h)(3)(vi)(B)

13.15.1 All reviews of adverse determinations must be performed by a review committee, the majority of which must be physicians. The review of the adverse determination must be performed by a review committee composed of at least three persons.⁵⁰ A majority of the review committee members must be physicians, and any nonphysician members of the review committee must be health care providers.⁵¹

13.15.2 Qualifications of review committee members.

13.15.2.1 Qualifications of physician members of the review committee. The physician members of the review committee must:

- (1) possess a current and valid non-restricted license to practice medicine in the state in which the health care service under appeal has been, or is proposed to be, provided;⁵²
- (2) be board certified or board eligible in the same or similar specialty as the health care provider who typically manages the Subscriber's medical condition or disease or provides the health care service that is under appeal;⁵³
- (3) have been practicing in such area of specialty for a period of at least five years;⁵⁴
- (4) be knowledgeable about the health care service that is under appeal;⁵⁵
- (5) not be a subordinate of the physician who made the adverse determination;⁵⁶
- (6) not be employed by, or a director of, the MCO or an Authorized Payer.⁵⁷

13.15.2.2 Qualifications of nonphysician members of the review committee. A nonphysician member of the review committee must:

- (1) possess a current and valid non-restricted license, certificate or registration from the state in which the health care service under appeal has been, or is proposed to be, provided;⁵⁸
- (2) where applicable, be credentialed by a national accrediting body in the same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service that is under appeal;⁵⁹
- (3) have been practicing in such area of specialty for a period of at least five years;⁶⁰
- (4) be knowledgeable about the health care service that is under appeal;⁶¹

⁵⁰ 40 P.S. Section 991.2161(c)(1)

⁵¹ N.C.G.S.A. 58-50-62(e)(2); McKinney's Insurance Law § 4900(b)(2) and McKinney's Insurance Law § 4904(d); V.A.M.S. § 376.1385(1)(3)

⁵² C.G.S.A. § 38a-226c(7); N.C.G.S.A. 58-50-61(j)

⁵³ McKinney's Insurance Law 4900(b)(2)(A); La. Admin Code. tit. 32, pt. III, § 503(B)(1); N.D.C.C. 26.1-26.4-04(10); N.D. Admin. Code § 45-06-10-02

⁵⁴ McKinney's Insurance Law § 4900(b)(2)(A)

⁵⁵ NY McKinney's Insurance Law § 4900(b)(2)(A)

⁵⁶ 29 C.F.R. § 2560.502-1(h)(3)(ii)

⁵⁷ Va. Code Ann. § 32.1-137.15(B)

⁵⁸ McKinney's Insurance Law 4900(b)(2)(B)(i)

⁵⁹ McKinney's Insurance Law 4900(b)(2)(B)(ii)

⁶⁰ McKinney's Insurance Law 4900(b)(2)(B)(iii)

⁶¹ McKinney's Insurance Law 4900(b)(2)(B)(iv)

(5) where applicable to such health care provider's scope of practice, be clinically supported by a physician who possesses a current and valid non-restricted license to practice medicine in the state in which the health care service under appeal has been, or is proposed to be, provided;⁶²

(6) not be a subordinate of the physician who made the adverse determination;⁶³

(7) not be employed by, or a director of, the MCO or an Authorized Payer.⁶⁴

13.15.3 Prior uninvolvement of review committee members required. Review committee members must not have been involved in making the adverse determination.⁶⁵

13.15.4 Conflict of interest prohibited. Committee members must not have a financial interest in the outcome of the appeal.⁶⁶

13.15.5 Rights of an MP Professional during the appeal process

13.15.5.1 MP Professional's right to appear in person before the review committee. The MP Professional will have the right to appear in person before the review committee.⁶⁷ However, the MP Professional's right to a full and fair review concerning the adverse determination will not be conditioned on the MP Professional's appearance at the review meeting.⁶⁸ In cases in which the MP Professional cannot appear in person, which may include, but is not limited to, an expedited appeal, the MCO or Authorized Payer will offer the MP Professional the opportunity to communicate with the review committee, at the review committee's expense, by conference call, video conferencing, or other available technology.⁶⁹

13.15.5.2 Location of the review committee meeting. If the MP Professional requests an in-person meeting with the review committee, that meeting must be held during regular business hours at a location reasonably accessible to the MP Professional.⁷⁰

13.15.5.3 MP Professional's right to obtain information without charge. The MCO or Authorized Payer must ensure that, upon request by an MP Professional, MP Professional will without charge be given reasonable access to, and copies of, all documents, records, and information that are relevant to the adverse determination. Such documents, records, and information will include, but will not be limited to, information that was considered when the adverse determination was made.⁷¹

13.15.5.4 MP Professional's right to submit materials that support the MP Professional's position with regard to the adverse determination. The MP Professional will have the right to submit to the review committee written comments, documents, records, and other information relating to the appeal that support the MP Professional's position concerning the adverse determination. Such written comments, documents, records, and other information may be submitted before, during, and after the MP Professional meets with the review committee.⁷² The MP Professional may submit these written

⁶² McKinney's Insurance Law 4900(b)(2)(B)(v); NC 58-50-61(j);

⁶³ 29 C.F.R. § 2560.503-1(h)(3)(ii)

⁶⁴ Va. Code Ann. § 32.1-137.15(B)

⁶⁵ NC 58-50-62(e)(2); ME 02-031 CMR Ch. 850, § 8(G)(1)(b); V.A.M.S. 376.1385(1)(3); 11:24-8.6(a) and (b); VA § 32.1-137.15(B); West's F.S.A. § 641.511(4)(b);

⁶⁶ N.C.G.S.A. 58-50-62(f)(2)

⁶⁷ N.C.G.S.A. § 58-50-62(f)(1)(b)

⁶⁸ NC 58-50-62(g)(3)

⁶⁹ NE 44-7309(3)(a); LSA-R.S. 22:1131(D)(1); 3 Colo. Code Regs. 702-4:4-2-17(11)(G)(3); NC 58-50-62(g)(3)

⁷⁰ LSA-R.S. 22:1131(D)(1); 3 Colo. Code Regs. 702-4:4-2-17(11)(G)(3).

⁷¹ NH 420-J:5(I)(e); NC 58-50-62(f); 29 C.F.R. § 2560.503-1(h)(2)(iii)

⁷² NC 58-50-62(f)(1)(b);

materials without regard to whether those materials were considered when the adverse determination was made.⁷³

13.15.5.5 MP Professional's right to present or provide testimony. The MP Professional will have the right to provide testimony to the review committee in person and in writing via affidavit.⁷⁴

13.15.5.6 MP Professional's right to pose questions during the review committee meeting. The MP Professional will have the right to ask questions of any member of the review committee during the review committee meeting.⁷⁵

13.15.5.7 MP Professional's right to legal representation. The MP Professional will have the right to be assisted or represented by an attorney during the appeal process.⁷⁶

13.15.5.8 Scheduling of review committee meeting involving an adverse determination that is not the subject of an expedited appeal. If the MP Professional requests a nonexpedited appeal of an adverse determination, the review committee must schedule and hold a meeting concerning the appeal within 45 working days of receiving the request. The MCO or Authorized Payer must provide the MP Professional with written notice of the time and place of the meeting. Such notice must be given to the MP Professional at least 15 business days in advance of the review meeting.⁷⁷

13.15.5.9 De novo proceeding. The review committee must consider all information, documentation, or other material submitted or presented in connection with the appeal without regard to whether such information was submitted or considered in when the adverse determination was made.⁷⁸ The MCO's or Authorized Payer's review of the appeal must be performed without deference to the adverse determination.⁷⁹

13.16 Deadlines within which appeal decisions and notifications concerning appeal decisions must be made.

13.16.1 Deadlines applicable to expedited appeal decisions.

13.16.1.1 Decision no later than one (1) business day from receipt of appeal. All decisions concerning expedited appeals must be made no later than one (1) business day after the MCO or Authorized Payer receives the appeal from an MP Professional and all information necessary to decide the appeal.⁸⁰

13.16.1.2 Deadline within which the MP Professional must be notified of the expedited appeal decision. The MCO or Authorized Payer must notify the MP Professional of the decision under section 13.16.1.1 either electronically or in writing on the day of the decision or on the next working day if the MP Professional's office is closed on the day on which the expedited appeal decision is made.⁸¹

13.16.2 Deadlines applicable to nonexpedited appeals.

⁷³ NH 420-J:5(I)(d); 29 C.F.R. § 2560.503-1(h)(2)(iv)

⁷⁴ N.C.G.S.A. § 58-50-62(f)(1)(b); La. Admin Code. tit. 32, pt. IX, § 503(B)(1)(b)(ii)

⁷⁵ NC 58-50-62(f)(1)(b)

⁷⁶ NC 58-50-62(f)(1)(b)

⁷⁷ La. Admin Code. tit. 32, pt. IX, § 503(B)(1)(a)

⁷⁸ NH 420-J:5(I)(f)

⁷⁹ 29 C.F.R. § 2560.503-1(h)(3)(ii)

⁸⁰ VA 32.1-137.15(E); 28 TAC § 19.1712(4)

⁸¹ Ala. Admin. Code r. 420-5-6-.08(6)(h)

13.16.2.1 Decision no later than thirty (30) days from receipt of appeal. The review committee must decide a nonexpedited appeal not later than the thirty (30) days after the date on which the MCO or Authorized Payer received the MP Professional's appeal, and all information from the MP Professional necessary to decide appeal.⁸²

13.16.2.2 Deadline within which the MP Professional must be notified of the appeal decision. The review committee must orally notify the MP Professional of its decision and issue a written decision within five (5) working days after concluding the review meeting.⁸³

13.17 Requirements applicable to notifications of appeal decisions.

13.17.1. Notification requirements applicable when the adverse determination has been reversed on appeal. A notification that an adverse determination has been reversed on appeal must satisfy the requirements specified in section 13.7.

13.17.2 Notification requirements applicable when the adverse determination is upheld on appeal. If the review committee upholds the adverse determination, the written or electronic notification of the review committee's decision must:

(1) describe the review committee's understanding of the adverse determination and all of the facts pertinent to that understanding;⁸⁴

(2) contain a description of the evidence that the review committee considered when making its appeal decision, and such description must include a detailed explanation in clear, understandable language of the factual basis of the decision;⁸⁵

(3) discuss the Subscriber's presenting symptoms or condition, diagnosis, and treatment interventions and the specific reasons such medical evidence failed to meet the relevant written clinical criteria;⁸⁶

(4) describe the clinical rationale underlying the appeal decision, and such rationale must reference and include any written clinical criteria or policy or plan provisions that the review committee used when making its decision;⁸⁷

(5) contain instructions for requesting copies of any referenced evidence, documentation, written clinical criteria, or plan or policy provisions not previously provided to the MP Professional;⁸⁸

(6) (in a state in which the review committee's decision is not binding on the MCO or the Authorized Payer) state the rationale for the MCO's or Authorized Payer's appeal decision if the MCO's decision differs from the review committee's recommendation;⁸⁹

(7) include a description of alternative benefits, services, or supplies covered by the Subscriber's plan or policy, if any;⁹⁰

⁸² OR Admin. R. 836-053-1100(1)(b); NH 420-j:5(IV)(a)

⁸³ NE 44-7309(3)(f); MD Code, Insurance, § 15-10A-02(f)(1) and (2)

⁸⁴ NC 58-50-62(h)(2)

⁸⁵ NC 58-50-62(h)(4); MD Code, Insurance, § 15-10A-02(i)(1)(ii)(1)

⁸⁶ 105 CMR 128.307(B)(2); M.S.A. § 72A.285

⁸⁷ NC 58-50-62(h)(5); NH 420-J:5(V)(a)(1); NH 420-J:5(V)(a)(2); 105 CMR 128.307(B)(4)

⁸⁸ 02-031 CMR Ch. 850, § 8(G)(1)(c)(iv)

⁸⁹ NC 58-50-62(h)(6)

⁹⁰ KRS § 304.17A-607(1)(j)(3); KRS § 304.17A-617(2)(e)(3); 105 CMR 128.307(B)(3)

(8) contain a statement that the MP Professional is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the adverse determination and appeal;⁹¹

(9) contain a statement that the MPP has a right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act to challenge an adverse determination that is upheld on appeal;⁹²

(10) satisfy the requirements specified in section 13.13(4) above;⁹³

(11) state that the appeal decision is the MCO's or Authorized Payer's final decision concerning the adverse determination and that all internal appeal mechanisms have been exhausted;⁹⁴

(12) specifically describe how the MP Professional may obtain an external review of the appeal decision, and include any forms required to initiate an external review;⁹⁵

(13) state that the identity and qualifications of any medical expert who was consulted as part of the review committee's consideration of the appeal must be made available to the MP Professional if the MP Professional so requests, regardless of whether or not the review committee relied on information and advice provided by the medical expert when making its appeal decision;⁹⁶

(14) identify the name, title, qualifying credentials, specialty designations, state of licensure, and medical license number of each member of the review committee;⁹⁷ and

(15) contain the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."⁹⁸

13.18 Effect of the MCO's or an Authorized Payer's failure to comply with the applicable deadlines specified by this Article. A failure of the MCO or an Authorized Payer to comply with the applicable deadlines specified in this Article will result in any disagreement between an MP Professional and the MCO or Authorized Payer being deemed resolved in favor of the MP Professional.⁹⁹

13.19 Continuation of services

13.19.1 Continuation of services pending preauthorization. When the request for preauthorization concerns the continuation of a health care service that the MCO or an Authorized Payer has previously authorized, the MCO and Authorized Payer will continue to pay MP Professional for providing the requested health care service until such time as the MP Professional receives notification of an adverse determination concerning that service, unless the MP Professional appeals the adverse determination.¹⁰⁰

⁹¹ 29 C.F.R. § 2560-503.1(j)(3)

⁹² 29 C.F.R. § 2560.503-1(j)(4)

⁹³ 29 C.F.R. § 2560.503-1(j)(5)(i)

⁹⁴ C.G.S.A. § 38a-226c(a)(1)(F), NC 58-50-62(h)(7)

⁹⁵ N.J. Admin. Code tit. 11, 11:24-8.6(f)

⁹⁶ NH 420-j:5(II)(c); 29 C.F.R. § 2560.503-1(h)(3)(iv)

⁹⁷ KRS § 304.17A-617(2)(e)(2); N.C.G.S.A. section 58-50-62(h)(1); Code Me. R. 02-031 Ch. 850, § 8(G)(1)(c)(i); M.S.A. § 72A.285

⁹⁸ 29 C.F.R. § 2560.503-1(j)(5)(iii)

⁹⁹ M.G.L.A. 176O § 13(c); 105 CMR 128.311(A)

¹⁰⁰ ME Code Me. R. 02-031 Ch. 850, § 8(E)(3)(b); West's F.S.A. § 641.511(6)(d); M.G.L.A. 176O § 12(c); V.A.M.S. 376.1363(3)(2); Neb.Rev.St. § 44-7311(6); N.H. Rev. Stat. § 415-A:4-b(IV)(b); N.H. Rev. Stat. § 420-J:5(IV)(b); SDCL § 58-17C-101; Code Me. R. 02-031 Ch. 850, § 8(E)(3)(b) & (G)(2)(d); 211 CMR 52.08(5)(c); R.C. § 1751.81(D)(2); N.C.G.S.A. § 58-50-61(f)

13.19.2 Continuation of treatment pending resolution of appeal. If an MP Professional appeals an adverse determination concerning an ongoing health care service, the MCO or Authorized Payer will continue to pay the MP Professional for providing that service until such time as the MP Professional is notified of the MCO's or Authorized Payer's appeal decision. For the purposes of this section 13.19.2, "ongoing health care service" includes only those health care services that, at the time they were initiated, were authorized by the MCO or Authorized Payer and does not include health care services that were terminated pursuant to a specific time or episode-related exclusion under the Subscriber's policy or benefit plan.¹⁰¹

13.20 No cost to MP Professional. The MCO and Authorized Payers must perform all utilization review activities, including, but not limited to, reviews of preauthorization requests and appeals of adverse determinations, without cost to the MP or any MP Professional.¹⁰²

13.21 The MCO and an Authorized Payer may not require preauthorization when the MCO or Authorized Payer is a secondary payer and the primary payer requires preauthorization. In some cases, the MCO's or Authorized Payer's payment obligation may be secondary to another payer's payment obligation. In such cases, the MCO or Authorized Payer is the "secondary payer" and the other payer is the "primary payer." Under these circumstances, if both the secondary payer (the MCO or Authorized Payer) require preauthorization of a health care service, the MP Professional shall request preauthorization from the primary payer, but shall not be required to obtain preauthorization concerning the health care service from the secondary payer (the MCO or Authorized Payer). The MCO or Authorized Payer shall not refuse payment for such a health care service solely on the basis that the MCO or Authorized Payer did not preauthorize the health care services.¹⁰³

13.22 Delegation. If the MCO or an Authorized Payer delegates any of its responsibilities under this Article to a third party, the MCO or Authorized Payer will be legally responsible for that third-party's failure to comply with any of the requirements of this Article.¹⁰⁴

¹⁰¹ 105 CMR 128.312; West's RCWA 48.43.530(7)

¹⁰² C.G.S.A. § 38a-226c(a)(7); 18 Del. Admin. Code 1301-11.0(11.1); MD Code, Insurance, § 15-10B-08(c); N.H. Rev. Stat. § 415-A:4-b(VII); N.H. Rev. Stat. § 420-J:5(VII); 29 C.F.R. § 2560.501-1(b)(3) and (c)(3)(v)

¹⁰³ NH 420-J:3-b

¹⁰⁴ MD Code, Insurance, § 15-10A-02(1)(2)(ii); KRS § 304.17A-605(2)(a) – (d); 02-031 CMR Ch. 850, § 8(3)(B); V.A.M.S. 376.1353; Neb.Rev.St. § 44-5425; NDCC, 26.1-26.4-04.2; R.C. § 1751.78(B)(2); 28 TAC § 19.1705(4);