Minnesota Department of Health
Health Regulation Division
Managed Care Systems Section

Final Report

PreferredOne Community Health Plan

Quality Assurance Examination
For the Period:
August 1, 2011 through April 30, 2014

Final Issue Date:
November, 21, 2014
Revised February 17, 2015

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Minnesota Department of Health
Executive Summary

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of Preferred One Community Health Plan (PCHP) to determine whether it is operating in accordance with Minnesota law. Our mission is to protect, maintain and improve the health of all Minnesotans. MDH has found that PCHP is compliant with Minnesota and federal law, except in the areas outlined in the "Deficiencies" and "Mandatory Improvements" sections of this report. Deficiencies are violations of law. "Mandatory Improvements" are required corrections that must be made to non-compliant policies, documents or procedures where evidence of actual compliance is found in file review or where the file sample did not include any instances of the specific issue of concern. The listed "Recommendations" are areas where, although compliant with law, MDH identified improvement opportunities.

To address recommendations, PCHP should:

Establish a written policy/procedure for the Lock-In program to ensure consistency in administering the program, including the enrollee's right to appeal the decision.

Revise both the *Appropriate Professionals (MM/P004)* policy and the *Integrated Services Department Program* to include more information about the process PCHP has for behavioral health/substance abuse utilization management denials and appeals.

Improve its explanation of the process it uses for chiropractic utilization review by including chiropractic reviews in its *Appropriate Professionals (MM/P004)* policy.

To address mandatory improvement, PCHP must:

Revise its certificate of coverage to accurately describe the procedure for all oral complaints, accurately state timelines for written complaints and clearly describe the right to file a complaint with the commissioner and the separate right to request an External Review.

Include in its notification letters the enrollee's right to receive continued coverage pending outcome of the appeals process.

Revise its utilization policy to include the enrollee's right to file a complaint regarding a determination not to certify directly to the Commissioner of Health.

To address deficiencies, PCHP and its delegates must:

Conduct ongoing evaluation of medical records.

Document its offer of an oral complaint and written complaint form and its offer of assistance in submitting a written complaint, including an offer to complete the form and send it to the enrollee for signature. In addition, PCHP must document its offer of both an oral complaint and a written complaint.

This report including these deficiencies, mandatory improvements and recommendations is approved and adopted by the Minnesota Commissioner of Health pursuant to authority in Minnesota Statutes, chapter 62D.

Darcy Miner, Director
Health Regulation Division

2/17/15
Date

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I. Introduction

A. History:

PreferredOne Community Health Plan (PCHP) is a Minnesota nonprofit corporation organized on December 2, 1994 under Chapter 317A of the Minnesota Statutes. PCHP became operational in 1996. Contributing members of PCHP are Fairview Health Services and North Memorial Health Care. The sole non-contributing member is PreferredOne Physician Associates. Minnesota Statutes provide that 40% of an HMO's Board be enrollees of the health plan. The current Board of Directors consists of ten members: two representatives each from Fairview, North Memorial, and PPA; and four consumer board members elected by the PCHP membership.

PCHP offers a variety of fully-insured HMO products for both large and small employers and has an open-access provider network. Plans offer a variety of benefit options including 100% preventive coverage and options for out-of-network coverage.

B. Membership: PCHP self-reported enrollment as of May 1, 2014 consisted of the following:

Product	**Enrollment**
Fully Insured Commercial	
Large Group	6,226
Small Employer Group	9,499
Individual	0
Total	15,725

C. Onsite Examinations Dates: July 14 through July 16, 2014

D. Examination Period: August 1, 2011 through April 30, 2014
File Review Period: May 1, 2013 through April 30, 2014
Opening Date: May 20, 2014

E. National Committee for Quality Assurance (NCQA): PCHP is accredited by NCQA based on 2012 standards. The Minnesota Department of Health (MDH) evaluated and used results of the NCQA review in one of three ways:

1. If NCQA standards do not exist or are not as stringent as Minnesota law, the accreditation results were not used in the MDH examination process [No NCQA checkbox].
2. If the NCQA standard was the same or more stringent than Minnesota law and the health plan was accredited with 100% of the possible points, the NCQA results were accepted as meeting Minnesota requirements [NCQA ☒] unless evidence existed indicating further investigation was warranted [NCQA ☐].
3. If the NCQA standard was the same or more stringent than Minnesota law, but the review resulted in less than 100% of the possible points on NCQA's score sheet or identified an opportunity for improvement, MDH conducted its own examination.

F. Sampling Methodology: Due to the small sample sizes and the methodology used for sample selection for the quality assurance examination, the results cannot be extrapolated as an overall deficiency rate for the health plan.

G. Performance standard: For each instance of non-compliance with applicable law or rule identified during the quality assurance examination that covers a three year audit period, the health plan is cited with a deficiency. A deficiency will not be based solely on one outlier file if MDH has sufficient evidence. This evidence may be obtained through: 1) file review; 2) policies and procedures; and 3) interviews that indicate a plan's overall operation is compliant with an applicable law.

II. Quality Program Administration

Section II documents whether PCHP met requirements established by Minnesota Rules, parts 4685.1110 through 4685.1130.

Minnesota Rules, Part 4685.1110. Program

Subp. 1.	Written Quality Assurance Plan	Met ☒ Not Met ☐
Subp. 2.	Documentation of Responsibility	Met ☒ Not Met ☐ NCQA ☐
Subp. 3.	Appointed Entity	Met ☒ Not Met ☐ NCQA ☐
Subp. 4.	Physician Participation	Met ☒ Not Met ☐ NCQA ☐
Subp. 5.	Staff Resources	Met ☐ Not Met ☐ NCQA ☒
Subp. 6.	Delegated Activities	Met ☒ Not Met ☐ NCQA ☐
Subp. 7.	Information System	Met ☐ Not Met ☐ NCQA ☒
Subp. 8.	Program Evaluation	Met ☐ Not Met ☐ NCQA ☒
Subp. 9.	Complaints	Met ☒ Not Met ☐
Subp. 10.	Utilization Review	Met ☒ Not Met ☐
Subp. 11.	Provider Selection and Credentialing	Met ☐ Not Met ☐ NCQA ☒
Subp. 12.	Qualifications	Met ☐ Not Met ☐ NCQA ☒
Subp. 13.	Medical Records	Met ☐ Not Met ☒

Subp. 6. Minnesota Rules, part 4685.1110, subpart 6, states the HMO must develop and implement review and reporting requirements to assure that the delegated entity performs all delegated activities. NCQA established delegation standards are considered the community standard and were used for the purposes of this examination. The following delegated entities and functions were reviewed:

Delegated Entities and Functions								
Entity	**UM ***	**UM Appeals**	**QM ***	**Complaints / Grievances**	**Cred ***	**Claims**	**Network**	**Care Coord ***
ClearScript						X	X	
Health Services Management (HSM)	X		X		X		X	

*Utilization Management (UM), Quality Management (QM), Credentialing (Cred), Care Coordination (Care Coord)

Review of delegation oversight documents and HSM UM file review indicate PCHP performs appropriate oversight of the delegated functions according to community standards. Review of delegation oversight documents and network evaluations for Clearscript indicate PCHP performs appropriate oversight of the delegated functions according to community standards.

Subp. 9. Minnesota Rules, part 4685.1110, subpart 9, states the quality program must conduct ongoing evaluation of enrollee complaints related to quality of care. PCHP reports no quality of care complaints in the file review period.

Subp. 13. Minnesota Rules, part 4685.1110, subpart 13, states the quality assurance entity shall conduct ongoing evaluation of medical records. PCHP does not routinely collect medical record documentation to ensure adherence to its required elements. Medical record reviews are conducted on an as needed basis if there are reasons for concerns (i.e., related to quality of care cases, Healthcare Effectiveness Data and Information Set (HEDIS®) hybrid reviews, investigation of claims fraud, etc.). PCHP has a policy for its medical record documentation required elements. PCHP stated that with the movement and requirement for practitioners to have electronic medical records (EMR) in place, all of the major players in EMR documentation meet these requirements. PCHP must conduct ongoing evaluation of medical records. **(Deficiency #1)**

Minnesota Rules, Part 4685.1115. Activities

Subp. 1.	Ongoing Quality Evaluation	☐Met ☐Not Met ☒NCQA
Subp. 2.	Scope	☐Met ☐Not Met ☒NCQA

Minnesota Rules, Part 4685.1120. Quality Evaluation Steps

Subp. 1.	Problem Identification	☐Met ☐Not Met ☒NCQA
Subp. 2.	Problem Selection	☐Met ☐Not Met ☒NCQA
Subp. 3.	Corrective Action	☐Met ☐Not Met ☒NCQA
Subp. 4.	Evaluation of Corrective Action	☐Met ☐Not Met ☒NCQA

Minnesota Rules, Part 4685.1125. Focus Study Steps

Subp. 1.	Focused Studies	☒Met ☐Not Met
Subp. 2.	Topic Identification and Selection	☒Met ☐Not Met
Subp. 3.	Study	☒Met ☐Not Met
Subp. 4.	Corrective Action	☒Met ☐Not Met
Subp. 5.	Other Studies	☒Met ☐Not Met

Minnesota Rules, Part 4685.1130. Filed Written Plan and Work Plan

Subd. 1.	Written Plan	☒Met ☐Not Met
Subp. 2.	Work Plan	☐Met ☐Not Met ☒NCQA

III. Complaint System

MDH examined PCHP's fully-insured commercial complaint system under Minnesota Statutes, chapter 62Q.68 through 73.

MDH reviewed a total (all) of 20 complaint system files.

Complaint System File Review	
Complaint Files--Oral	0
Complaint Files--Written	17
Non-Clinical Appeal Files	3
Total # Reviewed	**20**

MDH appreciates PCHP's clarification of its complaint system. PCHP offers only fully insured commercial HMO products. In addition to Minnesota law, PCHP must also comply with U.S. Department of Labor (DOL) law. PCHP's complaint system uses categories of complaints based on the DOL categories: e.g., pre-service or post-service claims. By definition pre-service claims are processed under Minnesota Statutes, Chapter 62M. However, post-service claims, by definition are retrospective (were not reviewed pre-service (62M)) and are processed under Minnesota Statutes, sections 62Q.68 through 62Q.73. Any medical necessity aspect of the post-service claims is reviewed under Minnesota Statutes, section 62M.06.

Minnesota Statutes, Section 62Q.69. Complaint Resolution

Subd. 1.	Establishment	☒Met ☐Not Met
Subd. 2.	Procedures for Filing a Complaint	☐Met ☒Not Met
Subd. 3.	Notification of Complaint Decisions	☒Met ☐Not Met

Subd. 2. Minnesota Statutes, section 62Q.69, subdivision 2, states in pertinent part that an enrollee may file a complaint by telephone or in writing. If the complaint is submitted orally and the resolution is partially or wholly adverse to the enrollee or is not resolved within ten days, the plan must inform the enrollee of the right to file a complaint in writing and the plan must offer assistance submitting a written complaint, including an offer to complete the form and send it to the enrollee for signature.

In its 2011 quality assurance exam (issued April 10, 2012) MDH found that in four of six oral complaints PCHP records did not document that a complaint form and assistance submitting the form were offered, including its offer to complete the form and send it to the enrollee for signature. PCHP MDH found no error in the oral complaints reviewed during the mid-cycle review. In the 2014 quality assurance exam, PCHP reported that it received no oral complaints within the file review period.

In file review of written complaints, MDH found one complaint file where the resolution was adverse to the enrollee, but Customer Service notes did not document its investigation, its offer of a written complaint form, or assistance submitting the complaint in writing, including its offer to complete the form and send it to the enrollee for signature.

In three additional files, notes said the enrollee telephoned, but no notes documented PCHP's offer of assistance submitting a written complaint, including its offer to complete the form and send it to the enrollee for signature. The written complaint form was in file and the investigation notes were in the file, but no investigation was documented until the written form was received.

PCHP states that "The first page of the three-page written complaint form . . . clearly states that PCHP Customer Service is available to provide assistance in completing the form." A written statement on the form sent to the enrollee does not fulfill the statutory requirement to offer assistance submitting a written complaint, including an offer to complete the form and send it to the enrollee for signature.

Without documentation, it is not possible to determine if the enrollee was offered assistance submitting a written complaint, including an offer to complete the form and send it to the enrollee for signature.

In addition, PCHP also states its practice when the enrollee calls is to offer the option to submit the complaint orally or in writing. PCHP procedures require the Customer Service Representative to document the record:

- *Customer Service Oral Complaint Procedure* (ref #CSC0103, page 1) states "Document all action that was taken to try to resolve the complaint", and
- *Customer Service Written Complaint Procedure* (Ref #CSC0107, page 1) states "the Customer Service Representative will document the details of the phone call"

However, file review shows that PCHP does not follow its own procedures. In the four files identified above there was no documentation of PCHP's offer of both an oral complaint and a written complaint. Without documentation it is not possible to determine if the enrollee was offered both an oral complaint and a written complaint form. This failure to document its offer

of both an oral complaint and the written complaint is not consistent with PCHP policy/procedures. **(Deficiency #2)**

(Also see Minnesota Statutes, section 62Q.71, below.)

Minnesota Statutes, Section 62Q.70. Appeal of the Complaint Decision

Subd. 1.	Establishment	☒Met ☐Not Met
Subd. 2.	Procedures for Filing an Appeal	☒Met ☐Not Met
Subd. 3.	Notification of Appeal Decisions	☒Met ☐Not Met

Minnesota Statutes, Section 62Q.71. Notice to Enrollees

☐Met ☒Not Met

Minnesota Statutes, section 62Q.71, states the plan must provide enrollees with a clear, concise description of its complaint resolution procedure in the certificate of coverage. The certificate of coverage (COC) statements must be revised to be consistent with Minnesota law as follows:

- Minnesota Statutes, section 62Q.69, subdivision 1, states the plan must provide a clear and concise description of how to submit a complaint in documents such as the certificate of coverage. In the 1000.80.1 Large Group COC, PCHP explains oral complaints under XVIII. Internal Appeal Process, section 1, *Complaints About Administrative Operations and Matter* (page 76). However an oral complaint is not confined to "administrative" issues. Under Minnesota Statutes, section, 62Q.68, subdivision 2, a complaint is any grievance not the subject of litigation, and specifically includes retrospective denials or limitations of payment for services. The COC must accurately describe the procedure for all oral complaints.

- Minnesota Statutes, section 62Q.69, subdivision 2(a), states the oral complaint must be resolved within ten days. Subdivision 3(a), states the plan must send written notice of the decision on a written complaint within 30 days. PCHP COC, page 76 states "If your telephone complaint is not resolved to your satisfaction within ten calendar days after PCHP receives your complaint, you may submit your complaint in writing." The COC also states "PCHP will notify you of its decision on your post-service claim complaint within 30 calendar days from the date that it receives your complaint." The COC must state the enrollee's written complaint will be resolved within 30 days.

- Minnesota Statutes, section 6Q.71 (4), states the COC must include a description of the right to file a complaint with MDH, including the toll free number. The Large Group COC includes the right to file a complaint with the commissioner under *XIX. External Review*. The right to file a complaint with the Commissioner at any time and the right to External Review upon exhaustion of the internal appeal process are two separate processes. The COC should distinguish the right to file a complaint with the Commissioner from requesting an External Review.

(Mandatory Improvement #1)

Minnesota Statutes, Section 62Q.73. External Review of Adverse Determinations

Subd. 3.	Right to External Review	☒Met ☐Not Met

IV. Access and Availability

Section IV documents whether the plan met requirements established by Minnesota Statutes, section 62D.124; Minnesota Rules, part 4685.1010; and access to specific types of services as required under Minnesota Statutes, chapters 62D, 62Q and Minnesota Rules, part 4685.1010.

Minnesota Statutes, Section 62D.124. Geographic Accessibility

Subd. 1.	Primary Care, Mental Health Services, General Hospital Services	☒Met ☐Not Met
Subd. 2.	Other Health Services	☒Met ☐Not Met
Subd. 3.	Exception	☒Met ☐Not Met

Minnesota Rules, Part 4685.1010. Availability and Accessibility

Subp. 2.	Basic Services	☒Met ☐Not Met
Subp. 5.	Coordination of Care	☒Met ☐Not Met
Subp. 6.	Timely Access to Health care Services	☒Met ☐Not Met

Subp. 5. Minnesota Rules, part 4685.1010, subdivision 5, A (2), states that if requested by an enrollee, or if determined necessary because of a pattern of inappropriate utilization of services, an enrollee's health care may be supervised and coordinated by the primary care provider. PCHP provided a description of its Lock-In program and of the changes made to the program. Because the program restricts the enrollee's access to providers (voluntarily or otherwise), PCHP should establish a written policy/procedure for the Lock-In program to ensure consistency in administering the program, including the enrollee's right to appeal the decision.
(Recommendation #1)

Minnesota Statutes, Section 62Q.55. Emergency Services

☒Met ☐Not Met

Minnesota Statutes, Section 62Q.121. Licensure of Medical Directors

☒Met ☐Not Met

Minnesota Statutes, Section 62Q.527. Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance

Subd. 2.	Required Coverage for Anti-psychotic Drugs	☒Met ☐Not Met
Subd. 3.	Continuing Care	☒Met ☐Not Met
Subd. 4.	Exception to formulary	☒Met ☐Not Met

Minnesota Statutes, Section 62Q.535. Coverage for Court-Ordered Mental Health Services

Subd. 1.	Mental health services	☒Met ☐Not Met
Subd. 2.	Coverage required	☒Met ☐Not Met

Minnesota Statutes, Section 62Q.56. Continuity of Care

Subd. 1.	Change in health care provider, general notification	☒Met ☐Not Met
Subd. 1a.	Change in health care provider, termination not for cause	☒Met ☐Not Met
Subd. 1b.	Change in health care provider, termination for cause	☒Met ☐Not Met
Subd. 2.	Change in health plans	☒Met ☐Not Met
Subd. 2a.	Limitations	☒Met ☐Not Met
Subd. 2b.	Request for authorization	☒Met ☐Not Met
Subd. 3.	Disclosures	☒Met ☐Not Met

V. Utilization Review

Section V documents whether PCHP met requirements established by Minnesota Statutes, sections 62M.04 through 62M.11.

MDH reviewed a total of 33 files as follows:

UM System File Review	
File Source	**#Reviewed**
UM Denial Files	
PCHP	11
HSM	9
Subtotal	20
Clinical Appeal Files	
PCHP	10
HSM	3
Subtotal	13
Total	33

Minnesota Statutes, Section 62M.04. Standards for Utilization Review Performance

Subd. 1. Responsibility on Obtaining Certification ☒Met ☐Not Met

Subd. 2. Information upon which Utilization Review is Conducted ☒Met ☐Not Met

Minnesota Statutes, Section 62M.05. Procedures for Review Determination

Subd. 1. Written Procedures ☒Met ☐Not Met

Subd. 2. Concurrent Review ☐Met ☐Not Met ☒NCQA

Subd. 3. Notification of Determinations ☒Met ☐Not Met

Subd. 3a. Standard Review Determination

(a) Initial determination to certify (10 business days) ☒Met ☐Not Met ☐NCQA

(b) Initial determination to certify (telephone notification) ☒Met ☐Not Met

(c) Initial determination not to certify ☒Met ☐Not Met

(d) Initial determination not to certify (notice of right to external appeal) ☒Met ☐Not Met ☐NCQA

Subd. 3b. Expedited Review Determination ☒Met ☐Not Met ☐NCQA

Subd. 4. Failure to Provide Necessary Information ☒Met ☐Not Met

Subd. 5. Notifications to Claims Administrator ☐Met ☐Not Met ☒NA

Minnesota Statutes, Section 62M.06. Appeals of Determinations not to Certify

Subd. 1. Procedures for Appeal ☐Met ☒Not Met

Subd. 2.	Expedited Appeal	☒Met ☐Not Met
Subd. 3.	Standard Appeal	
(a)	Appeal resolution notice timeline	☒Met ☐Not Met
(b)	Documentation requirements	☒Met ☐Not Met
(c)	Review by a different physician	☒Met ☐Not Met ☐NCQA
(d)	Time limit in which to appeal	☒Met ☐Not Met
(e)	Unsuccessful appeal to reverse determination	☒Met ☐Not Met ☐NCQA
(f)	Same or similar specialty review	☒Met ☐Not Met
(g)	Notice of rights to external; review	☒Met ☐Not Met ☐NCQA
Subd. 4.	Notification to Claims Administrator	☐Met ☐Not Met ☒N/A

Subd. 2. Minnesota Statutes section 62M.06, subdivision 1(b), states in pertinent part that the enrollee must be allowed to receive continued coverage pending the outcome of the appeals process. PCHP included this in its policy *Pre-Service Appeals (MM/P008a).* File review indicated it is being done, however it is not included in the appeal rights notification sent to the member informing he/she of the denial. PCHP must include in its notification letters the enrollee's right to receive continued coverage pending outcome of the appeals process. **(Mandatory Improvement #2)**

Minnesota Statutes, Section 62M.08. Confidentiality

☐Met ☐Not Met ☒NCQA

Minnesota Statutes, Section 62M.09. Staff and Program Qualifications

Subd. 1.	Staff Criteria	☐Met ☐Not Met ☒NCQA
Subd. 2.	Licensure Requirements	☒Met ☐Not Met ☐NCQA
Subd. 3.	Physician Reviewer Involvement	☒Met ☐Not Met ☐NCQA
Subd. 3a.	Mental Health and Substance Abuse Review	☒Met ☐Not Met
Subd. 4.	Dentist Plan Reviews	☐Met ☐Not Met ☐NCQA ☒ N/A
Subd. 4a.	Chiropractic Reviews	☒Met ☐Not Met ☐NCQA
Subd. 5.	Written Clinical Criteria	☒Met ☐Not Met ☐NCQA
Subd. 6.	Physician Consultants	☒Met ☐Not Met ☐NCQA
Subd. 7.	Training for Program Staff	☐Met ☐Not Met ☒NCQA
Subd. 8.	Quality Assessment Program	☐Met ☐Not Met ☒NCQA

Subd. 3a. Minnesota Statutes, section 62M.09, subdivision 3a, states a peer of the treating mental health or substance abuse provider, a doctoral-level psychologist, or a physician must review requests for outpatient services in which the utilization review organization has concluded that a determination not to certify a mental health or substance abuse service for clinical reasons is appropriate. It further states that a doctoral-level psychologist shall not review any request or final determination not to certify a mental health or substance abuse service or treatment if the treating provider is a psychiatrist. The policy *Appropriate Professionals* (MM/P004) has a grid indicating the Associate Medical Director for Behavioral Health is Board Certified and does case

review and appeals. In the *PreferredOne Integrated Services Department Program*, it states the Associate Medical Director for Behavioral Health is Board Certified in Psychiatry and is responsible for reviewing behavioral/substance abuse cases for denials. Both the policy MM/P004 and the *Integrated Services Department Program* should be revised to include more information about the process PCHP has for behavioral health/substance abuse utilization management denials and appeals. **(Recommendation #2)**

Subd. 4a. Minnesota Statutes section 62M.09, subdivision 4a, states a chiropractor must review all cases in which the utilization review organization has concluded that a determination not to certify a chiropractic service or procedure for clinical reasons is appropriate and an appeal has been made by the attending chiropractor, enrollee, or designee. Chiropractic reviews are not addressed in the policy *Appropriate Professionals (MM/P004).* However, the *Integrated Services Department Program* does state that Health Services Management (HSM), PCHP's chiropractic delegate, "performs utilization review for chiropractic services." PCHP should improve its explanation of the process it uses by including chiropractic reviews in its policy *Appropriate Professionals (MM/P004).* **(Recommendation #3)**

Minnesota Statutes, Section 62M.11. Complaints to Commerce or Health

☐Met ☒Not Met

Minnesota Statutes section 62M.11, states that notwithstanding the provisions of sections 62M.01 to 62M.16, an enrollee may file a complaint regarding a determination not to certify directly to the commissioner responsible for regulating the utilization review organization. File review indicated this information was in the notification of denial to the member, however it was not found in any policy. PCHP must revise its utilization policy to include the enrollee's right to file a complaint regarding a determination not to certify directly to the Commissioner of Health. **(Mandatory Improvement #3)**

VI. Recommendations

1. To better comply with Minnesota Rules, part 4685.1010, subdivision 5, A(2), PCHP should establish a written policy/procedure for the Lock-In program to ensure consistency in administering the program, including the enrollee's right to appeal the decision.

2. To better comply with Minnesota Statutes, section 62M.09, subdivision 3a, PCHP should revise both the *Appropriate Professionals* (MM/P004) policy and the *Integrated Services Department Program* to include more information about the process PCHP has for behavioral health/substance abuse utilization management denials and appeals.

3. To better comply with Minnesota Statutes, section 62M.09, subdivision 4a, PCHP should improve its explanation of the process it uses for chiropractic utilization review by including chiropractic reviews in its *Appropriate Professionals (MM/P004)* policy.

VII. Mandatory Improvements

1. To comply with Minnesota Statutes, section 62Q.71, PCHP must revise its certificate of coverage to accurately describe the procedure for all oral complaints, accurately state timelines for written complaints and clearly describe the right to file a complaint with the commissioner and the separate right to request an External Review.

2. To comply with Minnesota Statutes, section 62M.06, subdivision 1(b), PCHP must include in its notification letters the enrollee's right to receive continued coverage pending outcome of the appeals process.

3. To comply with Minnesota Statutes, section 62M.11, PCHP must revise its utilization policy to include the enrollee's right to file a complaint regarding a determination not to certify directly to the Commissioner of Health.

VIII. Deficiencies

1. To comply with Minnesota Rules, part 4685.1110, subpart 13, PCHP must conduct ongoing evaluation of medical records.

2. To comply with Minnesota Statutes, section 62Q.69, subdivision 2, PCHP must document its offer of assistance in submitting a written complaint, including its offer to complete the form and send it to the enrollee for signature. In addition, PCHP must document its offer of both an oral complaint and a written complaint.