

**State of Connecticut Insurance Department
Request for Proposals for External Appeals Entities to Review Appeals
of Utilization Review Determinations**

**Responses to Questions
June 17, 2009**

1. Does the RFP require the EAE to become licensed by the Commissioner as a Utilization Review Company in order to conduct the EAE activities?
No
2. Does the RFP require the bidder to be registered with the State of Connecticut to conduct business?
No
3. What is the average number of cases referred to an EAE on an annual basis?
The number of appeals received by each vendor is dependent on the number of appeals received and the number of vendors selected. We cannot project the volume of appeals for each vendor.
4. How many business references are preferred/required for the response?
The Connecticut Insurance Department ("CID") does not require a specified number of references from bidders.
5. Is there a specific time of day on Tuesday, June 30, 2009 the final proposal is due?
All bids must be delivered by close of business (4:00 Eastern Time) on June 30, 2009.
6. Please clarify that the requirement stated in Section 3 (2) regarding the fax or e mail accessibility is for receipt of *request* for an appeal or does it include processing **all** (medical records, documentation etc.) information related to the external appeal?
The fax or e-mail accessibility is for all information related to external appeals, not strictly the initial request.
7. Is there a preferred method of electronic transmission and receipt of data, such as secure FTP or secure e-mail?
It is the aim of the CID to process all information exchange through secure e-mail.

8. Will the contractor receive and send data files or is the electronic transmission and receipt limited to medical records and reports?
At the present time, the CID has no plans for utilizing data files in its transmissions.
9. If data files are to be received or sent, can the layouts for these files be provided?
Data file transmissions are not anticipated at this time.
10. Does a signed copy of Appendix D need to be included in the Proposal or is this for after contract award? If signature is required with proposal, please identify where the bidder is to sign?
Appendix D is a sample of the expected agreement for services to be executed by the winning contractors. This should not be executed by Proposers.
11. In Appendix A, External Appeals Regulation, 38a-478n-3(b), it is stated that an enrollee or any provider acting on behalf of an enrollee shall have “thirty (30) days after receiving final written notice of the denial or determination...” to submit a request for external appeal. Currently, the timeframe for submission is 60 days. Just to confirm did the timeframe change back to 30 days? Or will it remain at 60 days?
The current timeframe for filing an external appeal is 60 days and will remain unchanged. The External Appeals Regulation 38a-478n-3(b) will be amended in the near future to reflect the 60 day time frame as shown in External Appeal Statute 38a-478n (b)(1).
12. Is it acceptable to send the Results of Preliminary Review – Accepted to any/all parties via email? The Regulation requires facsimile or overnight delivery service.
Email notification may be sent to any insurance carrier working in a secured e-mail environment. In addition, e-mail communication is acceptable for any enrollee who provided an e-mail address on their External Appeal application.
13. In Section 1 – Technical Proposal, 2(D), it is requested that a “summary of the procedure and diagnosis codes for which an external appeal was sought” be provided. In most cases we have received in the past, this information is not provided. Is the External Appeals Entity expected to code each appeal that is received for purposes of this requirement?
Carriers must provide a procedure or diagnostic code in their final determination letter or in lieu of this, they may provide this at time of external appeal. The CID will be responsible for ensuring that this information is provided to the External Appeals Entities.

14. Is the contract exclusive or will Connecticut Insurance Department (CID) be utilizing several review entities?
The CID will be utilizing multiple vendors with the exact number TBD.
15. Who is/are the incumbent(s)?
Empire State Medical, Scientific & Educational Foundation, Island Peer Review Organization, Maximus Federal Services and Permedion
16. On average, approximately how many external appeals can a single review entity expect to receive monthly or annually?
The number of appeals received by each vendor is dependent on the number of appeals received and number of vendors selected. We cannot project the volume of appeals for each vendor.
17. How many reviews were filed in the last year? How many full reviews were conducted?
210 requests for External Appeals were filed in 2008 of which 173 were accepted for full review.
18. What would be the estimated volume for the following types of case: standard reviews, expedited and experimental/investigational?
We do not keep statistics on the number of complaints that are of a standard nature vs. those that are experimental/investigational. Expedited review is only being added by statute effective October 1, 2009.
19. What is the average page number or size of the medical record or information provided for external appeals?
We do not keep statistics on this topic.
20. What is the anticipated volume of cases from the Connecticut Department of Social Services, CT HUSKY B and Charter Oak managed care program? What would be the breakdown of standard reviews, expedited and experimental/investigational?
We have only received one Husky B external appeal and that appeal was voluntary withdrawn and the claim was paid by the Connecticut Department of Social Services. We have received no Charter Oak external appeals.
21. What is the likelihood that CID will enter into a Memorandum of Understanding to administer the external review process for enrollees of the State of CT Employees Benefit Plan? What would be the anticipated volume and breakdown of types of reviews?

The CID presently handles external appeals complaints for the State of CT Employees Benefit Plans. We do not keep statistics based on employer.

22. How is the cost for External Review billed? Does the review entity bill or is this done by the CID?

External Appeals Entities bill the CID for services performed.

23. Should the full review fee include the preliminary review fee, or is the preliminary review charged separately?

The Preliminary Review fee should be a separate charge and should be in addition to the charges for Full Review.

24. Does CID have any historical data that would assist the review entities in determining appropriate fees for the requested services?

Presently the range of fees for Preliminary Review are \$100 - \$145, the range of fees for reversal prior to a completed Full Review due to New Information are \$100 - \$350, and the range of fees for Full Review are \$500 - \$800.

25. Is it necessary for an organization to submit the Certificate of Good Standing from the Connecticut Secretary of State's Office at the time of submitting the bid or is that a contract requirement that must be completed prior to the start of the contract?

No

26. Will the review entity only communicate with CID personnel or will there be a need to communicate with providers or enrollee's associated with the reviews?

It is anticipated that the primary communication will be with CID personnel, however the External Appeal Entity will be responsible for issuing standard letters to providers and enrollees as outlined in the RFP.

27. Under the new Public Act No. 09-49 Sec. 2. Section 38a-478n(b)(5) (which takes effect October 1, 2009) it states that upon completion of the preliminary review, the review entity is to notify the enrollee or provider, as applicable as to whether the appeal is accepted for full review or if not accepted, the reason why. Does the review entity also notify the commissioner and/or the managed care company, health insurer or utilization review company? This is unclear, since under Section 38a-478n(b)(6), if accepted for full review, the commissioner notifies these entities of the request for external review and the name of the review entity. There also seems to be an inconsistency with the external appeal regulations on this issue, to the extent there is an inconsistency, which is to be followed?

We are currently developing the process in this regard based upon the new Public Act.

28. Will the assignment from the commissioner, include all the information necessary for the review entity to conduct the preliminary review, including information to determine whether the issue under appeal is a covered benefit? Under the new Public Act No. 09-49 Sec. 2. Section 38a-478n(b)(6) (which takes effect October 1, 2009), it appears that the managed care company, health insurer or utilization review company would only be notified of the external appeal after a preliminary review has already been conducted and has been accepted for full review. The existing regulations seem to differ on this issue, to the extent there is an inconsistency, which is to be followed?

[See 38a-478n\(b\)\(4\) that describes the role of the External Appeals Entity to conduct a preliminary review.](#)

29. Is there a specific report format required by the CID for the final review determination?

[The CID requests that all final review reports contain at a minimum: 1\) List of documents reviewed when making the final case determination; 2\) Synopsis of the case; 3\) Narrative of the rationale behind the reviewer decision; 4\) List of sources used to support the conclusion; and 5\) Qualifications of the reviewer](#)