1999 DRAFTING REQUEST

Bill

Received: **02/23/1999**

Received By: **kahlepj**

Wanted: **As time permits**

Identical to LRB:

For: **Gregg Underheim (608) 266-2254**

By/Representing: **himself**

This file may be shown to any legislator: NO

Drafter: **kahlepj**

May Contact:

Alt. Drafters:

Subject: **Insurance - health**

Extra Copies:

Pre Topic:

No specific pre topic given

Topic:

Require independent review for grievances by insureds regarding medical necessity determinations

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Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Resuired
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/P2	kahlepj 03/1111999	wjackson 03/12/1999	jfrantze 03/15/1999	_____ _____	lrb-docadmin 03/15/1999		S&L
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FE Sent For:

10/4/99

<END>

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mrc 9/20 mrc/ch 9/20

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Extra Copies: All Editors

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/2 9/14 WLJ 9/14 9/14

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Vers.	Drafted	Reviewed	Typist	Proofed	Submitted	Jacketed	Required

FE Sent For:

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I999 DRAFTING REQUEST

Bill

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Received By: **kahlepj**

Wanted: **As time permits**

Identical to LRB :

For: **Gregg Underheim (608) 266-2254**

By/Representing: **himself**

This file may be shown to any legislator: **NO**

Drafter: **kahlepj**

May Contact:

Alt. Drafters:

Subject: **Insurance - health**

Extra Copies:

Pre Topic:

No specific pre topic given

Topic:

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Instructions:

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Subject: **Insurance - health**

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/?	kahlepj	/pr 2/24 WLJ	2/24	2/24	DO submit P's		

FE Sent For:

<END>

2-15-99

Bill draft request — Underheim, Sandy
Dick Sweet

re. independent, external review (require it)
of medical necessity decisions
of value of services rendered or to be rendered
* >$500 ; applies to all ins. plans

if managed care (or any other that has grievance procedure) applies after grievance procedure

when coverage or payment denied, plan / insurer must inform insured of the process & how to request it.

OCI certifies independent reviewers
OCI promulgates rules re. standards for certifying; procedures for independent reviewers to follow; time w/in which decision must be rendered & sooner time if condition is life-threatening (see stat. on MC grievance procedure)
(app procedure)
independent reviewers pay $400 for certification and $100 annually thereafter —
they must also file an annual report

(s. 601.31)

decision of independent reviewer must be consistent w/ policy terms

new evidence (not heard in any preceding hearing) may be heard in indep. review proceeding

decisions are admissible in court

insured must pay $50 to file grievance — but is refunded if he or she prevails

insurer pays remainder (OCI set by rule?)

(PR appropriation)

eff. date → 6 months

give OCI emergency rule-making authority

↙ ½-vote

(how can they do rules and certify some indep. reviewers in 6 mo.?)

can talk to Pete Farrow, Eileen Mallow, Dirk Sweet

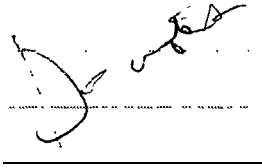
decisions are binding except may be appealed to court?

who's fee paid to? (for appropriation purposes)
if reviewer

how does side reviewer get paid

do these acts go directly to side reviewer or to appropriation?

(to the individual or?)



D-note decision is admissible??
w/o side reviewer as expert?

(why wouldn't it be admissible)

Side 300

just admissible? or for a purpose?

no objections possible?

D-vote re anticipation → once anticipd always cert unless revoked or suspended ?
what reasons?
or is anticipation monthly that must be done annually unless

include child support, tax delin, etc. ?

State af Wisconsin
1999 - 2000 LEGISLATURE

LRB-2313/2 P1
PJK...:.../...:...
WLJ

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

Drafter's SOON (2-24-99)

AN ACT ...; **relating to:** independent review of denials of coverage on the basis of medical necessity, granting rule-making authority and providing an exemption from emergency rule procedures.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided in a later version.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 601.31 (1) (Lp) of the statutes is created to read:

601.31 **(1)** (Lp) For certifying as an independent reviewer under s. 632.83, $400.

SECTION 2. 601.31 (1) (Lr) of the statutes is created to read:

601.31 **(1)** (Lr) For each annual recertification as an independent reviewer under s. 632.83, $100.

SECTION 3. 632.83 of the statutes is created to read:

632.83 Independent review of medical necessity determinations. (1) In this section, "health benefit plan" has the meaning given in s. 632.745 (11).

(2) (a) Every health benefit plan shall establish an independent review procedure whereby an insured under the health benefit plan may request and obtain an independent review of any decision denying coverage for medical services that was made by or on behalf of the health benefit plan if all of the following conditions apply:

1. Coverage was denied on the basis of the medical necessity of the services provided or to be provided.

2. The value of the services for which coverage was denied exceeded or would exceed $500.

(b) An independent review under this section must be conducted by an independent reviewer certified under sub. (4).

(c) If a health benefit plan has an internal grievance procedure, the health benefit plan may require an insured to use the health benefit plan's internal grievance procedure before the insured may request an independent review.

(d) Whenever a health benefit plan denies coverage for services exceeding $500 in value on the basis of medical necessity, the health benefit plan shall advise the insured of the insured's right to obtain and how to request the independent review required under this section.

(3) (a) To request an independent review under this section, an insured shall pay a $50 fee to the independent reviewer. If the insured prevails on the review, the entire amount paid shall be refunded to the insured. For each independent review in which it is involved, a health benefit plan shall pay to the independent reviewer a nonrefundable fee determined by the commissioner by rule.

(b) An independent reviewer may accept for consideration any evidence that the independent reviewer determines is relevant, regardless of whether the evidence has been submitted for consideration at any hearing previously.

(c) A decision of an independent reviewer must be consistent with the terms of the health benefit plan under which coverage was denied. A decision shall be in writing, signed by the independent reviewer and served by personal delivery or by mailing a copy to the insured and to the health benefit plan, or to a party's attorney of record. A decision of an independent reviewer is subject to judicial review and shall be binding on the insured and the health benefit plan unless either party petitions for judicial review.

(4) (a) The commissioner shall certify individuals who may act as independent reviewers. An individual certified under this paragraph must be recertified on an annual basis in order to continue to act as an independent reviewer. The commissioner may, for cause, revoke or suspend an individual's certification, or refuse to recertify an individual, as an independent reviewer.

(b) An individual applying for certification or recertification as an independent reviewer shall pay the applicable fee under s. 601.31 (1) (Lp) or (Lr). Every individual who is certified or recertified as an independent reviewer shall file an annual report with the commissioner.

(5) The commissioner shall promulgate rules for the independent review required under this section. The rules shall include at least all of the following:

(a) The application procedure for certification or recertification as an independent reviewer.

(b) The standards that the commissioner will use for certifying or recertifying individuals as independent reviewers.

(c) Hearing procedures that independent reviewers must follow, including the times within which decisions must be rendered. The commissioner shall require a decision to be rendered more expeditiously if the services for which coverage was denied relate to a life-threatening condition.

(d) What must be included in the annual report required under sub. (4).

(e) The fee that a health benefit plan must pay for each independent review in which it is involved.

SECTION 4. Nonstatutory provisions.

(1) **RULES** REGARDING INDEPENDENT REVIEW. Usingthe procedure under section 227.24 of the statutes, the commissioner of insurance shall promulgate rules required under section 632.83 (5) of the statutes, as created by this act, for the period before the effective date of the permanent rules promulgated under section 632.83 (5) of the statutes, as created by this act, but not to exceed the period authorized under section 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) (a), (2) (b) and (3) of the statutes, the commissioner is not required to provide evidence that promulgating a rule under this subsection as an emergency rule is necessary for the preservation of the public peace, health, safety or welfare and is not required to provide a finding of emergency for a rule promulgated under this subsection.

SECTION 5. Effective date.

(1) This act takes effect on the first day of the 7th month beginning after publication.

(END)

DRAFTER'S NOTE
FROMTHE
LEGISLATIVE REFERENCE BUREAU

2313/P1dn
LRB-2237/P1dn
PJK...:/...:... A
WLJ

note- different number

1. I am a little unclear about these independent reviewers. Will they always be individuals? How would a particular independent reviewer be chosen by a person (or by the person's health benefit plan) who wants an independent review?

2. How do you want to structure the payments to the independent reviewers? Do you want the fees paid directly to independent reviewers (as drafted) so that there is no appropriation? Do you want OCI to pay each independent reviewer so that the fees get paid to OCI and there is an appropriation? I provided for payment of a fee by a health benefit plan involved in a review. I assume that this fee must be substantial enough to be an incentive for individuals to want to be certified as independent reviewers. Are these fees ($50 of which may be refunded) the only compensation for an independent reviewer? Will the possibility of refunding $50 act as an incentive for the reviewer to decide in favor of the health benefit plan?

3. You wanted a decision of an independent reviewer to be admissible in court. I'm not sure why it wouldn't be. Did you want to allow the decision to be reviewed in court without the independent reviewer having to come and testify in person? If a matter that has been independently reviewed goes to court, is the court addressing the decision of the independent reviewer or the original decision of the health benefit plan? Is the decision of the independent reviewer binding on the health benefit plan? See how s. 632.83 (3) (c) is drafted. I made the decision subject to judicial review and binding unless judicial review is requested. The court would be reviewing the decision of the independent reviewer, so the decision would not only be admissible, it would be the issue. Is this okay?

4. I wasn't real clear about how you wanted to structure the certification of independent reviewers. Do you want them to be affirmatively recertified each year (as drafted) or do you want them to always be certified once certified (as insurance agents are, except that they are licensed) unless the commissioner revokes or suspends certification? I assumed that you wanted the commissioner to be able to revoke or suspend certification. If so, do you want to specify grounds for doing so? The grounds could also be added to the rules that the commissioner must promulgate.

5. Is six months enough time to promulgate rules and, in addition, certify enough independent reviewers to make the process operational?

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266-2682
E-mail: Pam.Kahler@legis.state.wi.us

"IR organization" ← change to

9 months (instead of 6 mo.)

OCI det freq of report — not necessarily annual

biennial cert. (instead of annual)

med drugs, devices or services (instead of serv alone)

cash flow → insurer pay the $50 if person gets it back

no appropriations

State Representative
GREGGUNDERHEIM
Chair: Assembly Committee on Health
Chair: Assembly Committee on State & Federal Relations

RO. Box 8953 • State Capitol
Madison. WI 53708-8953
(608) 266-2254

Rep.Underheim@legis.state.wi.us

Message Hotline:
1 (800) 362-9472
TDD: 1 (800) 228.2115

1652 Beech Street
Oshkosh, WI 54901
(414) 233.1082

FACSIMILE COVER SHEET
FAX #: (608) 282-3654

Number of pages attached, including cover page 3

If all pages are not received or are illegible, please call -
1 (888) 534-0054 or (608) 266-2254.

PLEASEDELIVER TO:

Pam Kahlen

FAX NUMBER OF ADDRESSEE: 4-8522

FROM: STATE REPRESENTATIVE GREGG UNDERHEIM

Dawn -
Let bet you thought I forgot you!
Sorry - Sandy

1. Draft should apply reference to **certified** independent review **organizations** to **s. 601.43.** I believe existing law will subject the IRO to orders and forfeiture penalties. 633.06(1)

2. Add the following to sub. (5):

"**(e)** Standards for the **practices** and conduct of the **IRO.**

(f) Standards, in addition to those otherwise provided by this section, addressing conflict of interest by IRO.

3. Add the following

628.10 (2)(b)

"(6) The commissioner may revoke, suspend or **limit** in whole or in part, a certification issued under this **section if the commissioner finds the IRO is** unqualified. not of good character, or has **violated a law, rule or order, or if the IRO's** methods **or practices** in the **conduct of its business, or its financial** resources are inadequate to safeguard, the interests of **consumers** or the public. The commissioner may summarily suspend a **certificate** under **s.** 227.51 (3).

endanger

4. Draft should not address how managed care organization compensates IRO.

5. IRO addressed as organizations **rather** than individuals.

6. Change page 4 par. C. to refer to "procedures and process" rather than "Hearing procedures"-

7. I didn't **include** on the list the issue of duration of the certification of **IROs.** I think we agreed that one year was too short.

8. From the **NAIC** draft model language on conflict of interest and on immunity:

A. "An independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state or local trade **association** of health benefit plans, or a national, state or local trade association of health care providers.

B. The independent review **organization** selected to conduct the external review nor the diniwl peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or **financial** interest with any of the following:

(1) The health carrier that is the subject of the external review;

(2) Any **officer, director** or management employee of the health carrier that is the subject of the external review,

(3) The health **care** provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(4) The facility at which the recommended health care service or treatment would be provided; or

(5) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review.'

9. language for immunity:

'No independent review organization or clinical peer reviewer working on behalf of an independent review organization shall be liable in damages to any person for any opinions rendered during or upon completion of an external review conducted pursuant to this Act."

Sandy → 6-2254

J-notes

✓ (1) re removing redundant language from (4)(a)

✓ (2) adding "endanger" see s. 628.10(2)(b)

(3) remove language altogether about hbp paying a fee?

3-21 (4) some of changed & cl p re

4-7

4-9

✓ org beardonator?

Section #. 149.14 (4m) of the statutes is amended to read:

149.14 **(4m)** PAYMENT IS PAYMENT IN FULL. Except for copayments, coinsurance or deductibles required or authorized under the plan, a provider of a covered service or article shall accept as payment in full for the covered service or article the payment rate determined under ss. 149.143, 149.144 and 149.15 (3) (e) and may not bill an eligible person who receives the service or article for any amount by which the charge for the service or article is reduced under s. 149.143, 149.144 or 149.15 (3) (e).

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237.

Kahler, Pam

From: Lonergan, Sandra
Sent: Thursday, March 11, 1999 9:48 AM
To: Kahler, Pam
Subject: RE: OCI changes to LRB-2313

Hi Pam,
Ignore the circles -- they are meaningless. I am always happy to talk with you, but for us. today is going to be fun filled with 2 consecutively running Leg Council hearings both voting. Maybe later in the day?
Thanks,
Sandy

-----Original Message-----
From: Kahler, Pam
Sent: Thursday, March 11, 1999 9:44 AM
To: Lonergan, Sandra
Subject: OCI changes to LRB-2313

Hi, Sandy:
I thought I would e-mail you, in case we have a difficult time connecting. My main question about the OCI fax is whether there is any significance to the circled numbers. Should I ignore the circling or do you want me only to include those items that are circled? I think I will have to call you, though, with questions about specific items. Usually getting answers to these questions requires an immediate give-and-take, which is impossible by mail, e or otherwise.
Pam

State of Wisconsin
1999 - 2000 LEGISLATURE

LRB–2313/P2
PJK:wlj:jf

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

AN ACT *to create* 601.31 (1) (Lp), 601.31 (1) (Lr) and 632.83 of the statutes; **relating to:** independent review of denials of coverage on the basis of medical necessity, granting rule-making authority and providing an exemption from emergency rule procedures.

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SECTION 3. 632.83 of the statutes is created to read:

632.83 Independent review of medical necessity determinations. (1) In this section, "health benefit plan" has the meaning given in s. 632.745 (11).

(2) (a) Every health benefit plan shall establish an independent review procedure whereby an insured under the health benefit plan may request and obtain an independent review of any decision denying coverage for medical services made by or on behalf of the health benefit plan if all of the following conditions apply:

1. Coverage was denied on the basis of the medical necessity of the services provided or to be provided.

2. The value of the services for which coverage was denied exceeded or would exceed $500.

(b) An independent review under this section must be conducted by an independent reviewer certified under sub. (4).

(c) If a health benefit plan has an internal grievance procedure, the health benefit plan may require an insured to use the health benefit plan's internal grievance procedure before the insured may request an independent review.

(d) Whenever a health benefit plan denies coverage for services exceeding $500 in value on the basis of medical necessity, the health benefit plan shall advise the insured of the insured's right to obtain and how to request the independent review required under this section.

(3) (a) To request an independent review under this section, an insured shall pay a $50 fee to the independent reviewer. If the insured prevails on the review, the entire amount paid shall be refunded to the insured. For each independent review

in which it is involved, a health benefit plan shall pay to the independent reviewer a nonrefundable fee determined by the commissioner by rule.

(b) An independent reviewer may accept for consideration any evidence that the independent reviewer determines is relevant, regardless of whether the evidence has been submitted for consideration at any time previously.

(c) A decision of an independent reviewer must be consistent with the terms of the health benefit plan under which coverage was denied. A decision shall be in writing, signed by the independent reviewer and served by personal delivery or by mailing a copy to the insured and to the health benefit plan, or to a party's attorney of record. A decision of an independent reviewer is subject to judicial review and binding on the insured and the health benefit plan unless either party petitions for judicial review.

(4) (a) The commissioner shall certify individuals who may act as independent reviewers. An individual certified under this paragraph must be recertified on a biennial basis to continue to act as an independent reviewer. The commissioner may, for cause, revoke or suspend an individual's certification or refuse to recertify an individual as an independent reviewer.

(b) An individual applying for certification or recertification as an independent reviewer shall pay the applicable fee under s. 601.31 (1) (Lp) or (Lr). Every individual certified or recertified as an independent reviewer shall file an annual report with the commissioner in accordance with rules promulgated under sub. (5) (d).

(5) The commissioner shall promulgate rules for the independent review required under this section. The rules shall include at least all of the following:

(a) The application procedures for certification and recertification as an independent reviewer.

(b) The standards that the commissioner will use for certifying ~~or~~ and recertifying individuals as independent reviewers.

(c) ~~Hearing~~ procedures that independent reviewers must follow, including the times within which decisions must be rendered. The commissioner shall require a decision to be rendered more expeditiously if the services for which coverage was denied relate to a life-threatening condition.

(d) What must be included in the ~~annual~~ report required under sub. (4) (b).

(e) The fee that a health benefit plan must pay for each independent review in which it is involved.

SECTION 4. Nonstatutory provisions.

(1) **RULES REGARDING INDEPENDENT REVIEW.** Using the procedure under section 227.24 of the statutes, the commissioner of insurance shall promulgate rules required under section 632.83 (5) of the statutes, as created by this act, for the period before the effective date of the permanent rules promulgated under section 632.83 (5) of the statutes, as created by this act, but not to exceed the period authorized under section 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) (a), (2) (b) and (3) of the statutes, the commissioner is not required to provide evidence that promulgating a rule under this subsection as an emergency rule is necessary for the preservation of the public peace, health, safety or welfare and is not required to provide a finding of emergency for a rule promulgated under this subsection.

SECTION 5. Effective date.

(1) This act takes effect on the first day of the 10th month beginning after publication.

(END)

1999–2000 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-2313/P1ins
PJK:wlj:jf

INSERT A

Under current law, every managed care plan is required to have an internal grievance procedure under which an enrollee may submit a written grievance and a grievance panel must investigate the grievance and, if appropriate, take corrective action. This bill requires every health benefit plan, including managed care plans, to have an independent review procedure for grievances related to denials of coverage for medical services, equipment, drugs or devices. To be eligible for independent review, a denial must be based on medical necessity, and the value of the services, equipment, drug or device for which coverage was denied must be at least $500. An insured under a plan with an internal grievance procedure may be required to use the internal grievance procedure before requesting an independent review.

To request an independent review, an insured must pay $50, which is refunded to the insured if he or she prevails, in whole or in part, in the independent review. Any relevant evidence may be considered in an independent review, even if the evidence has not been considered at any time before. The decision at the conclusion of an independent review must be consistent with the terms of the health benefit plan and it must be in writing and served on both the insured who requested the review and the health benenfit plan. The decision is binding on the insured and the health benefit plan and subject to judicial review.

Under the bill, an independent review may be conducted only by an independent review organization, or a clinical peer reviewer on behalf of the organization, that has been certified by the commissioner of insurance (commissioner). A certified independent review organization must be recertified every two years to continue to conduct independent reviews. The commissioner may revoke, suspend or limit the certification of an independent review organization for various reasons specified in the bill.

The bill contains prohibitions aimed at avoiding conflicts of interest for independent review organizations, such as prohibiting an independent review organization from owning, controlling or being a subsidiary of a health benefit plan or an association of health benefit plans. The bill also provides independent review organizations and clinical peer reviewers who conduct independent reviews on behalf of independent review organizations with immunity from liability for decisions made in independent reviews.

Finally, the bill requires the commissioner to promulgate rules relating to such topics as the application procedures and standards for certification and recertification of independent review organizations, the procedures and processes that independent review organizations must use in independent reviews, standards for the practices and conduct of independent review organizations and additional standards related to conflicts of interest.

(END OF INSERT A)

INSERT 3-3

No ¶ conducting an independent review on behalf of an independent review organization

(END OF INSERT 3-3)

INSERT 3-21

¶ (c) The commissioner may examine, audit or accept an audit of the books and records of an independent review organization as provided for examination of licensees and permittees under s. 601.43 (1), (3), (4) and (5), to be conducted as provided in s. 601.44, and with costs to be paid as provided in s. 601.45.'

¶ (d) The commissioner may revoke, suspend or limit in whole or in part the certification of an independent review organization, or may refuse to recertify an independent review organization, if the commissioner finds that the independent review organization is unqualified, is not of good character or has violated an insurance statute or rule or a valid order of the commissioner under s. 601.41 (4), or if the independent review organization's methods or practices in the conduct of its business endanger, or its financial resources are inadequate to safeguard, the legitimate interests of consumers and the public. The commissioner may summarily suspend an independent review organization's certification under s. 227.51 (3).

(END OF INSERT 3-21)

INSERT 4-7

No ¶ and the frequency with which the report must be filed with the commissioner

(END OF INSERT 4-7)

INSERT 4-9

↓

Ins. 4-9

(e) Standards for the practices and conduct of independent review organizations,

(f) Standards, in addition to those in sub. (6), addressing conflicts of interest by independent review organizations.

(6) (a) An independent review organization may not own or control, be a subsidiary of, be owned or controlled in any way by, or exercise control with, any of the following:

1. A health benefit plan.

2. A national, state or local trade association of health benefit plans.

3. A national, state or local trade association of health care providers,

(b) An independent review organization selected to conduct an independent review and a clinical peer reviewer assigned by an independent review organization to conduct an independent review may not have a material professional, familial or financial interest with any of the following:

1. The health benefit plan that is the subject of the independent review.

2. Any officer, director or management employe of the health benefit plan that is the subject of the independent review.

3. The health care provider who recommended or provided the services, equipment, drug or device that is the subject of the independent review, or the health care provider's medical group or independent practice association.

4. The facility at which the services, equipment, drug or device that is the subject of the independent review was or would be provided.

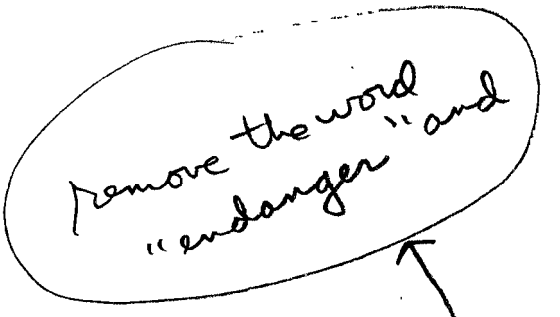
5. The developer or manufacturer of the principal procedure, equipment, drug or device that is the subject of the independent review.

(7) A certified independent review organization and a clinical peer reviewer who conducts reviews on behalf of a certified independent review organization shall not be liable in damages to any person for any opinion rendered during or at the completion of an independent review under this section.

(END OF INSERT 4-9)

DRAFTER'S NOTE
FROMTHE
LEGISLATIVE REFERENCE BUREAU

P 2
LRB-23 13/P1dn
PJK:wlj:jf



1. Because the language that OCI submitted on revoking, suspending and limiting certifications (see s. 632.83 (4) (d)) made the last sentence of s. 632.83 (4) (a) in the draft somewhat redundant, I removed that last sentence. Okay?

2. The language that OCI submitted on revoking, suspending and limiting certifications (s. 632.83 (4) (d)) is very similar to s. 628.10 (2) (b) in current law. I added the word "endanger" after "conduct of its business", which is the wording of s. 628.10 (2) (b), but I'm not sure that the omission of the word "endanger" was inadvertent. Is the language as drafted okay? If the omission was intentional, I will ~~just~~ move the commas around so that the language would mean that the methods or practices in the conduct of an independent review organization's business, as well as its financial resources, are inadequate to safeguard the interests of consumers or the public.

3. On the same topic (s. 632.83 (4) (d)), would an organization have "good ~~or bad~~ character?"

4. OCI indicated that the draft should not address how health benefit plans compensate independent review organizations. Should the last sentence of s. 632.83 (3) (a) be deleted altogether instead of just the part about OCI determining the fee?

5. Notice that I changed some references to "independent reviewer" in the previous version of the draft to "clinical peer reviewer" instead of to "independent review organization" because it seemed more appropriate. Are these changes okay? Are there any other instances where you would prefer "clinical peer reviewer"?

Pamela J. Kahler
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DRAFTER'S NOTE
FROMTHE
LEGISLATIVE REFERENCE BUREAU

LRB–2313/P2dn
PJK:wlj:jf

March 15, 1999

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Pamela J. Kahler
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DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–2313/P1dn
PJK:wlj:jf

March 15, 1999

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~~[illegible]~~

✓ p. 3, line 12 — An insured shall exhaust the health care plan's grievance procedure before the insured may req. of the health care plan an ind. review unless this would cause irreparable harm to the insured, as defined by the com by rule

(use seriously jeopardize, etc. see p 5, l 16)

✓ insert 4-10 — the IRO may not provide services unless cert by the com

✓ p 4 line 17 — add a report by com to leg on number & disposition of grievances filed

✓ amend 601.42(4) → to make it apply to IROs

in stats → paper review — no hearing or ~~personal appearances~~ (may not appear)

✓ (5)(g) standards for insurer contracts w/ IRO's

(put time frames in stats?)

State af Wisconsin
1999 - 2000 LEGISLATURE

LRB-23 13/P2
PJK:wlj:jf

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

AN ACT *t*o ***create*** 601.31 (1) (Lp), 601.31 (1) (Lr) and 632.83 of the statutes; **relating to:** independent review of denials of coverage on the basis of medical necessity, granting rule-making authority and providing an exemption from emergency rule procedures.

Analysis by the Legislative Reference Bureau

Under current law, every managed care plan is required to have an internal grievance procedure under which an enrollee may submit a written grievance and a grievance panel must investigate the grievance and, if appropriate, take corrective action. This bill requires every health benefit plan, including managed care plans, to have an independent review procedure for grievances related to denials of coverage for medical services, equipment, drugs or devices. To be eligible for independent review, a denial must be based on medical necessity, and the value of the services, equipment, drug or device for which coverage was denied must be at least $500. An insured under a plan with an internal grievance procedure may be required to use the internal grievance procedure before requesting an independent review.

To request an independent review, an insured must pay $50, which is refunded to the insured if he or she prevails, in whole or in part, in the independent review. Any relevant evidence may be considered in an independent review, even if the evidence has not been considered at any time before. The decision at the conclusion of an independent review must be consistent with the terms of the health benefit plan and it must be in writing and served on both the insured who requested the review

and the health benefit plan. The decision is binding on the insured and the health benefit plan and subject to judicial review.

Under the bill, an independent review may be conducted only by an independent review organization, or a clinical peer reviewer on behalf of the organization, that has been certified by the commissioner of insurance (commissioner). A certified independent review organization must be recertified every two years to continue to conduct independent reviews. The commissioner may revoke, suspend or limit the certification of an independent review organization for various reasons specified in the bill.

The bill contains prohibitions aimed at avoiding conflicts of interest for independent review organizations, such as prohibiting an independent review organization from owning, controlling or being a subsidiary of a health benefit plan or an association of health benefit plans. The bill also provides independent review organizations and clinical peer reviewers who conduct independent reviews on behalf of independent review organizations with immunity from liability for decisions made in independent reviews.

Finally, the bill requires the commissioner to promulgate rules relating to such topics as the application procedures and standards for certification and recertification of independent review organizations, the procedures and processes that independent review organizations must use in independent reviews, standards for the practices and conduct of independent review organizations and additional standards related to conflicts of interest.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 601.31 (1) (Lp) of the statutes is created to read:

601.31 **(1)** (Lp) For certifying as an independent review organization under s. *632.83, $400.*

SECTION 2. 601.31 (1) (Lr) of the statutes is created to read:

601.31 **(1)** (Lr) For each biennial recertification as an independent review organization under s. 632.83, $100.

SECTION 3. 632.83 of the statutes is created to read:

632.83 Independent review of medical necessity determinations. (1) In this section, "health benefit plan" has the meaning given in s. 632.745 (11).

(2) (a) Every health benefit plan shall establish an independent review procedure whereby an insured under the health benefit plan may request and obtain an independent review of any decision made by or on behalf of the health benefit plan denying coverage for medical services or equipment or drug or device if all of the following conditions apply:

1. Coverage was denied on the basis of the medical necessity of the services, equipment, drug or device.

2. The value of the services, equipment, drug or device for which coverage was denied exceeded or would exceed $500.

(b) An independent review under this section must be conducted by an independent review organization certified under sub. (4).

(c) ~~If a health benefit plan has an internal grievance procedure, the~~ health benefit plan may require an insured to use the health benefit plan's internal grievance procedure before the insured may request an independent review.

(d) Whenever a health benefit plan denies coverage for services or equipment or a drug or device exceeding $500 in value on the basis of medical necessity, the health benefit plan shall advise the insured of the insured's right to obtain and how to request the independent review required under this section.

(3) (a) To request an independent review under this section, an insured shall pay a $50 fee to the independent review organization. If the insured prevails on the review, in whole or in part, the entire amount paid by the insured shall be refunded to the insured. For each independent review in which it is involved, a health benefit plan shall pay a fee to the independent review organization.

(b) A clinical peer reviewer conducting an independent review on behalf of an independent review organization may accept for consideration any evidence that the

clinical peer reviewer determines is relevant, regardless of whether the evidence has been submitted for consideration at any time previously.

(c) A decision of an independent review organization must be consistent with the terms of the health benefit plan under which coverage was denied. A decision shall be in writing, signed by the clinical peer reviewer conducting the review on behalf of the organization and served by personal delivery or by mailing a copy to the insured and to the health benefit plan. A decision of an independent review organization is binding on the insured and the health benefit plan and creates a rebuttable legal presumption in any subsequent action

(4) (a) The commissioner shall certify independent review organization. An organization certified under this paragraph must be recertified on a biennial basis to continue to act as an independent review organization.

(b) An organization applying for certification or recertification as an independent review organization shall pay the applicable fee under s. 601.31 (1) (Lp) or (Lr). Every organization certified or recertified as an independent review organization shall file a report with the commissioner in accordance with rules promulgated under sub. (5) (d).

(c) The commissioner may examine, audit or accept an audit of the books and records of an independent review organization as provided for examination of licensees and permittees under s. 601.43 (1), (3), (4) and (5), to be conducted as provided in s. 601.44, and with costs to be paid as provided in s. 601.45.

(d) The commissioner may revoke, suspend or limit in whole or in part the certification of an independent review organization, or may refuse to recertify an independent review organization, if the commissioner finds that the independent review organization is unqualified, is not of good character or has violated an

insurance statute or rule or a valid order of the commissioner under s. 601.41 (4), or if the independent review organization's methods or practices in the conduct of its business endanger, or its financial resources are inadequate to safeguard, the legitimate interests of consumers and the public. The commissioner may summarily suspend an independent review organization's certification under s. 227.51 (3).

(5) The commissioner shall promulgate rules for the independent review required under this section. The rules shall include at least all of the following:

(a) The application procedures for certification and recertification as an independent review organization.

(b) The standards that the commissioner will use for certifying and recertifying organizations as independent review organizations.

(c) Procedures and processes that independent review organizations must follow, including the times within which decisions must be rendered. The commissioner shall require a decision to be rendered more expeditiously if the services, equipment, drug or device for which coverage was denied relate to a life–threatening condition, serious injury, impairment or as determined by the insured's treating provider (or the same)

(d) What must be included in the report required under sub. (4) and the frequency with which the report must be filed with the commissioner.

(e) Standards for the practices and conduct of independent review organizations.

(f) Standards, in addition to those in sub. (6), addressing conflicts of interest by independent review organizations.

(6) (a) An independent review organization may not ~~own or control, be a subsidiary of, be owned or controlled in any way by, or exercise control~~ be affiliated with, any of the following:

1. A health benefit plan.

2. A national, state or local trade association of health benefit plans.

3. A national, state or local trade association of health care providers.

(b) An independent review organization selected to conduct an independent review and a clinical peer reviewer assigned by an independent review organization to conduct an independent review may not have a material professional, familial or financial interest with any of the following:

1. The health benefit plan that is the subject of the independent review.

2. Any officer, director or management employe of the health benefit plan that is the subject of the independent review.

3. The health care provider that recommended or provided the services, equipment, drug or device that is the subject of the independent review, or the health care provider's medical group or independent practice association.

4. The facility at which the services, equipment, drug or device that is the subject of the independent review was or would be provided.

5. The developer or manufacturer of the principal procedure, equipment, drug or device that is the subject of the independent review.

6. The insured or his or her authorized representative.

(7) A certified independent review organization and a clinical peer reviewer who conducts reviews on behalf of a certified independent review organization shall not be liable in damages to any person for any opinion rendered during or at the completion of an independent review under this section.

SECTION 4. Nonstatutory provisions.

(1) **RULES REGARDING INDEPENDENT REVIEW.** Using the procedure under section 227.24 of the statutes, the commissioner of insurance shall promulgate rules required under section 632.83 (5) of the statutes, as created by this act, for the period

before the effective date of the permanent rules promulgated under section 632.83 (5) of the statutes, as created by this act, but not to exceed the period authorized under section 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) (a), (2) (b) and (3) of the statutes, the commissioner is not required to provide evidence that promulgating a rule under this subsection as an emergency rule is necessary for the preservation of the public peace, health, safety or welfare and is not required to provide a finding of emergency for a rule promulgated under this subsection.

SECTION 5. Effective date.

(1) This act takes effect on the first day of the ~~10th~~ 13 month beginning after publication.

(END)

but rule-making immediately

HIAA®
Health Insurance Association of America

April 2, 1999

Rep. Gregg Underheim
P.O. Box 8953
Room 11 North
Madison, WI 53708

Dear Gregg:

I've sketched below some of the issues for consideration with respect to your external review bill. The preliminary draft of the legislation has already incorporated a number of the elements about which the industry feels strongly, but there some additionalissues pertaining to the intended scope of the legislation you may want to look at. Additionally, I'm attaching a memorandum we developed highlighting those issues we believe most-important: for external review. You will find a number of passages containing language; which may, be of some help, as you work through the process.

- The bill is unclear as to who can request a review. The patient or his-representative should be, allowed, but probably not a provider except in very narrow circumstances. Suggested language is attached.

- The bill is unclear as to the process by which the Independent Review Organization becomes involved. Some clarification is needed to define just how this process will work; what level of government involvement will be required and some specifics on time.

- The draft bill includes an appropriate provision for a threshold below which claims may not be brought. This is included to reflect the significant administrative costs associated with a review and attempts to balance the interests of the covered person with the problems posed by less than meritorious claims. We would request that you considering lifting that number to $1000 initially and then indexing it for inflation based on the medical CPI.

- The draft bill requires that a plan pay a fee to the IRO, but sets no limits or conditions on such fees. Language should be included to limit such an open-ended statement.

- The draft appropriately binds the parties to the decision of the IRO, but is silent about what weight such a decision would carry in any subsequent judicial proceeding. The bill also does not address the issue of the liability of a carrier if it is sued for acting in accordance with the decision of an IRO. We would suggest that the law contain language that in a subsequent legal action there is a rebuttable presumption in favor of the finding of the IRO and that a carrier may not be held liable for any damages resulting from its acting in accordance with the decision.

- Minimum standards for reviewers need to be created, HIAA believes that in order to have a creditable procedure, strong conflict of interest provisions are required. Some suggested language is attached.

- The IRO should be required to maintain a quality assurance mechanism.

- The IRO must be required by statute to hold the medical records it receives in confidence.

There are a number of other less important issues to be addressed, but the attached will give you a pretty comprehensive overview of the issues to be considered as you move forward.

Thank you for the opportunity to submit this information to you. I'm interested in participating in refining this bill as it moves along and would invite you to call on HIAA for that purpose at any time. Please call me if you have any question on anything above or attached.. I'll look forward to seeing you again when I'm next in Madison.

Sincerely,

Jeffrey L. Gabardi
Legislative Director and Counsel

Scope of External Review

The range of issues subject to external review should be limited to decisions regarding medical necessity of covered services and not to issues involving coverage questions. Other key health care issues such as quality, access, and emergency care are governed by state law. Establishing an external review process to examine a wide range of issues is unnecessary and would lead to large cost increases without promoting health care quality. Some suggested language is:

A health carrier shall make available an external review process to examine the carrier's coverage decisions for covered persons who have been denied coverage based on:

1. ***a determination, by the' carrier that the service or treatment does not meet the definition of "medical necessity" as set forth in the covered person's evidence of coverage under the plan;***
2. ***the service or treatment is not considered experimental or investigational by the health carrier; and***
3. ***the service or treatment would be a covered benefit; except for. the -carrier's determination that the service or treatment does not meet the definition of "medical necessity".***

IL Who may access External Review procedures

Only covered persons and their legal guardians or representatives (in the case of those who are incapacitated or minors) should be permitted to file for external review. Attending physicians should only be permitted to file on their behalf with the express written consent of the covered person (or the covered person's legal guardian). Health carriers already have established internal procedures to resolve differences with physicians and other health professionals. Additionally, ensuring patients' privacy in their medical records is difficult, if not impossible, unless the health carrier can require a signed statement from its member permitting it to release medical records to outside individuals for the purpose of conducting the external review. We suggest the following language:

(I) A coveredperson, or in the case of a minor or an incapacitated individual, the covered person's legal guardian or representative shall have the right to request an external review.

(II) A coveredperson's attending physician may only request a review on behalf of a covered person if at the time of the request for external review, the covered person has:

(a) provided the attending physician with a written authorization to request the external appeal for the disputed treatment or service on covered person's behalf; and

(b) Provided the health carrier with a written authorization to release the coveredperson 's medical records to the external review entity.

III. How to Access External Review

Individuals should be required to exhaust a heath carrier's internal grievance procedures before filing an external review. Health carrier's internal procedures have served as an effective first step to address concerns about adverse coverage determinations, and these procedures should be allowed to work. Often disagreements about coverage can be resolved immediately and with minimal cost, through a simple telephone conversation that provides, for example, missing information needed to resolve a coverage question or issue: We suggest the following language:

A coveredperson shall be eligible to submit an adverse decision for external review if:

(1) The coveredperson is a member of the health carrier in good standing, and is otherwise, eligible to receive covered benefits under the health plan; and

(2) The coveredperson has exhausted the health carrier 's internal appeals procedures except that the health carrier and coveredperson may jointly agree to waive this requirement.,

External review requirements should include a minimum dollar threshold for the -value of services subject to review. This threshold should reflect, the significant administrative costs associated with the external review process. Without a minimum dollar threshold, covered persons could file appeals for coverage of relatively low-cost services. Under such a system, health carriers would have an incentive to cover medically ***unnecessary*** services that cost less than an external review -- to avoid the significant administrative expenses associated with this process. Such an outcome would not promote quality care, and it would increase costs significantly. Some suggested language is:

A coveredperson is entitled to request an external review if all other applicable criteria are met, and if the proposed service or treatment at issue would require the health carrier to incur $1,000.00 or more of expenditures to cover such treatment or service. This threshold amount shall be indexed annually for inflation by reference to the medical care component of the CPI.

IV. Qualifications of External Review Entities

The Commissioner should certify external review entities that have met certain minimum requirements. Health carriers must select external review entities from a list of certified external review entities when sending an appeal for external review. This places the decision whether to approve an external review entity outside the control of the health carrier and ensures impartiality. Additionally, the entities eligible for inclusion on the Commissioner's list should

meet certain quality standards, and should be free of any conflict of interest. We suggest the following:

(I) The Commissioner shall compile a list of external review entities.

(II) External review entities qualified for inclusion on the list maintained by the Commissioner shall meet the following requirements:

(I) Expert reviewers must be physicians or other appropriate providers who meet the following minimum requirements:

(a) Are expert in the treatment of the coveredperson 's medical condition, .and knowledgeable about. the recommended service or treatment through actual clinical experience;

(b) Hold a non-restricted.license in a state of the United States, and for physicians, a current certification by a recognized American medical specialty board in the areas appropriate to the subject of review; and

(c) Have no history of disciplinary actions or sanctions taken or pending by any, hospital, government or regulatory body.

(2) The external review entity shall not be a subsidiary of, nor in any way owned or controlled by, a health plan, a trade association or health plans, or a professional association of health care providers.

(3) Neither the expert reviewer, nor the external review entity, has any material professional, familial, orfinancial conflict of interest with any of the following:

(a) The health carrier;

(b) Any officer, director, or management employee of the health carrier;

(c) The physician, the physician 's medical group, or the independent practice association proposing the service or treatment;

(d) The institution at which the service or treatment would be provided; or

(e) The development or manufacture of the principal drug, device, procedure, or other therapy proposedfor the coveredperson whose treatment is under review.

(4) The term "conflict of interest" shall not be interpreted to include:

(a) A contract under which an academic medical center, or other similar medical research center, provides health services to the carrier 's enrollees;

(b) Affiliations which are limited to staff privileges at a health facility;

(c) An expert reviewer's participation as a carrier 's contracting provider where the reviewer does not have a material interest in the financialperformance of the carrier; or

(d) An expert reviewer 's affiliation with an academic medical center or other similar medical research center that is acting as an external review entity under this section where the reviewer does not have a material interest in the financial performance of the medical center.

(III) The health carrier may only contract with external review entities qualified for inclusion on the list maintained by the Commissioner.

V. Standard of Review and Review procedures

External reviewers should not be allowed to change contractterms. External review entities - which are not accountable for quality of care or cost of coverage -- should not have the authority to make decisions that are inconsistent with the terms of health plan contracts negotiated with employers voluntarily providing coverage:

External reviewers should be required to make written determinations. External review entities should be required to state the basis for their decisions, and the grounds (and evidence) upon which those decisions are based.

We suggest the following language:

The external review entity 's determination shall be in writing and shall state the reasons the requested service or treatment should or should not be covered under the terms and conditions setforth in the evidence of coverage. The external review entity shall make determination based on the applicable coverage documents, including any defined terms that are providedfor, such as "'medially necessary ", and shall not expand the contractually agreed upon coverage. The external review entity determination shall specifically cite the relevant provisions in the evidence of coverage, the covered person 's specific medical condition, and the relevant documents provided pursuant to this Act to support the external review entity 's decision.

External reviewers should make timely decisions, and specific procedures for the conduct of the appeal should be included. External review entities and the individuals wishing to access their services should have time frames within which to operate. We suggest the following:

(I) The coveredperson shall initiate an external review no later than 45 days after the coveredperson receives notice from the health carrier of an adverse determination from an internal appeal.

(II) The request for an external review shall be made in writing to the carrier.

(III) An external review shall be a non-adversarialproceeding. The coveredperson and the health carrier shall have the opportunity to submit additional documentation to the external review entity.

(IV) The external review entity shall make its determination, in writing, within 20 working days of its receipt of all necessary documentation. However, if the external review entity cannot make a decision within 20 working days due to circumstances beyond the external review entity's control, the external review entity may take up to an additional 10 working days to issue its decision, if the external review entity provides written notice to the covered person and the health carrier of the extension and the reasons for the delay on or before the twentieth working day after receiving a request for review and all necessary documentation.

(V) Notwithstanding the provisions of paragraph (IV) of this subsection, if the covered person 's attending physician states in writing that a delay in providing the health care service would pose an imminent or serious threat to the health of the covered person, the external review shall be completed as soon as required or appropriate for the condition, but in no event later than 7 days from the date of receipt of the attending physician 's written notice.

(VI) In making its final decision, the external review entity shall consider, the clinical standards of the health carrier, the information provided concerning the covered person, including the attending physician 's recommendations.

VI. Post-decision

External review decisions should be binding on both the health plan and the covered person. Without a binding decision, external review would add no value to the dispute resolution process; a covered person could continue filing external appeals until he or she obtained the desired result. Additionally, health carriers should have immunity from liability for their actions taken in accordance with an external review entity's decision. We suggest the following:

(I) The determinations of the external review entity shall be binding on the carrier and the covered person.

(II) In any subsequent action resulting from the same facts underlying the external review, there shall be a rebuttable presumption in favor of the decision of the external review entity.

(III) In any subsequent action resultingfrom the same facts underlying the external review, the health carrier shall not be liable for any damages resultingfrom its acting in accordance with the decision of the external review entity.

Mallow, Eileen

From: Nepple, Fred
Sent: Monday, March 22, 1999 3:00 PM
To: Mallow, Eileen
cc: Walsh, Julie
Subject: Independent review

1. "An insured is not required to use or exhaust the independent review provided under this section prior to seeking any other remedy, in court or otherwise, permitted under state or federal law."

2. "600.01 (2) (c) Group or blanket insurance described in sub. (1) (b) 3 and 4, is not exempt from s. 632.83."