State af Wisconsin
1999 - 2000 LEGISLATURE

LRB-2313/P3
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.

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.

FE-SL

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

Insert 2-11

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:

Insert 2-6

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 of 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 the independent review required under this section.

(3) (a) To request an independent review under this section, an insured 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 is subject to judicial review.

(4) (a) The commissioner shall certify independent review organizations. 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. 60 1.3 l(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 (l), (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, as determined by the insured's health care provider

(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 with~~ 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. This act takes effect on the first day of the ~~12th~~ month beginning after publication, except as follows:

(END)

(1) The treatment of section 632.835(5) of the statutes and SECTION 4 of this act take effect on the day after publication.

(End)

Insert 1-A

(CS) NOTE: Except for a couple of technical changes, this analysis has not been changed from the "P2" version of the draft. The analysis will be finalized with the next version, after all of the information for the draft has been received.

(end of ins. 1-A)

Insert 2-1

Section #. 600.01 (2) (b) of the statutes is amended to read:

600.01 (2) (b) Group or blanket insurance described in sub. (1) (b) 3. and 4. is not exempt from ss. 632.745 to 632.749 or ch. 633 or 635.

History: 1971 c. 260; 1975 c. 375,421; 1975 c. 422 s. 163; 1977 c. 203; 1979 c. 89, 102, 177; 1983 a. 358 s. 14; 1989 a. 31; 1989 a. 187 s. 29; 1989 a. 317,336; 1991 a. 39, 69, 250, 309; 1993 a. 16; 1995 a. 116, 150,289; 1997 a. 27, 35.

632.83 or 632.835

(end of ins. 2-1)

Insert 2-6

Section #. 601.42 (4) of the statutes is amended to read:

601.42 (4) **Replies.** Any officer, manager or general agent of any insurer authorized to do or doing an insurance business in this state, any person controlling or having a contract under which the person has a right to control such an insurer, whether exclusively or otherwise, any person with executive authority over or in charge of any segment of such an insurer's affairs, any individual practice association or officer, director or manager of an individual practice association, any insurance agent or other person licensed under chs. 600 to 646, any provider of services under a continuing care contract, as defined in s. 647.01 (2), or any health care provider, as defined in s. 655.001 (8), shall reply promptly in writing or in other designated form, to any written inquiry from the commissioner requesting a reply.

History: **1977 c. 339 s. 43; 1979 c. 89; 1979 c. 102 ss. 69, 236** (8), **(21); 1979 c. 177; 1983 a. 358 ss. 9, 14; 1987 a. 247; 1989 a. 23; 1989 a. 187 ss. lm, 29; 1989 a. 332; 1991 a. 316; 1997 a. 237.**

any independent review organization certified under s. 632.835(4)

continued on-line

INSERT 2-6 CONTD

SECTION 1. 609.15 (1) (intro.) of the statutes is renumbered 609.15 and amended to read:

609.15 Grievance procedure. Each limited service health organization, preferred provider plan and managed care plan shall ~~do all of the following:~~ establish and use an internal grievance procedure as nrovided in s. 632.83.'

History: 1985 a. 29; 1997 a. 237.

SECTION 2. 609.15 (1) (a) of the statutes is renumbered 632.83 (2) (a) and amended to read:

632.83 (2) (a) Establish and use an internal grievance procedure that is approved by the commissioner and that complies with sub. (2) for the resolution of ~~enrollees'~~ insureds' grievances with the ~~limited . rvice health organization, preferred provider plan or managed care~~ health benefit plan.

History: 1985 a. 29; 1997 a. 237.

SECTION 3. 609.15 (1) (b) of the statutes is renumbered 632.83 (2) (b) and amended to read:

632.83 (2) (b) Provide ~~enrollees~~ insureds with complete and understandable information describing the internal grievance procedure under par. (a).

History: 1985 a. 29; 1997 a. 237.

SECTION 4. 609.15 (1) (c) of the statutes is renumbered 632.83 (2) (c).

SECTION 5. 609.15 (2) (intro.) of the statutes is renumbered 632.83 (3) (intro.) and amended to read:

632.83 (3) (intro.) The internal grievance procedure established under sub. ~~(1)~~ (2) (a) shall include all of the following elements:

History: 1985 a. 29; 1997 a. 237.

SECTION 6. 609.15 (2) (a) of the statutes is renumbered 632.83 (3) (a) and amended to read:

ins. 2-6 cont'd

632.83 (3) (a) The opportunity for an ~~enrollee~~ insured to submit a written grievance in any form.

History: 1985 a 29; 1991 a. 237.

SECTION 7. 609.15 (2) (b) of the statutes is renumbered 632.83 (3) (b) and amended to read:

632.83 (3) (b) Establishment of a grievance panel for the investigation of each grievance submitted under par. (a), consisting of at least one individual authorized to take corrective action on the grievance and at least one ~~enrollee~~ insured other than the grievant, if an ~~enrollee~~ insured is available to serve on the grievance panel.

History: 1985 a. 29; 1997 a. 237.

SECTION 8. 609.15 (2) (c) of the statutes is renumbered 632.83 (3) (c).

SECTION 9. 609.15 (2) (d) of the statutes is renumbered 632.83 (3) (d).

SECTION 10. 609.15 (2) (e) of the statutes is renumbered 632.83 (3) (e).

SECTION 11. 632.83 of the statutes is created to read:

632.83 Internal grievance procedure. (1) In this section, "health benefit plan" has the meaning given in s. 632.745 (11).

(2) Each health benefit plan shall do all of the following:

(ENDOFINSERT2-6)

INSERT 3-14

(c) An insured must exhaust the health benefit plan's internal grievance procedure before the insured may request an independent review under this section, unless the delay will result for the insured in serious injury or impairment or a life-threatening condition, as determined by the insured's health care provider.

(END OF INSERT 3-14)

INSERT 3–18

, how to request the review and the time within which the review must be requested

(END OF INSERT 3–18)

INSERT 3–19

(2m) Beginning in 2001, to reflect changes in the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, the commissioner shall at least annually adjust the value of the services, equipment, drugs or devices for which coverage must be denied in order for an insured to be eligible for independent review under this section.

(END OF INSERT 3-19)

INSERT 3–20

or his or her authorized representative shall provide written notice of the request for independent review to the health benefit plan that denied the coverage. The health benefit plan shall immediately notify the commissioner of the request, and the commissioner shall appoint an independent review organization to conduct the review. The insured or his or her authorized representative must

(END OF INSERT 3–20)

INSERT 3-24

2 spaces after (b) in draft →

An independent review under this section shall be based on the record of the proceedings, if any, in which the decision under review was made.

(END OF INSERT 3–24)

INSERT 4–2

An independent review under this section may not include appearances by the insured or his or her authorized representative, any person representing the health benefit plan or any witness on behalf of either the insured or the health benefit plan.

(END OF INSERT 4–2)

INSERT 4–9

A rebuttable presumption that the decision was correct applies in any subsequent legal proceeding.

(END OF INSERT 4–9)

INSERT 4–10

0 mly an independent review organization that has been certified by the commissioner may provide independent review services under this section.

(END OF INSERT 4–10)

INSERT4-12

provide independent review services under this section

(END OF INSERT 4-12)

INSERTS-~

(e) The commissioner shall annually submit a report to the legislature under s. 13.172 (2) that specifies the number of independent reviews requested under this section in the preceding year, the insurers and health benefit plans involved in the independent reviews and the dispositions of the independent reviews.

(END OF INSERT 5–5)

INSERT 5-22

(g) Standards for contracts between insurers and independent review organizations.

(END OF INSERT 5-22)

INSERT 6-21

(b) A health benefit plan that is the subject of an independent review and the insurer that issued the health benefit plan shall not be liable in damages to any person for complying with any decision rendered by an independent review organization during or at the completion of an independent review under this section.

(END OF INSERT 6-21)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-2313/P3dn
PJK:wlj:jf

1. In addition to requiring group or blanket insurance described in s. 600.01 (1) (b) 3. and 4. to be subject to the independent review requirement, I made it subject to the internal grievance procedure requirement. Is this okay?

2. I made s. 601.42 (4) apply only to independent review organizations that are certified by the commissioner. Is this okay?

3. I kept a few "clinical peer reviewers" in the draft. See s. 632.835 (6) and (7). Is this okay?

4. Do you want to specify a date by which OCI must submit its report on independent reviews? Notice that I made the report include the insurers and health benefit plans for which independent reviews were requested. See s. 632.835 (4) (e).

5. On the issue of confidentiality of medical records (I assumed the issue was whether medical records used in a review would remain confidential), ss. 51.30, 146.82 and 252.15 provide that certain types of health care records are confidential. Section 146.82 (2) (b) specifically prohibits redisclosure of identifying information from patient health care records by any recipient who obtains the information without informed consent under s. 146.82 (2) (a). If the information is obtained with informed consent under s. 146.82 (1), presumably the consent limits to whom the information may be disclosed (the recipient). Section 51.30 (4) (a) provides that mental health records are confidential and may be released only with the informed consent of the individual who is the subject of the records, except for the situations specified in s. 51.30 (4) (b), under which the records may be released without informed consent. Section 252.15 (5) (a) provides that HIV test records may not be disclosed except by the individual who is the subject of the test and except in the situations specified in s. 252.15 (5) (a) 1. to 19. I think that there are sufficient safeguards under current law for keeping health care records in the possession of an independent review organization confidential.

6. Is s. 632.835 (2) (c) okay as drafted? I specified that the condition of the insured would be determined by the insured's health care provider, as in the rule under s. 632.835 (5) (c).

7. Section 632.835 (6) (b) 1. and 2. were changed to the insurer that issued the health benefit plan. Should s. 632.835 (6) (a) 1. or 2. be changed similarly to an insurer that offers a health benefit plan?

8. I moved the ch. 609 internal grievance procedure requirement to s. 632.83. Under ch. 609, the requirement applied to preferred provider plans, limited service health

organizations and managed care plans. I believe that the definition in s. 632.745 (11) for health benefit plan includes all three (the definition in s. 609.01 (lg) does not). Please verify this with OCI.

9. I specified in s. 632.835 (3) (b) that any previous record and any additional typed *or printed* evidence may be considered. Do you want to allow filmed depositions? Do you want to require that a party provide a copy to the other party of any evidence submitted to the independent review organization, especially since new evidence may be submitted? If so, the other party should have some time to submit evidence in response.

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DRAFTER'S NOTE
FROMTHE
LEGISLATIVE REFERENCE BUREAU

LRB–2313/P3dn
PJK:wlj:jf

April 20, 1999

1. In addition to requiring group or blanket insurance described in s. 600.01 (1) (b) 3. and 4. to be subject to the independent review requirement, I made it subject to the internal grievance procedure requirement. Is this okay?

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do slash 1 next

✓* def for adverse determination - basis for triggering IR

✓ IRO ⇒ requires contract of 3 yrs

✓* hb plan contract w/ IRO (one or more) require hb plans to contract (even before an IR)

✓* hbp fails to renew, notice OCI + tele reasons for not renewing

✓* GA stat. pp 6+7 experimental-treatment language is

✓ get rid of "med. nec" concept

✓ keep $500

wants to introduce in early Sept. (hearing on 14th)

Drafting Note: This Act governs the processes relating to external review procedures only. For processes related to a health carrier's internal grievance procedures, see the NAIC Health Carrier Grievance Procedure Model Act.

Drafting Note: States are strongly encouraged to adopt both this Act and the NAIC's Health Carrier Grievance Procedure Model Act, which sets out an internal grievance process for the review of written grievances stemming from adverse determinations, as defined in that Act. The external review procedures of this Act assume the existence of the internal grievance process outlined in the NAIC Health Carrier Grievance Procedure Model Act. This Act also assumes that any adverse determination that remains in dispute after the health carrier's internal grievance process has been exhausted and for which a request for an external review is made under this Act, will be considered a "final adverse determination," as that term is defined by this Act. Further, this Act assumes that, in a case in which the health carrier's internal grievance process has not been exhausted prior to a request for external review under this Act, the subject of the request for external review will be the adverse determination made by the health carrier or its designee utilization review organization pursuant to the NAIC's Utilization Review Model Act.

Section 3. Definitions

For purposes of this Act:

A. "Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

Drafting Note: The definition of "adverse determination" should be interpreted broadly to ensure that all adverse determinations where the covered person believes the treatment or service is medically necessary are eligible for external review in accordance with the provisions of this Act. It includes, for example, adverse determinations regarding cosmetic procedures, when the covered person requests the health care service on medical necessity grounds rather than for cosmetic reasons. It also includes adverse determinations related to out-of-network services, when the covered person requests health care services from a provider that does not participate in the health carrier's provider network because the clinical expertise of the provider may be medically necessary for treatment of the covered person's medical condition and that expertise is not available in the health carrier's provider network. States may wish to consider carving out adverse determinations related to out-of-network services depending on their regulatory structure relating to utilization review and out-of-network ~~adequacy~~ treatment decisions, including any concurrent jurisdiction among state agencies that may be applicable, in determining the scope of the external review process.

Denials of coverage based on a determination that a treatment or service is experimental also are adverse determinations. The NAIC believes, however, that the review of these denials should be

Draft: 7/16/99

The NAIC solicits comments on this draft. Comments should be addressed to Jolie H. Matthews, NAIC, 444 N. Capitol St., N.W., Suite 701, Washington, D.C. 20001-1512. Underlining and overstrikes show changes from the 6/10/99 draft.

HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Health Carrier External Review Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act as a regulation. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as a regulation.

Section 2. Purpose and Intent

The purpose of this Act is to provide standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in this Act.

subject to separate external review standards and procedures. The NAIC will develop a section to be included in this model law or develop a new model law to address these denials. Any state adopting this model law prior to the development of separate standards and procedures for denials based on experimental treatment should consider developing separate external review standards and procedures for these denials.

B. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

C. (1) "Authorized representative" means :

(a) A person to whom a covered person has given express written consent to represent the covered person in an external review;

(b) A person authorized by law to provide substituted consent for a covered person; or

(c) A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent.

D. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

E. "Certification" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

F. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

G. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

H. "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

I. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

J. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

K. "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

L. "Disclose" means to release, transfer or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

M. "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

N. "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

0. "Facility" means an institution providing health care services or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

P. "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

Drafting Note: States that do not require covered persons to exhaust a health carrier's internal grievance process procedures before filing a request for an external review should not adopt the definition of "final adverse determination" in Subsection P and should not use the term in the rest of the law.

Q. "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

R. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate "persons."

S. "Health care provider" or "provider" means a health care professional or a facility.

T. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

U. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

V. "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(1) The past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(2) The provision of health care services to an individual; or

(3) Payment for the provision of health care services to an individual.

W. "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

X. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

Y. "Prospective review" means utilization review conducted prior to an admission or a course of treatment.

Z. "Protected health information" means health information:

(1) That identities an individual who is the subject of the information; or

(2) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

AA. "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

BB. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.

cc. "Utilization review" means a set of formal techniques' designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

DD. "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing a review for its own health plans.

Section 4. Applicability and Scope

A. Except as provided in Subsection B, this Act shall apply to all health carriers that provide or perform utilization review.

B. The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Section 5. Notice of Right to External Review

A. A health carrier shall notify the covered person in writing of the covered person's right to request an external review and include the appropriate statements and information set forth in Subsection B at the time the health carrier sends written notice of:

(1) An adverse determination upon completion of the health carrier's utilization review process set forth in [insert reference to state law equivalent to the Utilization Review Model Act]; and

(2) A final adverse determination.

B. (1) The health carrier shall include in the notice required under Subsection A:

(a) For a notice related to an adverse determination, a statement informing the covered person that:

(i) If the, covered person has a medical condition where the timeframe for completion of an expedited review of a grievance involving an adverse determination set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to Section 9 of this Act at the same time the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act], but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review; and

(ii) The covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process as set forth in [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act], but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within thirty

(30) days following the date the covered person or the covered person's authorized representative files the grievance with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review pursuant to Section 6 of this Act and shall be considered to have exhausted the health carrier's internal grievance process for purposes of Section 7 of this Act; and

(b) For a notice related to a final adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to Section 9 of this Act; or

(ii) If the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person or the covered person's authorized representative may request an expedited external review pursuant to Section 9 of this Act.

(2) In addition to the information to be provided pursuant to Paragraph (l), the health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant to Section 17 of this Act, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

Drafting Note: States may wish to specify more particularly the information that must be included in the written notice.

(3) As part of any forms provided under Paragraph (2), the health carrier shall include an authorization form, or other document approved by the commissioner, by which the covered person, for purposes of conducting

an external review under this Act, authorizes the health carrier to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review, as provided in [insert reference to state law equivalent to Section 10H of the Health Information Privacy Model Act].

Section 6. Request for External Review

Option 1.

Drafting Note: The following Option 1 for Section 6A applies to states that choose to establish the external grievance process in the office of the commissioner and require that covered persons tile all requests for external review with the commissioner.

A. Except for a request for an expedited external review as set forth in Section 9 of this Act, all requests for external review shall be made in writing to the commissioner.

Option 2.

Drafting Note: The following Option 2 for Section 6A applies to states that choose to establish responsibility for the external grievance process with the health carrier and require that covered persons file requests for external review with the health carrier.

A. Except for a request for an expedited external review as set forth in Section 9 of this Act, all requests for external review shall be made in writing to the health carrier.

B. A covered person or the covered person's authorized representative may make a request for an external review of an adverse determination or final adverse determination.

Section 7. Exhaustion of Internal Grievance Process

A. (1) Except as provided in Subsection B, a request for an external review pursuant to Section 8 or 9 of this Act shall not be made until the covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

(2) A covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section, if the covered person or the covered person's authorized representative:

(a) Has filed a grievance involving an adverse determination pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act]; and

(b) Except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within thirty (30) days following the date the covered person or the covered person's authorized representative filed the grievance with the health carrier.

(3) Notwithstanding Paragraph (2), a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination made pursuant to [insert reference in state law equivalent to the Utilization Review Model Act] until the covered person has exhausted the health carrier's internal grievance process.

B. (1) (a) At the same time a covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act], the covered person or the covered person's authorized representative may file a request for an expedited external review of the adverse determination under Section 9 of this Act if the covered person has a medical condition where the timeframe for completion of an expedited review of the grievance involving an adverse determination set forth in [insert reference to state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

(b) Upon receipt of a request for an expedited external review under Subparagraph (a), the independent review organization conducting the external review in accordance with the provisions of Section 9 of this Act shall determine whether the covered person ~~should~~ shall be required to complete the expedited review process set forth in [insert reference to state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] before it conducts the expedited external review.

(c) Upon a determination made pursuant to Subparagraph (b) that the covered person must first complete the expedited grievance review process set forth in [insert reference to state law equivalent to

Section 10 of the Health Carrier Grievance Procedure Model Act], the independent review organization immediately shall notify the covered person and, if applicable, the covered person's authorized representative of this determination and that it will not proceed with the expedited external review set forth in Section 9 of this Act until completion of the expedited grievance review process and the covered person's grievance at the completion of the expedited g r i e v a n c e

(2) A request for an external review of an adverse determination may be made before the covered person has exhausted the heath carrier's internal grievance procedures as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] whenever the health carrier agrees to waive the exhaustion requirement.

C. If the requirement to exhaust the health carrier's internal grievance procedures is waived under Subsection B(2), the covered person or the covered person's authorized representative may file a request in writing for a standard external review as set forth in Section 8 of this Act.

Drafting Note: States are strongly encouraged to adopt both this Act and the NAIC's Health Carrier Grievance Procedure Model Act, which sets out an internal grievance process for the review of written grievances stemming from adverse determinations, as defined in that Act. The external review procedures of this Act assume the existence of the internal grievance process outlined in the NAIC Health Carrier Grievance Procedure Model Act. This Act also assumes that any adverse determination that remains in dispute after the health carrier's internal grievance process has been exhausted and for which a request for an external review is made under this Act, will be considered a "final adverse determination," as that term is defined by this Act. Further, this Act assumes that, in a case in which the health carrier's internal grievance process has not been exhausted prior to a request for external review under this Act, the subject of the request for external review will be the adverse determination made by the health carrier or its designee utilization review organization pursuant to the NAIC's Utilization Review Model Act.

Drafting Note: States that do not require exhaustion of the internal grievance process prior to filing a request for external review should not adopt this section.

Section 8. Standard External Review

Option 1.

Drafting Note: Option 1 for this ~~Section 8~~ section of this Act applies to states that choose to establish the external review process in the office of the commissioner and require that covered persons file all requests for external review with the commissioner. This option also provides that the commissioner will conduct a preliminary review of the request for external review to ensure that it meets all of the requirements to be eligible for external review. If the request for external review is determined to be eligible for external review, the commissioner is required to

assign an independent review organization to conduct the external review. This option requires the assigned independent review organization to provide the commissioner with a written recommendation on whether to uphold or reverse the adverse determination or final adverse determination, Immediately upon receipt of the recommendation, the commissioner is required to review the recommendation to ensure that it is not contrary to the terms of coverage under the covered person's health benefit plan.

A. (1) Within sixty (60) days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 5 of this Act, a covered person or the covered person's authorized representative may file a request for an external review with the commissioner.

(2) Upon receipt of a request for an external review pursuant to Paragraph (l), the commissioner immediately shall notify and send a copy of the request to the health carrier that made the adverse determination or final adverse determination that is the subject of the request.

B. Within five (5) days after the date of receipt of a request for an external review, the commissioner shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;

(2) The health care service that is the subject of the adverse determination or final adverse determination reasonably appears to be a covered service under the covered person's health benefit plan;

(3) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 7 of this Act; and

(4) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under Section 5B of this Act.

C. (1) Upon completion of the preliminary review pursuant to Subsection B, the commissioner immediately shall notify the covered person ~~or~~ and, if applicable, the covered person's authorized representative in writing whether:

(a) The request is complete; and

(b) The request has been accepted for external review.

(2) If the request is accepted for external review, the commissioner shall:

(a) Include in the notice provided pursuant to Paragraph (1) a statement that the covered person or the covered person's authorized representative may submit to the commissioner in writing within seven (7) days following the date of receipt of the notice additional information and supporting documentation that the assigned independent review organization shall consider when conducting the external review; and

(b) Immediately notify the health carrier in writing of the acceptance of the request for external review.

(3) If the request:

(a) Is not complete, the commissioner shall inform the covered person ~~or~~ and, if applicable, the covered person's authorized representative what information or materials are needed to make the request complete; or

(b) Is not accepted for external review, the commissioner shall inform the covered person ~~or~~, if applicable, the covered person's authorized representative, and the health carrier in writing of the reasons for its nonacceptance.

D. (1) At the time a request is accepted for external review pursuant to Subsection C, the commissioner shall assign an independent review organization that has been approved pursuant to Section 12 of this Act to conduct the external review and provide a written recommendation to the commissioner on whether to uphold or reverse the adverse determination or the final adverse determination.

(2) In reaching a recommendation, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review Model Act] or the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

E. (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Subsection C(2), the health carrier-or its designee utilization review organization shall provide to the assigned independent review

organization, the documents and any information considered in making the adverse determination or the final adverse determination.

(2) Except as provided in Paragraph (3), failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in Paragraph (1) shall not delay the conduct of the external review.

(3) (a) Upon receipt of a notice from the assigned independent review organization that the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in Paragraph (l), the commissioner may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the decision under Subparagraph (a), the commissioner shall notify the assigned independent review organization, the covered person ~~or,~~ if applicable, the covered person's authorized representative, and the health carrier.

F. (1) The assigned independent review organization, shall review all of the information and documents received pursuant to Subsection E and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to Subsection C(2) that has been forwarded to the independent review organization by the commissioner.

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection C(2), at the same time the commissioner forwards the information to the independent review organization, the commissioner shall forward the information to the health carrier.

G. (1) Upon receipt of the information required to be forwarded pursuant to Subsection F(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to Paragraph (1) shall not delay or terminate the external review.

(3) The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or

payment for the health care service that is the subject of the adverse determination or final adverse determination.

(4) (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3), the health carrier shall notify the covered person ~~or~~, if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph (a).

H. In addition to the documents and information provided pursuant to Subsection E, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a recommendation:

(1) The covered person's pertinent medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier;

(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization.

I. (1) The independent review organization assigned pursuant to Subsection D shall provide its recommendation to the commissioner within thirty (30) days after the date of receipt of the request for an external review.

(2) The independent review organization shall include in its recommendation provided pursuant to Paragraph (1):

(a) A general description of the reason for the request for external review;

(b) The date the independent review organization received the assignment from the commissioner to conduct the external review;

(c) The date the external review was conducted;

(d) The date of its recommendation;

(e) The principal reason or reasons for its recommendation;

(f) The rationale for its recommendation; and

(g) References to the evidence or documentation, including the practice guidelines, considered in reaching its recommendation.

(3) Upon receipt of the assigned independent review organization's recommendation pursuant to Paragraph (l), the commissioner immediately shall review the recommendation to ensure that it is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

J. (1) The commissioner shall notify the covered person ~~or~~, if applicable, the covered person's authorized representative, and the health carrier in writing of the decision to uphold or reverse the adverse determination or the final adverse determination within fifteen (15) days after the date of receipt of the selected independent review organization's recommendation provided pursuant to Subsection I(1).

(2) The commissioner shall include in the notice sent pursuant to Paragraph (1):

(a) The principal reason or reasons for the decision, including, as an attachment to the notice or in any other manner the commissioner considers appropriate, the information provided by the selected independent review organization in regard to its recommendation pursuant to Subsection I(2); and

(b) If appropriate, the principal reason or reasons why the commissioner did not follow the assigned independent review organization's recommendation.

(3) Upon receipt of a notice of a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

Option 2.

Drafting Note: Option 2 for ~~Section 8~~ this section of this Act applies to states that choose not to review the external review decision of an independent review organization as in Option 1. Option 2 requires covered persons to file all requests for external review with the commissioner. The commissioner then conducts a preliminary review of the request for external review to ensure that it nieets all of the requirements to be eligible for external review. If the commissioner determines that the request meets specified requirements to be eligible for external review, the commissioner then assigns an independent review organization to conduct the external review.

A. (1) Within sixty (60) days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 5 of this Act, a covered person or the covered person's authorized representative may file a request for an external review with the commissioner.

(2) Upon receipt of a request for an external review pursuant to Paragraph (l), the commissioner immediately shall notify and send a copy of the request to the health carrier that made the adverse determination or final adverse determination that is the subject of the request.

B. Within five (5) days after the date of receipt of a request for an external review, the commissioner shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;

(2) The health care service that is the subject of the adverse determination or final adverse determination reasonably appears to be a covered service under the covered person's health benefit plan;

(3) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person

is not required to exhaust the health carrier's internal grievance process pursuant to Section 7 of this Act; and

(4) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under Section 5B of this Act.

C. (1) Upon completion of the preliminary review pursuant to Subsection B, the commissioner immediately shall notify the covered person ~~or~~ and, if applicable, the covered person's authorized representative in writing whether:

(a) The request is complete; and

(b) The request has been accepted for external review.

(2) If the request is accepted for external review, the commissioner shall:

(a) Include in the notice provided pursuant to Paragraph (1) a statement that the covered person or the covered person's authorized representative may submit to the commissioner in writing within seven (7) days following the date of the notice additional information and supporting documentation that the independent review organization shall consider when conducting the external review; and

(b) Immediately notify the health carrier in writing of the acceptance of the request for external review.

(3) If the request:

(a) Is not complete, the commissioner shall inform the covered person ~~or~~ and, if applicable, the covered person's authorized representative what information or materials are needed to make the request complete; or

(b) Is not accepted for external review, the commissioner shall inform the covered person ~~or~~, if applicable, the covered person's authorized representative, and the health carrier in writing of the reasons for its nonacceptance.

D. (1) At the time a request for external review is accepted pursuant to Subsection C, the commissioner shall assign an independent review organization to conduct the external review that has been approved pursuant to Section 12 of this Act.

(2) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review Model Act] or the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

E. (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Subsection C(2), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization, the documents and any information considered in making the adverse determination or the final adverse determination.

(2) Except as provided in Paragraph (3), failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in Paragraph (1) shall not delay the conduct of the external review.

(3) (a) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in Paragraph (l), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the decision under Subparagraph (a), the independent review organization shall notify the covered person ~~or~~, if applicable, the covered person's authorized representative, the health carrier, and the commissioner.

F. (1) The assigned independent review organization shall review all of the information and documents received pursuant to Subsection E and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to Subsection C(2) that has been forwarded to the independent review organization by the commissioner.

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection C(2), at the same time the commissioner forwards the information to the independent review organization, the commissioner shall forward the information to the health carrier.

G. (1) Upon receipt of the information required to be forwarded pursuant to Subsection F(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to Paragraph (1) shall not delay or terminate the external review.

(3) The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

(4) (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3), the health carrier shall notify the covered person ~~or~~, if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph (a).

H. In addition to the documents and information provided pursuant to Subsection E, the assigned independent review organization, to the extent the documents or information is available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization.

I. (1) Within forty-five (45) days after the date of receipt of the request for external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or final adverse determination to:

(a) The covered person ~~or~~;

(b) If applicable, the covered person's authorized representative;

~~(b)~~ (c) The health carrier; and

~~(c)~~ (d) The commissioner.

Drafting Note: States may want to consider requiring independent review organizations to identify in the notice provided to the commissioner under Subsection I(1) any problem contract or policy provisions, such as ambiguity, found during the conduct of the external review.

(2) The independent review organization shall include in the notice sent pursuant to Paragraph (1):

(a) A general description of the reason for the request for external review;

(b) The date the independent review organization received the assignment from the commissioner to conduct the external review;

(c) The date the external review was conducted;

(d) The date of its decision;

(e) The principal reason or reasons for its decision;

(f) The rationale for its decision; and

(g) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.

(3) Upon receipt of a notice of a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

Option 3.

Drafting Note: Option 3 for ~~**Section 8**~~ this section of this Act applies to states that choose to establish responsibility for the external review process with the health carrier and require that covered persons file requests for external review with the health carrier. This option also requires the health carrier to assign an independent review organization from the list of approved independent review organizations compiled by the commissioner to conduct a preliminary review of the request and conduct an external review of the request if the request has satisfied specified requirements to be eligible for external review.

A. (1) Within sixty (60) days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 5 of this Act, a covered person or the covered person's authorized representative may file a request for an external review with the health carrier.

(2) Upon receipt of a request for external review pursuant to Paragraph (l), the health carrier shall send a copy of the request to the commissioner.

B. At the time the health carrier receives a request for an external review, the health carrier shall assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to Section 12 of this Act to conduct a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;

(2) The health care service that is the subject of the adverse determination or the final adverse determination reasonably appears to be a covered service under the covered person's health benefit plan;

(3) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 7 of this Act; and

(4) The covered person has provided all the information and forms required to process an external review, including the release form provided under Section 5B of this Act.

C. (1) Within five (5) days after receipt of the request for external review, the independent review organization assigned pursuant to Subsection B shall complete the preliminary review and immediately notify the covered person ~~or~~ and, if applicable, the covered person's authorized representative in writing whether:

(a) The request is complete; and

(b) The request has been accepted for external review.

(2) The assigned independent review organization shall include in the notice ~~to the covered person or the covered person's authorized representative~~ provided pursuant to Paragraph (1) a statement that the covered person or the covered person's authorized representative may submit in writing to the independent review organization within seven (7) days following the date of receipt of the notice additional information and supporting documentation that the independent review organization shall consider when conducting the external review.

(3) If the request:

(a) Is not complete, the assigned independent review organization shall inform the covered person ~~or~~ and, if applicable, the covered person's authorized representative what information or materials are needed to make the request complete; or

(b) Is not accepted for external review, the assigned independent review organization shall inform the covered person ~~or~~, if applicable, the covered person's authorized representative, the health carrier, and the commissioner in writing of the reasons for its nonacceptance.

D. (1) Whenever a request for external review is accepted for external review following the preliminary review conducted pursuant to Subsection C, the assigned independent review organization shall notify the health carrier and the commissioner.

(2) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review Model Act] or the health carrier's

internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

E. (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Section D(l), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.

(2) Except as provided in Paragraph (3), failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in Paragraph (1) shall not delay the conduct of the external review.

(3) (a) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in Paragraph (l), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the decision under Subparagraph (a), the independent review organization shall notify the covered person ~~or~~, if applicable, the covered person's authorized representative, the health carrier, and the commissioner.

F. (1) The assigned independent review organization shall review all of the information and documents received pursuant to Subsection E and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to Subsection C(2).

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection C(2), the assigned independent review organization immediately shall forward the information to the health carrier.

G. (1) Upon receipt of the information, if any, required to be forwarded pursuant to Subsection F(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to Paragraph (1) shall not delay or terminate the external review.

(3) The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

(4) (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3), the health carrier shall notify the covered person ~~or~~, if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision,

(b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph (a).

H. In addition to the documents and information provided pursuant to Subsection E, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization.

I. (1) Within forty-five (45) days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:

(a) The covered person ~~or;~~

(b) If applicable, the covered person's authorized representative;

~~(b)~~ (c) The health carrier; and

~~(c)~~ (d) The commissioner.

Drafting Note: States may want to consider requiring independent review organizations to identify in the notice provided to the commissioner under Subsection I(1) any problem contract or policy provisions, such as ambiguity, found during the conduct of the external review.

(2) The independent review organization shall include in the notice sent pursuant to Paragraph (1):

(a) A general description of the reason for the request for external review;

(b) The date the independent review organization received the assignment from the health carrier to conduct the preliminary review of the external review request;

(c) The date the external review was conducted, if appropriate;

(d) The date of its decision;

(e) The principal reason or reasons for its decision;

(f) The rationale for its decision; and

(g) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.

(3) Upon receipt of a notice of a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

J. The assignment by a health carrier of an approved independent review organization to conduct an external review in accordance with this section shall be fair and impartial. The health carrier and the ~~An~~ independent review organization ~~and a health carrier~~ shall comply with standards promulgated by the commissioner by regulation to ensure fairness and ~~impartially~~ impartiality in the assignment by health carriers of approved independent review organizations to conduct external reviews ~~in accordance with this section~~, including its term, its termination and payment arrangement.

Section 9. Expedited External Review

Option 1.

Drafting Note: Option 1 for this ~~Section 9~~ section of this Act applies to states that choose to establish the expedited external review process in the office of the commissioner and require covered persons-make all requests for an-expedited external review with the commissioner. This option requires the commissioner to assign the conduct of the expedited external review to an independent review organization if the request has met specified requirements to be eligible for an expedited external review. The assigned independent review organization is required to provide to the commissioner with a recommendation on whether to uphold or reverse the adverse determination or final adverse determination.

A. Except as provided in Subsection H, a covered person or the covered person's authorized representative may make a request for an expedited external review with the commissioner at the time the covered person receives:

(1) An adverse determination if:

~~the~~ The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function@

(b) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act]; or

(2) A final adverse determination:

(a) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(b) If the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility.

B. At the time the commissioner receives a request for an expedited external review, the commissioner immediately shall:

(1) Notify and provide a copy of the request to the health carrier that made the adverse determination or final adverse determination that is the subject of the request; and

(2) For a request that the commissioner has determined meets the reviewability requirements set forth in Section 8B of this Act, assign an independent review organization that has been approved pursuant to Section 12 of this Act to conduct the expedited external review and provide a written recommendation to the commissioner on whether to uphold or reverse the adverse determination or final adverse determination.

C. In reaching a recommendation, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review Model Act] or the health carrier's internal grievance process as set forth in [insert state law equivalent to the Health Carrier Grievance Procedure Model Act].

D. At the time the health carrier receives the notice pursuant to Subsection B, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

E. In addition to the documents and information provided or transmitted pursuant to Subsection D, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a recommendation:

(1) The covered person's pertinent medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier;

(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations.

F. (1) The assigned independent review organization shall provide its recommendation to the commissioner as expeditiously as the covered person's medical condition or circumstances requires, but in no event more than forty-eight (48) hours after the date the commissioner received the request for an expedited external review pursuant to Subsection A.

(2) Upon receipt of the assigned independent review organization's recommendation pursuant to Paragraph (l), the commissioner immediately shall review the recommendation to ensure that it is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

G. (1) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than twenty-four (24) hours after receiving the recommendation of the assigned independent review organization as required pursuant to Subsection F, the commissioner shall complete the review of the independent review organization's recommendation and notify the covered person ~~**or**~~**,** if applicable, the covered person's authorized representative, and the health carrier of the

decision to uphold or reverse the adverse determination or final adverse determination.

(2) If the notice provided pursuant to Paragraph (1) was not in writing, within two (2) days after the date of providing that notice, the commissioner shall:

(a) Provide written confirmation of the decision to the covered person ~~or~~, if applicable, the covered person's authorized representative, and the health carrier; and

(b) Include the information set forth in Section 8J(2) of this Act.

(3) Upon receipt of the notice a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

H. An expedited external review may not be provided for retrospective adverse or final adverse determinations.

Option 2.

Drafting Note: ~~This option~~ Option 2 for ~~Section 9~~ this section of this Act applies to states that choose not to review the external review decision of an independent review organization as in Option 1. Option 2 requires covered persons make all requests for an expedited external review with the commissioner. If the request has met specified requirements to be eligible for an expedited external review, the commissioner then immediately assigns an independent review organization to conduct the expedited external review.

A. Except as provided in Subsection G, a covered person or the covered person's authorized representative may make a request for an expedited external review with the commissioner at the time the covered person receives:

(1) An adverse determination if:

~~(a)~~ The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(b) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act]; or

(2) A final adverse determination:

(a) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(b) If the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility.

B. At the time the commissioner receives a request for an expedited external review, the commissioner immediately shall:

(1) Notify and provide a copy of the request to the health carrier that made the adverse determination or final adverse determination that is the subject of the request; and

(2) For a request that the commissioner has determined meets the reviewability requirements set forth in Section 8B of this Act, assign an independent review organization that has been approved pursuant to Section 12 of this Act to conduct the review and to make a decision to uphold or reverse the adverse determination or final adverse determination.

C. In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review Model Act] or the health carrier's internal grievance process as set forth in [insert state law equivalent to the Health Carrier Grievance Procedure Model Act].

D. At the time the health carrier receives the notice pursuant to Subsection B, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

E. In addition to the documents and information provided or transmitted pursuant to Subsection D, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations.

F. (1) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review, the assigned independent review organization shall:

(a) Make a decision to uphold or reverse the adverse determination or final adverse determination; and

(b) Notify the covered person ~~or,~~ if applicable, the covered person's authorized representative, the health carrier, and the commissioner of the decision.

(2) If the notice provided pursuant to Paragraph (1) was not in writing, within two (2) days after the date of providing that notice, the assigned independent review organization shall:

(a) Provide written confirmation of the decision to the covered person ~~or~~, if applicable, the covered person's authorized representative, the health carrier, and the commissioner; and

(b) Include the information set forth in Section 8 I(2) of this Act.

(3) Upon receipt of the notice a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

G. An expedited external review may not be provided for retrospective adverse or final adverse determinations.

Option 3.

Drafting Note: Option 3 for ~~Section 9~~ this section of this Act applies to states that choose to establish responsibility for the expedited external review process with the health carrier and require that covered persons file requests for an expedited external review with the health carrier. This option also requires the health carrier to assign an approved independent review organization to conduct an expedited external review of the request if the request has satisfied specified requirements to be eligible for an expedited external review.

A. Except as provided in Subsection F, a covered person or the covered person's authorized representative may make a request for an expedited external review with the health carrier at the time the covered person receives:

(1) An adverse determination if:

~~(a)~~ The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(b) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in [insert

reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act]; or

(2) A final adverse determination:

(a) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(b) If the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility.

B. (1) At the time the health carrier receives a request for an expedited external review, the health carrier immediately shall:

(a) Assign an independent review organization from the list compiled and maintained pursuant to Section 12 of this Act to determine whether the request meets the reviewability requirements set forth in Section 8B of this Act and conduct the external review if the request meets the reviewability requirements of Section 8B of this Act; and

(b) Send a copy of the request to the commissioner.

(2) In reaching a decision in accordance with Subsection E, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review Model Act] or the health carrier's internal grievance process as set forth in [insert state law equivalent to the Health Carrier Grievance Procedure Model Act].

C. At the time the health carrier assigns an independent review organization to conduct the expedited external review pursuant to Subsection B, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

D. In addition to the documents and information provided or transmitted pursuant to Subsection C, the assigned independent review organization, to the extent the

information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations.

E. (1) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in Section 8B of this Act, the assigned independent review organization shall:

(a) Make a decision to uphold or reverse the adverse determination or final adverse determination; and

(b) Notify the covered person ~~or,~~ if applicable, the covered person's authorized representative, the health carrier, and the commissioner of the decision.

(2) If the notice provided pursuant to Paragraph (1) was not in writing, within two (2) days after the date of providing that notice, the assigned independent review organization shall:

(a) Provide written confirmation of the decision to the covered person ~~or~~, if applicable, the covered person's authorized representative, ~~and~~ the health carrier, and the commissioner; and

(b) Include the information set forth in Section 8I(2) of this Act.

(3) Upon receipt of the notice a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

F. An expedited external review may not be provided for retrospective adverse or final adverse determinations.

G. The assignment by a health carrier of an approved independent review organization to conduct an external review in accordance with this section shall be fair and impartial. The health carrier and the &independent review organization ~~and a health carrier~~ shall comply with standards promulgated by the commissioner by regulation to ensure fairness and ~~impartially~~ impartiality in the assignment by health carriers of approved independent review organizations to conduct external reviews ~~in accordance with this section~~, including its term, its termination and payment arrangement.

Section 10. Binding Nature of External Review Decision

Option 1.

Drafting Note: ~~The following~~ Option 1 for ~~Section 10A~~ this section of this Act applies to states that choose to follow Option 1 for Sections 8 and 9 of this Act in establishing their external review processes where the commissioner makes the external review decision.

A. An external review decision is binding on the health carrier except to the extent the health carrier has other remedies available under applicable state law.

Drafting Note: States may wish to review their administrative procedure rules to see how they impact this section. In their review, states should pay particular attention to whether health carriers have a right to an automatic stay for any departmental decision, including an external review decision.

B. An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

C. A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to this Act.

Option 2.

Drafting Note: ~~The following~~ Option 2 for ~~Section 10A~~ this section of this Act applies to states that choose to follow Option 2 or Option 3 for Sections 8 and 9 of this Act in establishing their external review processes where the independent review organization makes the external review decision.

A. An external review decision is binding on the health carrier.

B. An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

C. A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to this Act.

Drafting Note: Regardless of whether a state uses Option 1 or Option 2 for this section of this Act, ~~States~~ states may wish to add a provision that specifies whether an external review decision made in accordance with this Act is subject to the state's Administrative Procedure Act.

Section 11. Filing Fees (Optional)

A. Except in the case of a request for an expedited external review, at the time of filing a request for external review, the covered person or the covered person's authorized representative shall submit to the commissioner with the request a filing fee of [$25].

B. The connnissioner may waive the filing fee upon a showing of undue financial hardship.

C. The filing fee shall be refunded to the person who paid the fee if the external review results in the reversal of the health carrier's adverse determination or final adverse determination that was the subject of the external review.

Drafting Note: This section is optional. Many states do not require filing fees for external reviews.

Section 12. Approval of Independent Review Organizations

A. The commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this Act to ensure that an independent review organization satisfies the minimum qualifications established under Section 13 of this Act.

B. The commissioner shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

C. (1) Any independent review organization wishing to be approved to conduct external reviews under this Act shall submit the application form and include with the form all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under Section 13 of this Act.

(2) The commissioner may charge an application fee that independent review organizations shall submit to the commissioner with an application for approval and reapproval.

D. (1) An approval is effective for two (2) years, unless the commissioner determines before expiration of the approval that the independent review organization is not satisfying the minimum qualifications established under Section 13 of this Act.

(2) Whenever the commissioner determines that an independent review organization no longer satisfies the minimum requirements established under Section 13 of this Act, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Act that is maintained by the commissioner pursuant to Subsection E.

E. The commissioner shall maintain and periodically update a list of approved independent review organizations.

F. The commissioner may promulgate regulations to carry out the provisions of this section.

Drafting Note: Instead of requiring the commissioner to approve independent review organizations, states may wish to consider accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet the minimum qualifications established pursuant to Section 13 of this Act. Under such an approach, the accrediting entity will make available to the state its current standards to demonstrate that the entity's standards for independent review organizations meet or exceed the minimum qualifications established pursuant to Section 13 of this Act. The private

accrediting entity shall file or provide the state with documentation that an independent review organization has been accredited by the entity. An independent review organization accredited by the private accrediting entity then would be deemed to have met the requirements of this section and Section 13 of this Act except for the requirement that the independent review organization maintain the information required under Section 15 of this Act. States should periodically review an independent review organization's private accreditation and eligibility for deemed compliance. Also, states may wish to consider utilizing a mechanism for monitoring the performance of an independent review organization, such as a peer review organization.

Section 13. Minimum Qualifications for Independent Review Organizations

A. To be approved under Section 12 of this Act to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in Sections 8 and 9 of this Act that include, at a minimum:

(1) A quality assurance mechanism in place that:

(a) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(b) Ensures the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases;

(c) Ensures the confidentiality of medical and treatment records and clinical review criteria; and

(d) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this Act;

(2) A toll-free telephone service to receive information on a 24-hour-day, 7-day-a-week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

Drafting Note: Paragraph (2) may not be necessary if the office of the commissioner is involved in the external review process. In such a case, the commissioner should maintain a toll-free telephone number for this purpose.

(3) Agree to maintain and provide to the commissioner the information set out in Section 15 of this Act.

B. All clinical peer reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

(2) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

(3) 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 area or areas appropriate to the subject of the external review; and

(4) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental or professional competence or moral character.

C. In addition to the requirements set forth in Subsection 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.

D. ~~(1)~~ In addition to the requirements set forth in Subsections A, B and C, to be approved pursuant to Section 12 of this Act to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

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

~~(2)~~(b) The covered person whose treatment is the subject of the external review or the covered person's authorized representative;

~~(3)~~(c) Any officer, director or management employee of the health carrier that is the subject of the external review;

~~(4)~~(d) 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;

~~(5)~~ (e) The facility at which the recommended health care service or treatment would be provided; or

~~(6)~~(f) 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.

(2) In determining whether an independent review organization or a clinical peer reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of Paragraph (1), the commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in Paragraph (l), but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical peer reviewer from conducting the external review.

Drafting Note: ~~States should be aware in~~ In applying Subsection D, states should be aware that ~~some conflicts of interest are unavoidable~~ conflict of interest questions involving independent review organizations and clinical peer reviewers might arise in a variety of situations. For example, conflict of interest questions may arise when an academic medical center, or other similar medical research center, that is seeking to be an approved independent review organization has a contract to provide health care services to enrollees of the health carrier that is the subject of an external review or when a health care provider, who is a clinical peer reviewer for an independent review organization, has staff privileges at the facility where the recommended health care service or treatment would be provided if the health carrier's adverse or final adverse determination is reversed. The question for states to consider is whether a ~~conflict of interest~~ relationship or connection with persons involved in an external review is a material conflict of interest such that the objectivity of the independent review organization to be assigned to conduct the external review or any clinical peer reviewer to be assigned by the independent review organization to conduct the external review may actually be or may perceived to be negatively impacted. Whether ~~a conflict of interest~~ the relationship or connection is a material conflict of interest will depend on the characteristics of each state's market. Therefore, states should consider adding provisions to this section that provide additional guidelines or procedures to address this issue given their local market characteristics.

Section 14. Hold Harmless for Independent Review Organizations

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, unless the opinion was rendered in bad faith or involved gross negligence.

Section 15. External Review Reporting Requirements

A. (1) An independent review organization assigned pursuant to Section 8 or Section 9 of this Act to conduct an external review shall maintain written records in the aggregate and by health carrier on all requests for external review for which it conducted an external review during a calendar year and submit a report to the commissioner, as required under Paragraph (2).

(2) Each independent review organization required to maintain written records on all requests for external review pursuant to Paragraph (1) for which it was assigned to conduct an external review shall submit to the commissioner, at least annually, a report in the format specified by the commissioner.

(3) The report shall include in the aggregate and for each health carrier:

(a) The total number of requests for external review;

(b) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(c) The average length of time for resolution;

(d) A summary of the types of coverages or cases for which an external review was sought;

~~(d)~~ (e) The number of external reviews pursuant to Section 8G of this Act that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

~~(e)~~ (f) Any other information the commissioner may request or require.

(4) The independent review organization shall retain the written records required pursuant to this subsection for at least three (3) years.

B. (1) Each health carrier shall maintain written records in the aggregate and for each type of health benefit plan offered by the health carrier on all requests for external review that are filed with the health carrier or that the health carrier receives notice of from the commissioner pursuant to this Act.

(2) Each ~~independent review organization~~ health carrier required to maintain written records on all requests for external review pursuant to Paragraph (1) shall submit to the commissioner, at least annually, a report in the format specified by the commissioner.

(3) The report shall include in the aggregate and by type of health benefit plan:

(a) The total number of requests for external review;

(b) From the number of requests for external review that are filed directly with the health carrier, the number of requests accepted for a full external review;

(c) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(d) The average length of time for resolution;

(e) A summary of the types of coverages or cases for which an external review was sought;

~~(e)~~ (f) The number of external reviews pursuant to Section 8G of this Act that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

~~(f)~~ (g) Any other information the commissioner may request or require.

(4) The ~~independent review organization~~ health carrier shall retain the written records required pursuant to this subsection for at least three (3) years.

Section 16. Funding of External Review

The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

Section 17. Disclosure Requirements

A. Each health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons.

B. The description required under Subsection A shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the commissioner. The statement shall include the telephone number and address of the commissioner.

Drafting Note: States that have not established an external review process in the office of the commissioner, such as those states that adopt Option 3 in Sections 8 and 9 of this Act, may wish to use the following provision in Subsection B: "The description required under Subsection A shall include a statement of the right of the covered person to contact the commissioner for assistance at any time. The statement shall include the telephone number and address of the commissioner."

C. In addition to Subsection B, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

Section 18. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 19. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 20. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 21. Effective Date

This Act shall be effective [insert date].

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1. Smith 175th 2. Turnquest 73rd 3. Dukes 161st
4. Bordeaux 151st 5. Graves 125th 6. Ehrhart 36tl

HB 732

H. B. No. 732 (AS PASSED HOUSE AND SENATE)
By: Representatives Smith of the 175th, Turnquest of the 73rd, Dukes of the 161st, Bordeaux of the 151st, Graves of the 125th and others

A BILL TO BE ENTITLED
AN ACT

To amend Chapter 1 of Title 51 of the Official Code of Georgia Annotated, relating to general provisions regarding torts, so as to establish a standard of care for certain entities which administer benefits or review or adjust claims under a managed care plan and provide for recovery for violations of that standard; to prohibit waivers, modifications, shifting, or delegation of liability; to provide conditions for maintaining certain causes of action; to provide for court orders and abatement of actions; to provide that certain other liability is not created; to amend Chapter 20A of Title 33 of the Official Code of Georgia Annotated, the "Patient Protection Act of 1996," relating to managed care plans, so as to provide for a short title; to provide for definitions; to provide certain enrollees of managed care plans with an independent review of plan determinations and provide for standards, conditions, and procedures relating thereto; to provide for duties, powers, and functions of the Health Planning Agency with regard to such reviews and provide for certification of independent review organizations; to provide for expert reviewers and decisions thereof; to provide for costs and expedited reviews; to provide for immunity from liability and presumptions; to prohibit certain conflicts of interest; to provide for quality assurance; to provide for applicability; to provide for effective dates; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 1 of Title 51 of the Official Code of Georgia Annotated, relating to general provisions regarding torts, is amended by adding at the end new Code sections to read as follows:

H. B. No. 732
-1-

HB 732/AP

"51-l-48.

(a) Any claim administrator, health care advisor, private **review agent, or other person or entity which administers benefits or reviews or adjusts claims under a managed care plan shall exercise ordinary diligence to do so in a timely and appropriate manner in accordance with the practices and standards of the profession of the health care provider generally. Notwithstanding any other provision of law to the contrary, any injury or death to an enrollee resulting from a want of such ordinary diligence shall be a tort for which a recovery may be had against the managed care entity offering such plan, but no recovery shall be had for punitive damages for such tort.**

(b) The provisions of this Code section may not be waived, shifted, or modified by contract or agreement and responsibility therefor shall be a duty which shall not be delegated. Any effort to waive, modify, delegate, or shift liability for a breach of the duty provided by this Code section, through a contract for indemnification or otherwise, shall be invalid.

(c) This Code section shall not create any liability on the part of an employer of an enrollee or that employer's employees, unless the employer is the enrollee's managed care entity. This Code section shall not create any liability on the part of an employee organization, a voluntary employee beneficiary organization, or a similar organization, unless such organization is the enrollee's managed care entity and makes coverage determinations under a managed care plan.

(d) As used in this Code section and in Code Section 51-1-49, the terms 'claim administrator,' 'enrollee,' 'health care advisor,' and 'private review agent,' shall be defined as set forth in Chapter 46 of Title 33 except that 'enrollee' shall include the enrollee's eligible dependents; 'managed care entity' and 'managed care plan' shall be defined as set forth in Code Section 33-20A-3; **and 'independent review' means a review pursuant to** Article 2 of Chapter 20A of Title 33, **the 'Patient's Right to Independent Review Act.'**

51-l-49.

(a) No person may maintain a cause of action pursuant to Code Section 51-1-48 unless the affected enrollee or the enrollee's representative:

(1) Has exhausted the grievance procedure provided for under Code Section 33-20A-5 and before instituting the action:

(A) Gives written notice of intent to file suit to the managed care entity; and

(B) Agrees to submit the claim to independent review if required under subsection (c) of this Code section; or

(2) Has filed a pleading alleging in substance that:

(A) Harm to the enrollee has already occurred for which the managed care entity may be liable; and

(B) The grievance procedure or independent review is not timely or otherwise available or would not make the enrollee whole,

in which case the court, upon motion by the managed care entity, shall stay the action and order such grievance procedure or independent review to be conducted and exhausted.

(b) The notice required by paragraph (1) of subsection (a) of this Code section must be delivered or mailed to the managed care entity not fewer than 30 days before the action is filed.

(c) The managed care entity receiving notice of intent to file suit may obtain independent review of the claim, if notice of a request for review is mailed or delivered to the Health Planning Agency, or its successor agency, and the affected enrollee within ten days of receipt of the notice of intent to file suit."

SECTION 2.

Chapter 20A of Title 33 of the Official.Code of Georgia Annotated, the "Patient Protection Act of 1996," is amended by designating Code Sections 33-20A-1 through 33-20A-10 as Article 1 of said chapter and substituting "this article"

for "this chapter" and "This article" for "This chapter" wherever such terms appear in the newly designated Article 1.

SECTION 3.

Said chapter is further amended by adding at the end thereof a new article to read as follows:

"ARTICLE 2

33-20A-30.

This article shall be known and may be cited as the 'Patient's Right to Independent Review Act.'

33-20A-31.

As used in this article: .

(1) 'Eligible enrollee' means a person who:

(A) Is an enrollee or an eligible dependent of an enrollee of a managed care plan or was an enrollee or an eligible dependent of an enrollee of such plan at the time of the request for treatment; and

(B) Seeks a treatment which reasonably appears to be a covered service or benefit under the enrollee's evidence of coverage; provided, however, that this subparagraph shall not apply if the notice from a managed care plan of the outcome of the grievance procedure was that a treatment is experimental.

(2) 'Grievance procedure' means the grievance procedure established pursuant to Code Section 33-20A-5.

(3) 'Independent review organization' means any organization certified as such by the planning agency under Code Section 33-20A-39.

(4) 'Medical and scientific evidence' means:

(A) Peer reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published

articles for review by experts who are not part of the editorial staff;

(B) Peer reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);

(C) Medical journals recognized by the United States secretary of health and human services, under Section 1861(t)(2) of the Social Security Act;

(D) The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information; or

(E) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

(5) 'Medical necessity,' 'medically necessary care,' or 'medically necessary and appropriate' means care based upon generally accepted medical practices in light of conditions at the time of treatment which is:

(A) Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the eligible enrollee's condition;

(B) Compatible with the standards of acceptable medical practice in the United States;

(C) Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the

symptoms;

(D) Not provided solely for the convenience of the eligible enrollee or the convenience of the health care provider or hospital; and

(E) Not primarily custodial care, unless custodial care is a covered service or benefit under the eligible enrollee's evidence of coverage.

(6) 'Planning agency' means the Health Planning Agency established under Chapter 6 of Title 31 or its successor agency.

(7) 'Treatment' means a medical service, diagnosis, procedure, therapy, drug, or device.

(8) Any term defined in Code Section 33-20A-3 shall have the meaning provided for that term in Code Section

33-20A-3 except that 'enrollee' shall include the enrollee's eligible dependents.

33-20A-32.

An eligible enrollee shall be entitled to appeal to an independent review organization when:

(1) The eligible enrollee has received notice of an adverse outcome pursuant to a grievance procedure or the managed care entity has not complied with the requirements of Code Section 33-20A-5 with regard to such procedure; or

(2) A managed care entity determines that a proposed treatment is excluded as experimental under the managed care plan, and all of the following criteria are met:

(A) The eligible enrollee has a terminal condition that, according to the treating physician, has a substantial probability of causing death within two years from the date of the request for independent review or the eligible enrollee's ability to regain or maintain maximum function, as determined by the treating physician, would be impaired by withholding the experimental treatment;

(B) After exhaustion of standard treatment as provided

by the evidence of coverage or a finding that such treatment would be of substantially lesser or of no benefit, the eligible enrollee's treating physician certifies that the eligible enrollee has a condition for which standard treatment would not be medically indicated for the eligible enrollee or for which there is no standard treatment available under the evidence of coverage of the eligible enrollee more beneficial than the treatment proposed;

(C) The eligible enrollee's treating physician has recommended and certified in writing treatment which is likely to be more beneficial to the eligible enrollee than any available standard treatment;

(D) The eligible enrollee has requested a treatment as to which the eligible enrollee's treating physician, who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the eligible enrollee's condition, has certified in writing that scientifically valid studies using accepted protocols,

such as control group or double-blind testing, published in peer reviewed literature, demonstrate that the proposed treatment is likely to be more beneficial for the eligible enrollee than available standard treatment; and

(E) A specific treatment recommended would otherwise be included within the eligible enrollee's certificate of coverage, except for the determination by the managed care entity that such treatment is experimental for a particular condition.

33-20A-33.

Except where required pursuant to Code Section 51-l-49, a proposed treatment must require the expenditure of a minimum of $500.00 to qualify for independent review.

33-20A-34.

(a) The parent or guardian of a minor who is an eligible enrollee may act on behalf of the minor in requesting independent review. The legal guardian or representative of an incapacitated eligible enrollee shall be authorized to act on behalf of the eligible enrollee in requesting

independent review. Except as provided in Code Section 51-1-49, independent review may not be requested by persons other than the eligible enrollee or a person acting on behalf of the eligible enrollee as provided in this Code section.

(b) A managed care entity shall be required to pay the full cost of applying for and obtaining the independent review.

(c) **The eligible enrollee and the managed care entity shall cooperate with the independent review organization to provide the information and documentation, including executing necessary releases for medical records, which are necessary for the independent review organization to make a determination of the claim.**

33-20A-35.

(a) In the event that the outcome of the grievance procedure under Code Section 33-20A-5 is adverse to the eligible enrollee, the managed care entity shall include with the written notice of the outcome of the grievance procedure a statement specifying that any request for independent review must be made to the planning agency on

forms developed by the planning agency, and such forms shall be included with the notification. Such statement shall be in simple, clear language in boldface type which is larger and bolder than any other typeface which is in the notice and in at least 14 point typeface.

(b) An eligible enrollee must submit the written request for independent review to the planning agency. Instructions on how to request independent review shall be given to all eligible enrollees with the written notice required under this Code section together with instructions in simple, clear language as to what information, documentation, and procedure are required for independent review.

(c) Upon receipt of a completed form requesting independent review as required by subsection (a) of this Code section, the planning agency shall notify the eligible enrollee of receipt and assign the request to an independent review organization on a rotating basis according to the date the request is received.

(d) Upon assigning a request for independent review to an independent review organization, the planning agency shall provide written notification of the name and address of the assigned organization to both the requesting eligible enrollee and the managed care entity.

(e) No managed care entity may be certified by the Commissioner under Article 1 of this chapter unless the entity agrees to pay the costs of independent review to the independent review organization assigned by the planning agency to conduct each review involving such entity's eligible enrollees.

33-20A-36.

(a) Within three business days of receipt of notice from the planning agency of assignment of the application for determination to an independent review organization, the managed care entity shall submit to that organization the following:

(1) Any information submitted to the managed care entity by the eligible enrollee in support of the eligible enrollee's grievance procedure filing;

(2) A copy of the contract provisions or evidence of coverage of the managed care plan; and

(3) Any other relevant documents or information used by the managed care entity in determining the outcome of the eligible enrollee's grievance.

Upon request, the managed care entity shall provide a copy of all documents required by this subsection, except for any proprietary or privileged information, to the eligible enrollee. The eligible enrollee may provide the independent review organization with any additional information the eligible enrollee deems relevant.

(b) The independent review organization shall request any additional information required for the review from the managed care entity and the eligible enrollee within five business days of receipt of the documentation required under this Code section. Any additional information requested by the independent review organization shall be submitted within five business days of receipt of the

request, or an explanation of why the additional information is not being submitted shall be provided.

(c) Additional information obtained from the eligible enrollee shall be transmitted to the managed care entity, which may determine that such additional information justifies a reconsideration of the outcome of the grievance procedure. A decision by the managed care entity to cover fully the treatment in question upon reconsideration using such additional information shall terminate independent review.

(d) The expert reviewer of the independent review organization shall make a determination within 15 business days after expiration of all time limits set forth in this Code section, but such time limits may be extended or shortened by mutual agreement between the eligible enrollee and the managed care entity. The determination shall be in writing and state the basis of the reviewer's decision. A copy of the decision shall be delivered to the managed care entity, the eligible enrollee, and the planning agency by at least first-class mail.

(e) The independent review organization's decision shall be based upon a review of the information and documentation submitted to it.

(f) Information required or authorized to be provided pursuant to this Code section may be provided by facsimile transmission or other electronic transmission.

33-20A-37.

(a) A decision of the independent review organization in favor of the eligible enrollee shall be final and binding on the managed care entity and the appropriate relief shall be provided without delay. A managed care entity bound by such decision of an independent review organization shall not be liable pursuant to Code Section 51-1-48 for abiding by such decision. Nothing in this Code section shall relieve the managed care entity from liability for damages proximately caused by its determination of the proposed treatment prior to such decision.

(b) A determination by the independent review organization in favor of a managed care entity shall create a

rebuttable presumption in any subsequent action that the managed care entity's prior determination was appropriate and shall constitute a medical record for purposes of Code Section 24-7-8.

(c) In the event that, in the judgment of the treating health care provider, the health condition of the enrollee is such that following the provisions of Code Section 33-20A-36 would jeopardize the life or health of the eligible enrollee or the eligible enrollee's ability to regain maximum function, as determined by the treating health care provider, an expedited review shall be available. The expedited review process shall encompass all elements enumerated in Code Sections 33-20A-36 and 33-20A-40; provided, however, that a decision by the expert reviewer shall be rendered within 72 hours after the expert reviewer's receipt of all available requested documents.

33-20A-38.

Neither independent review organization nor its employees, agents, or contractors shall be liable for damages arising from determinations made pursuant to this article, unless an act or omission thereof is made in bad faith or through gross negligence, constitutes fraud or willful misconduct, or demonstrates malice, wantonness, oppression, or that entire want of care which would raise the presumption of conscious indifference to the consequences.

33-20A-39.

(a) The planning agency shall certify independent review organizations that meet the requirements of this Code section and any regulations promulgated by the planning agency consistent with this article. The planning agency shall deem certified any independent review organization meeting standards developed for this purpose by an independent national accrediting organization. To qualify for certification, an independent review organization must show the following:

(1) Expert reviewers assigned by the independent review organization must be physicians or other appropriate

providers who meet the following minimum requirements:

(A) Are expert in the treatment of the medical condition at issue and are knowledgeable about the recommended treatment through actual clinical experience;

(B) Hold a nonrestricted license issued by a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of review; and

(C) Have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restriction, taken or pending by any hospital, government, or regulatory body;

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

(3) The independent review organization shall submit to the planning agency the following information upon initial application for certification, and thereafter within 30 days of any change to any of the following information:

(A) The names of all owners of more than 5 percent of any stock or options, if a publicly held organization;

(B) The names of all holders of bonds or notes in excess of $100,000.00, if any;

(C) The names of all corporations and organizations that the independent review organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business; and

(D) The names of all directors, officers, and executives of the independent review organization, as well as a statement regarding any relationships the directors, officers, and executives may have with any

health care service plan, disability insurer, managed care entity or organization, provider group, or board or committee.

(b) Neither the independent review organization nor any expert reviewer of the independent review organization may have any material professional, familial, or financial conflict of interest with any of the following:

(1) A managed care plan or entity being reviewed;

(2) Any officer, director, or management employee of a managed care plan which is being reviewed;

(3) The physician, the physician's medical group, health care provider, or the independent practice association proposing a treatment under review;

(4) The institution at which a proposed treatment would be provided;

(5) The eligible enrollee or the eligible enrollee's representative; or

(6) The development or manufacture of the treatment proposed for the eligible enrollee whose treatment is under review.

(c) As used in subsection (b) of this Code section, the term 'conflict of interest' shall not be interpreted to include a contract under which an academic medical center or other similar medical research center provides health care services to eligible enrollees of a managed care plan, except as subject to the requirement of paragraph (4) of subsection (b) of this Code section; affiliations which are limited to staff privileges at a health care facility; or an expert reviewer's participation as a contracting plan provider where the expert is affiliated with an academic medical center or other similar medical research center that is acting as an independent review

organization under this article. An agreement to provide independent review for an eligible enrollee or managed care entity is not a conflict of interest under subsection (b) of this Code section.

(d) The independent review organization shall have a

quality assurance mechanism in place that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts, and the confidentiality of medical records and review materials.

(e) The planning agency shall provide upon the request of any interested person a copy of all nonproprietary information filed with it pursuant to this article. The planning agency shall provide at least quarterly a current list of certified independent review organizations to all managed care entities and to any interested persons.

33-20A-40.

(a) For the purposes of this article, in making a determination as to whether a treatment is medically necessary and appropriate, the expert reviewer shall use the definition provided in paragraph (5) of Code Section 33-20A-31.

(b) For the purposes of this article, in making a determination as to whether a treatment is experimental, the expert reviewer shall determine:

(1) Whether such treatment has been approved by the federal Food and Drug Administration; or

(2) Whether medical and scientific evidence demonstrates that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that the adverse risks of the proposed treatment will not be substantially increased over those of standard treatments.

For either determination, the expert reviewer shall apply prudent professional practices and shall assure that at least two documents of medical and scientific evidence support the decision.

33-20A-41.

The planning agency shall provide necessary rules and regulations for the implementation and operation of this article."

SECTION 4.

For purposes of certifying independent review organizations by the Health Planning Agency, or its successor agency, this Act shall become effective upon its approval by the Governor or upon its becoming law without such approval. For all other purposes, this Act shall become effective on July 1, 1999, and shall be applicable to any contract, policy, or other agreement of a managed care plan or health maintenance organization if such contract, policy, or agreement provides for health care services or reimbursement therefor and is issued, issued for delivery, delivered, or renewed on or after July 1, 1999.

SECTION 5.

All laws and parts of laws in conflict with this Act are repealed.