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1999 SENATE BILL 246

September 30, 1999 – Introduced by Senators ROSENZWEIG, ROBSON, ROESSLER, PLACHE, RUDE, RISSER, ELLIS, PANZER, DARLING, ERPENBACH, GROBSCHMIDT, HUELSMAN and SCHULTZ, cosponsored by Representatives UNDERHEIM, HUBER, URBAN, COGGS, LADWIG, JESKEWITZ, WILLIAMS, F. LASEE, SERATTI, SPILLNER, OWENS, MUSSER, LA FAVE, BRANDEMUEHL, HASENOHRL and MILLER. Referred to Committee on Health, Utilities, Veterans and Military Affairs.

AN ACT ***to amend*** 601.42 (4); and ***to create*** 601.31 (1) (Lp), 601.31 (1) (Lr), 609.15 (3) and 609.16 of the statutes; **relating to:** independent review of managed care plan grievance procedure outcomes, providing an exemption from emergency rule procedures and granting rule–making authority.

Analysis by the Legislative Reference Bureau

Under current law, every managed care plan, limited service health organization and preferred provider plan (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 plan to have an independent review procedure under which an enrollee may have the outcome of a grievance reviewed by an entity that is independent from the plan. To be eligible for this independent review, the grievance determination must be adverse to the enrollee; the value of the medical service, procedure, therapy, drug or device (treatment) that was the subject of the grievance must be at least $500; and the request for independent review must be made within one year after the date of the adverse grievance determination.

Whenever a grievance determination is adverse to the enrollee, the plan must send to the enrollee, along with the notice of the determination, information about the independent review procedure and the forms necessary for requesting the review. To request a review, an enrollee must send the completed forms to the commissioner of insurance (commissioner). The commissioner must promptly assign the review, on a rotating basis according to the date on which the request is received, to an

independent review organization, which must assign the review to three of its expert reviewers. Only an independent review organization that has been certified by the commissioner may be assigned a review. The expert reviewers who conduct the review must be health care providers who satisfy specified criteria, including having expertise through actual clinical experience in treating the condition that is the subject of the review.

After assigning the review, the commissioner must notify both the enrollee and the plan of the identity of the independent review organization. Within three days of receiving this notice, the plan must send to the independent review organization all of the information that it used in making the adverse grievance determination. The enrollee may send any additional information that the enrollee considers relevant. Within five days after receiving the information from the plan, the independent review organization may request more information from either or both parties, who have five more days in which to supply the requested information.

The expert reviewers conducting the review must, within 15 days after the expiration of all relevant time limits in the matter, make a determination on the basis of the written information submitted by the parties. If an expedited review is required because of the enrollee's medical condition, all specified time limits are shortened, and the expert reviewers must make a determination within 72 hours after the expiration of all relevant time limits in the matter. The bill specifies review standards for the expert reviewers, including the circumstances under which the expert reviewers must find that denied treatment was medically necessary and appropriate and the circumstances under which the expert reviewers must find in favor of the enrollee if treatment was denied on the basis that it was experimental. An independent review determination in favor of the enrollee is binding on the plan, while an independent review determination in favor of the plan creates a rebuttable presumption in any subsequent action that the plan's original determination was appropriate. All costs of an independent review must be paid by the plan.

The bill contains prohibitions aimed at avoiding conflicts of interest for independent review organizations and expert reviewers, such as prohibiting an independent review organization from being a subsidiary of, or from being owned or controlled by, a health care plan, a trade association of health care plans or a professional association of health care providers. The bill also provides immunity from liability for determinations made in independent reviews to independent review organizations and employes, agents or contractors of an independent review organization.

Finally, the bill requires the commissioner to provide a current listing of all independent review organizations to any person who requests a copy and, at least quarterly, to every plan. The commissioner must submit an annual report on the independent review system to both houses of the legislature and to the governor.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

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

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

601.31 **(1)** (Lp) For certifying as an independent review organization under s. 609.16 (7), $400.

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

601.31 **(1)** (Lr) For each recertification as an independent review organization under s. 609.16 (7), $100.

SECTION 3. 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), any independent review organization certified under s. 609.16 (7) 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.

SECTION 4. 609.15 (3) of the statutes is created to read:

609.15 **(3)** Whenever the disposition of a grievance under this section is adverse to the enrollee, the notice of the grievance disposition under sub. (2) (d) shall include

a written statement that the enrollee may obtain an independent review of the disposition as provided in s. 609.16, instructions on how to request an independent review, instructions on what information and documentation are required for independent review and information about the procedure that will be followed in the independent review. The limited service health organization, preferred provider plan or managed care plan shall include with the notice the forms necessary for requesting independent review.

SECTION 5. 609.16 of the statutes is created to read:

609.16 Independent review of grievance procedure outcomes. (1) DEFINITION. In this section, "treatment" means a medical service, diagnosis, procedure, therapy, drug or device.

(2) REQUIREMENT TO ESTABLISH; ELIGIBILITY CRITERIA. Every limited service health organization, preferred provider plan and managed care plan shall establish an independent review procedure that is in compliance with this section. Under the independent review procedure, an enrollee of the plan shall be able to request and obtain an independent review of a grievance determination under s. 609.15 if all of the following apply:

(a) The grievance determination is adverse to the enrollee.

(b) The value of the treatment that was the subject of the grievance is at least $500.

(c) The commissioner receives a completed written request for independent review under sub. (3) (a) not more than one year after the date of the adverse grievance determination.

(3) REQUESTING INDEPENDENT REVIEW. (a) To request an independent review, an enrollee shall submit a written request to the commissioner on forms developed by

the commissioner and provided to the enrollee by the limited service health organization, preferred provider plan or managed care plan under s. 609.15 (3). An independent review may be requested on behalf of an enrollee by his or her legal guardian or representative, including an agent under a power of attorney or durable power of attorney or a health care agent under a power of attorney for health care, and on behalf of an enrollee who is a minor by the minor's parent or guardian.

(b) Upon receipt of a timely, completed written request for independent review, the commissioner shall notify the enrollee, or his or her authorized representative, that the request was received. The commissioner shall promptly assign the matter, on a rotating basis according to the date on which the request was received, to a certified independent review organization, which shall assign the matter to 3 of its expert reviewers who have expertise in treating the condition that is the subject of the review. The commissioner shall provide written notification to the enrollee, or his or her authorized representative, and the limited service health organization, preferred provider plan or managed care plan of the name and address of the independent review organization assigned to the matter.

(c) The limited service health organization, preferred provider plan or managed care plan involved in an independent review shall be responsible for the cost of applying for and obtaining the independent review.

(d) The enrollee and the limited service health organization, preferred provider plan or managed care plan shall cooperate fully with the independent review organization to provide the information and documentation necessary for making a determination, including executing any necessary releases for medical records.

(4) PROCEDURE. (a) Within 3 business days after receiving notification of the name and address of the independent review organization under sub. (3) (b), the

limited service health organization, preferred provider plan or managed care plan shall submit to the independent review organization copies of all of the following:

1. Any information submitted to the limited service health organization, preferred provider plan or managed care plan by the enrollee in support of the enrollee's position in the grievance under s. 609.15.

2. A copy of the contract provisions or evidence of coverage of the limited service health organization, preferred provider plan or managed care plan.

3. Any other relevant documents or information used by the limited service health organization, preferred provider plan or managed care plan in the grievance determination under s. 609.15.

(b) Upon the request of the enrollee, the limited service health organization, preferred provider plan or managed care plan shall submit to the enrollee copies of the documents and other information submitted to the independent review organization under par. (a), except for any proprietary or confidential information.

(c) The enrollee may provide to the independent review organization any additional information that the enrollee considers relevant.

(d) Within 5 business days after receiving the information under par. (a), the independent review organization shall request any additional information that it requires for the review from the enrollee or the limited service health organization, preferred provider plan or managed care plan. Within 5 business days after receiving a request for additional information, the enrollee or the limited service health organization, preferred provider plan or managed care plan shall submit the information or an explanation of why the information is not being submitted.

(e) The independent review organization shall provide to the limited service health organization, preferred provider plan or managed care plan any additional

information received from the enrollee under pars. (c) and (d). If, on the basis of the additional information, the limited service health organization, preferred provider plan or managed care plan reconsiders the enrollee's grievance and determines that the treatment that was the subject of the grievance should be covered, the independent review is terminated.

(f) If the independent review is not terminated under par. (e), the expert reviewers on behalf of the independent review organization shall, within 15 business days after the expiration of all time limits that apply in the matter, make a determination on the basis of the documents and information submitted under this subsection. The independent review organization shall send by 1st class mail to the commissioner, the enrollee and the limited service health organization, preferred provider plan or managed care plan a copy of the determination, which shall be in writing and state the basis for the decision.

(g) If, in the judgment of the enrollee's treating health care provider, the health condition of the enrollee is such that following the procedure outlined in pars. (a) to (f) would jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, the procedure outlined in pars. (a) to (f) shall be followed with the following differences:

1. The limited service health organization, preferred provider plan or managed care plan shall submit the information under par. (a) within one day after receiving the notification under sub. (3) (b).

2. The independent review organization shall request any additional information under par. (d) within 2 business days after receiving the information under par. (a).

3. The enrollee or limited service health organization, preferred provider plan or managed care plan shall, within 2 days after receiving a request under par. (d), submit any information requested or an explanation of why the information is not being submitted.

4. The expert reviewers shall make their determination under par. (f) within 72 hours after the expiration of the time limits under this paragraph that apply in the matter.

(h) Any time limits specified in this subsection may be extended by mutual agreement between the enrollee, or his or her authorized representative, and the limited service health organization, preferred provider plan or managed care plan.

(i) Any information required or authorized to be submitted under this subsection may be submitted by facsimile or other electronic transmission.

(5) STANDARDS FOR REVIEW. In making the determination under sub. (4) (f), all of the following apply:

(a) If coverage of the treatment that is the subject of the review was denied on the basis that the treatment was not medically necessary or appropriate, the expert reviewers shall find that the treatment was medically necessary and appropriate if, in light of conditions at the time the treatment was proposed, the treatment satisfied all of the following:

1. Was appropriate and consistent with the diagnosis and not providing it could adversely affect or fail to improve the enrollee's condition.

2. Was compatible with the standards of acceptable medical practice in the United States.

3. Was provided, or was to be provided, in a safe and appropriate setting, given the nature of the diagnosis and the severity of the symptoms.

4. Was not provided, or was not to be provided, solely for the convenience of the enrollee, the health care provider or the hospital.

5. Was not primarily custodial care, unless custodial care is a covered benefit under the enrollee's coverage.

(b) If coverage of the treatment that is the subject of the review was denied on the basis that the treatment was experimental, the expert reviewers shall find in favor of the enrollee if all of the following apply:

1. The treatment has been approved by the federal food and drug administration.

2. Medically and scientifically accepted 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 are not substantially higher than those of standard treatments.

(c) The expert reviewers shall apply prudent professional practices and shall ensure that medically and scientifically accepted evidence supports the determination.

(6) EFFECT OF DETERMINATION. (a) A determination under sub. (4) (f) in favor of the enrollee is final and binding on the limited service health organization, preferred provider plan or managed care plan, which shall promptly comply with the determination.

(b) A determination under sub. (4) (f) in favor of the limited service health organization, preferred provider plan or managed care plan creates a rebuttable presumption in any subsequent action that the original coverage determination of the limited service health organization, preferred provider plan or managed care plan was appropriate.

(c) An independent review organization is immune from any civil or criminal liability that may result because of an independent review determination made under this section. An employe, agent or contractor of an independent review organization is immune from civil liability and criminal prosecution for any act or omission done in good faith within the scope of his or her powers and duties under this section.

(7) INDEPENDENT REVIEW ORGANIZATIONS; CERTIFICATION. (a) The commissioner shall certify and recertify independent review organizations that may conduct independent reviews under this section.

(b) An independent review organization shall submit to the commissioner in its application for certification the following information:

1. The names of all owners of more than 5% of any stock or options, if a publicly held organization.

2. The names of all holders of bonds or notes in excess of $100,000, if any.

3. The names and types of business 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.

4. The names of all directors, officers and executives of the independent review organization and the nature of any relationship that a director, officer or executive has, if any, with a provider group or a health care insurer, including a limited service health organization, preferred provider plan or managed care plan.

(c) Within 30 days of any change in the information submitted under par. (b), the independent review organization shall notify the commissioner of the change.

(d) An independent review organization may not be a subsidiary of, or owned or controlled by, a health care plan, a trade association of health care plans or a professional association of health care providers.

(e) An expert reviewer assigned by an independent review organization to conduct a review must satisfy all of the following requirements:

1. Be a health care provider who is expert in treating the medical condition that is the subject of the review and who is knowledgeable about the treatment that is the subject of the review through actual clinical experience.

2. Hold a credential, as defined in s. 440.01 (2) (a), that is not limited or restricted; or hold a license, certificate, registration or permit that authorizes or qualifies the health care provider to perform acts that are substantially the same as those acts authorized by a credential, as defined in s. 440.01 (2) (a), that was issued by a governmental authority in a jurisdiction outside this state and that is not limited or restricted.

3. If a physician, hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the review.

4. Have no history of disciplinary sanctions, including loss of staff privileges, taken or pending by the medical examining board or another regulatory body or by any hospital or government.

(f) An independent review organization or an expert reviewer of the organization may not have any material professional, familial or financial conflict of interest with any of the following:

1. A limited service health organization, preferred provider plan or managed care plan that is involved in a review being conducted by the organization or reviewer.

2. An officer, director or management employe of a limited service health organization, preferred provider plan or managed care plan that is involved in a review being conducted by the organization or reviewer.

3. The health care provider, or the provider group or independent practice association of the health care provider, who proposed or who is proposing the treatment that is being reviewed.

4. The institution at which the treatment being reviewed was or would be provided.

5. The enrollee or his or her authorized representative.

6. The development or manufacture of the treatment being reviewed.

(g) An independent review organization shall have in operation a quality assurance mechanism to ensure the timeliness and quality of the reviews, the qualifications and independence of the expert reviewers and the confidentiality of the medical records and review materials.

(8) RULE MAKING AND REPORTING. (a) The commissioner shall promulgate rules for the implementation and operation of this section, including rules related to standards for certifying and recertifying independent review organizations.

(b) The commissioner shall provide a current listing of certified independent review organizations to all of the following:

1. Every limited service health organization, preferred provider plan and managed care plan that is subject to this section, at least quarterly.

2. Any person who requests a copy of the listing.

(c) The commissioner shall submit to the legislature under s. 13.172 (2) and to the governor an annual report on the operation of the independent review system under this section.

SECTION 6. Nonstatutory provisions.

(1) RULES REGARDING INDEPENDENT REVIEW. Using the procedure under section 227.24 of the statutes, the commissioner of insurance may promulgate rules required under section 609.16 (8) (a) of the statutes, as created by this act, for the period before the effective date of the permanent rules promulgated under section 609.16 (8) (a) 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 7. Effective dates. This act takes effect on the first day of the 13th month beginning after publication, except as follows:

(1) The treatment of section 609.16 (8) (a) of the statutes and SECTION 6 of this act take effect on the day after publication.

(END)