

**1999 DRAFTING REQUEST**

**Bill**

Received: **07/29/1999**

Received By: **kahlepj**

Wanted: **As time permits**

Identical to LRB:

For: **Peggy Rosenzweig (608) 266-2512**

By/Representing: **Gene Schaeffer**

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

Drafter: **kahlepj**

May Contact: **Dick Sweet**

Alt. Drafters:

Subject: **Insurance - health**

Extra Copies:

**Pre Topic:**

No specific pre topic given


**Topic:**

Provide for independent review of managed care plan decisions

**Instructions:**

See Attached

**Drafting History:**

<u>Vers.</u>	<u>Drafted</u>	<u>Reviewed</u>	<u>Typed</u>	<u>Proofed</u>	<u>Submitted</u>		<u>Required</u>
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/P1			jfrantze 08/27/1999	_____	lrb_docadmin 08/27/1999		S&L
/1	kahlepj 09/03/1999	chanaman 09/03/1999	kfollet 09/07/1999	_____	lrb_docadmin 09/07/1999		S&L
/2	kahlepj 09/09/1999	chanaman 09/09/1999	martykr 09/09/1999	_____	lrb_docadmin 09/09/1999	lrb_docadmin 09/29/1999	

FE Sent For:

G 09-30-99

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*KM 9*

*KF 9*

*KM 9*

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FE Sent For:		/	KJF 9/7	KJF/km 9/7			

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1/1	kahlepj	cmw 8/25 /1	8/26	8/27			

FE Sent For:

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

HB 732

HB 732/AP

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**

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

27 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

28 SECTION 1.

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

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- 1 "51-1-48.
- 2 (a) Any claim administrator, health care advisor, private  
3 review agent, or other person or entity which administers  
4 benefits or reviews or adjusts claims under a managed care  
5 plan shall exercise ordinary diligence to do so in a  
6 timely and appropriate manner in accordance with the  
7 practices and standards of the profession of the health  
8 care provider generally. Notwithstanding any other  
9 provision of law to the contrary, any injury or death to  
10 an enrollee resulting from a want of such ordinary  
11 diligence shall be a tort for which a recovery may be had  
12 against the managed care entity offering such plan, but no  
13 recovery shall be had for punitive damages for such tort.
- 14 (b) The provisions of this Code section may not be waived,  
15 shifted, or modified by contract or agreement and  
16 responsibility therefor shall be a duty which shall not be  
17 delegated. Any effort to waive, modify, delegate, or  
18 shift liability for a breach of the duty provided by this  
19 Code section, through a contract for indemnification or  
20 otherwise, shall be invalid.
- 21 (c) This Code section shall not create any liability on  
22 the part of an employer of an enrollee or that employer's  
23 employees, unless the employer is the enrollee's managed  
24 care entity. This Code section shall not create any  
25 liability on the part of an employee organization, a  
26 voluntary employee beneficiary organization, or a similar  
27 organization, unless such organization is the enrollee's  
28 managed care entity and makes coverage determinations  
29 under a managed care plan.
- 30 (d) As used in this Code section and in Code Section  
31 51-1-49, the terms 'claim administrator,' 'enrollee,'  
32 'health care advisor,' and 'private review agent,' shall  
33 be defined as set forth in Chapter 46 of Title 33 except  
34 that 'enrollee' shall include the enrollee's eligible  
35 dependents; 'managed care entity' and 'managed care plan'  
36 shall be defined as set forth in Code Section 33-20A-3;  
37 and 'independent review' means a review pursuant to  
38 Article 2 of Chapter 20A of Title 33, the 'Patient's Right  
39 to Independent Review Act.'
- 40 51-1-49.



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

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

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

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

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

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

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

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

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

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

29 SECTION 2.

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

34 for "this chapter" and "This article" for "This chapter"  
35 wherever such terms appear in the newly designated Article  
36 1.

37 SECTION 3.

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

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1 "ARTICLE 2

2 33-20A-30.

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

5 33-20A-31.

6 As used in this article:

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

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

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

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

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

23 (4) 'Medical and scientific evidence' means:

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

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

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

37 (C) Medical journals recognized by the United States  
38 secretary of health and human services, under Section  
39 1861(t)(2) of the Social Security Act;

42 USC 1861...?

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

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

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

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

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

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

28 symptoms;

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

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

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

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

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

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1 33-20A-3 except that 'enrollee' shall include the  
2 enrollee's eligible dependents.

3 33-20A-32.

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

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

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

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

22 (B) After exhaustion of standard treatment as provided

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

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

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

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

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

11 33-20A-33.

12 Except where required pursuant to Code Section 51-1-49, a  
13 proposed treatment must require the expenditure of a  
14 minimum of \$500.00 to qualify for independent review.

15 33-20A-34.

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

21 independent review. Except as provided in Code Section  
22 51-1-49, independent review may not be requested by  
23 persons other than the eligible enrollee or a person  
24 acting on behalf of the eligible enrollee as provided in  
25 this Code section.

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

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

35 33-20A-35.

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

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

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

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

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

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

31 33-20A-36.

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

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

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

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

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

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

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

*circled*

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

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

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

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

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1 33-20A-37.

2 (a) A decision of the independent review organization in  
 3 favor of the eligible enrollee shall be final and binding  
 4 on the managed care entity and the appropriate relief  
 5 shall be provided without delay. A managed care entity  
 6 bound by such decision of an independent review  
 7 organization shall not be liable pursuant to Code Section  
 8 51-1-48 for abiding by such decision. Nothing in this Code  
 9 section shall relieve the managed care entity from  
 10 liability for damages proximately caused by its  
 11 determination of the proposed treatment prior to such  
 12 decision.

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



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

19 (c) In the event that, in the judgment of the treating  
20 health care provider, the health condition of the enrollee  
21 is such that following the provisions of Code Section  
22 33-20A-36 would jeopardize the life or health of the  
23 eligible enrollee or the eligible enrollee's ability to  
24 regain maximum function, as determined by the treating  
25 health care provider, an expedited review shall be  
26 available. The expedited review process shall encompass  
27 all elements enumerated in Code Sections 33-20A-36 and  
28 33-20A-40; provided, however, that a decision by the  
29 expert reviewer shall be rendered within 72 hours after  
30 the expert reviewer's receipt of all available requested  
31 documents.

32 33-20A-38.

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

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1 33-20A-39.

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

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

13 providers who meet the following minimum requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (d) The independent review organization shall have a

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

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

*w/ date*

16 33-20A-40.

17 (a) For the purposes of this article, in making a  
18 determination as to whether a treatment is medically  
19 necessary and appropriate, the expert reviewer shall use  
20 the definition provided in paragraph (5) of Code Section  
21 33-20A-31.

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

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

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

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

37 33-20A-41.

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

2 For purposes of certifying independent review organizations  
3 by the Health Planning Agency, or its successor agency, this  
4 Act shall become effective upon its approval by the Governor  
5 or upon its becoming law without such approval. For all  
6 other purposes, this Act shall become effective on July 1,  
7 1999, and shall be applicable to any contract, policy, or  
8 other agreement of a managed care plan or health maintenance  
9 organization if such contract, policy, or agreement provides  
10 for health care services or reimbursement therefor and is  
11 issued, issued for delivery, delivered, or renewed on or  
12 after July 1, 1999.

13

SECTION 5.

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

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external review → after grievance procedure

review bd (see GA statute)

expedited review

p 11 (if following usual procedure...)

more

independent review organization

OCT picks organizations

choose 1 or more

categories

OCT choose for each case (assigns)

IRO = reviewer who works

for/w/ IRO

(size?) at least 3 for each case

3 individuals

ultimate decision made by IRO

\$500 threshold for reviewable

MCP picks up cost

include conflict of interest factors (p 13)

p 5 need an app → standard ~~app~~

that must be used by IRO

see pp 5 & 14

p 6 → don't separate out "experimental"

provide written notice of right to IRO

p 9 → info MCP provides to IRO

p 8 rotating basis a  
choose

OIG assign IRO w/in 3 days  
(choose one that can  
decide the issue)

Delayed eff date → 1yr

present

Written material

paper review

can be as long as 10 days for enrollee's stuff -  
then 15 days to vote decision

binding on MCP

rebuttal given for enrollee

include liability immunity

see for peer review org → 146, 138

check these for  
chapter  
similar  
provisions

include restrictions on reviews

include p 12, line 3.3600 et seq

OIG annual report to gov. & sec

med use / appns  
experimental

may need to differentiate  
between the 2 for  
review  
but not for eligibility  
to get an IR

optional to go to IRO  
but must go through grievance process first



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

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

6

37 (C) Medical journals recognized by the United States  
38 secretary of health and human services, under Section  
39 1861(t)(2) of the Social Security Act;

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

4

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

3

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

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

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

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

Pam Kahler  
6-2682

National Library of Medicine website

AMA  
ADA

Is it  
necessary  
to know  
if they're  
current  
publications

August 24, 1999

From: Dan Ritsche, Legislative Analyst [daniel.ritsche@legis.state.wi.us](mailto:daniel.ritsche@legis.state.wi.us)  
Legislative Reference Bureau  
267-0710

To: Judith Louer [jalouer@facstaff.wisc.edu](mailto:jalouer@facstaff.wisc.edu)  
UW Health Sciences Library Reference  
262-2376 262-4431

One of our legislative attorneys is drafting a bill using a piece of legislation from another state. She has asked me to check the accuracy/proper citations of the following list of databases, reference works and entities. Please make corrections where you can or suggest other contacts for further information. Thanks. The items are typed exactly as they appear in the bill draft.

Peer reviewed literature, biomedical compendia, and other medical literature that meet the criteria of:

National Institutes of Health's National Library of Medicine

It's a division of  
NIH

Index Medicus

Databases

Excerpta Medica<sup>g</sup> (EMBASE) *refers to electronic form*

Medline MEDLINE (all caps)

Medlars MEDLARS (my typing mistake)

Health Services Technology Assessment Research (HSTAR)

(word)  
HEALTH STAR is the current name  
database put out by Nat Libr of Medicine

The following standard reference compendia:

The American Hospital Formulary Service - Drug Information

Discontinued?  
" old?"

~~The American Medical Association Drug Evaluation~~

AMA info center (312) 464-5000

~~The United States Pharmacopeia - Drug Information~~

for the health care provider  
TDI and Dispensing Information 2 sections

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~~

under PHS  
+ HSS

National Institutes of Health

National Cancer Institute

National Academy of Sciences



State of Wisconsin  
1999 - 2000 LEGISLATURE

LRB-33577-PI  
PJK.....  
cmf

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

D-note  
(Friday, if possible)

gen cat

1 AN ACT <sup>✓</sup>; relating to: independent review of managed care plan grievance  
2 procedure outcomes and granting rule-making authority.

***Analysis by the Legislative Reference Bureau***

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

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

3 SECTION 1. 601.42 (4) of the statutes is amended to read:  
4 601.42 (4) REPLIES. Any officer, manager or general agent of any insurer  
5 authorized to do or doing an insurance business in this state, any person controlling  
6 or having a contract under which the person has a right to control such an insurer,  
7 whether exclusively or otherwise, any person with executive authority over or in  
8 charge of any segment of such an insurer's affairs, any individual practice  
9 association or officer, director or manager of an individual practice association, any  
10 insurance agent or other person licensed under chs. 600 to 646, any provider of

7  
↑

1 services under a continuing care contract, as defined in s. 647.01 (2), any  
2 independent review organization certified under s. 609.16 (3) or any health care  
3 provider, as defined in s. 655.001 (8), shall reply promptly in writing or in other  
4 designated form, to any written inquiry from the commissioner requesting a reply.

5 SECTION 2. 609.15 (3) of the statutes is created to read:

6 609.15 (3) Whenever the disposition of a grievance under this section is adverse  
7 to the enrollee, the notice of the grievance disposition under sub. (2) (d) shall include  
8 a written statement that the enrollee may obtain an independent review of the  
9 disposition as provided in s. 609.16, instructions on how to request an independent  
10 review, instructions on what information and documentation are required for  
11 independent review and information about the procedure that will be followed in the  
12 independent review. The limited service health organization, preferred provider  
13 plan or managed care plan shall include with the notice the forms necessary for  
14 requesting independent review.

15 SECTION 3. 609.16 of the statutes is created to read:

16 609.16 Independent review of grievance procedure outcomes. (1)

17 DEFINITION. In this section, "treatment" means a medical service, diagnosis,  
18 procedure, therapy, drug or device.

19 (2) REQUIREMENT TO ESTABLISH; ELIGIBILITY. Every limited service health  
20 organization, preferred provider plan and managed care plan shall establish an  
21 independent review procedure that is in compliance with this section and under  
22 which an enrollee of the plan may request and obtain an independent review of a  
23 grievance determination under s. 609.15. To be eligible for independent review, the  
24 determination must be adverse to the enrollee and the value of the treatment that  
25 was the subject of the grievance must be at least \$500.

1           (3) REQUESTING INDEPENDENT REVIEW. (a) To request an independent review, an  
2           enrollee shall submit a written request to the commissioner on forms developed by  
3           the commissioner and provided to the enrollee by the limited service health  
4           organization, preferred provider plan or managed care plan under s. 609.15 (3). An  
5           independent review may be requested on behalf of an enrollee by his or her legal  
6           guardian or representative and on behalf of an enrollee who is a minor by the minor's  
7           parent or guardian.

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

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

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

1 (4) PROCEDURE. (a) Within 3 business days after receiving notification of the  
2 name and address of the independent review organization under sub. (3) (b), the  
3 limited service health organization, preferred provider plan or managed care plan  
4 shall submit to the independent review organization copies of all of the following:

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

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

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

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

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

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

1 (e) The independent review organization shall provide to the limited service  
2 health organization, preferred provider plan or managed care plan any additional  
3 information received from the enrollee under pars. (c) and (d). If, on the basis of the  
4 additional information, the limited service health organization, preferred provider  
5 plan or managed care plan reconsiders the enrollee's grievance and determines that  
6 the treatment that is the subject of the grievance should be covered, the independent  
7 review is terminated.

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

16 (g) If, in the judgment of the enrollee's treating health care provider, the health  
17 condition of the enrollee is such that following the procedure outlined in pars. (a) to  
18 (f) would jeopardize the life or health of the enrollee or the enrollee's ability to regain  
19 maximum function, the procedure outlined in pars. (a) to (f) shall be followed except  
20 that the expert reviewers shall make their determination within 72 hours after  
21 receiving all available requested information.

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

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

3 (5) STANDARDS FOR REVIEW. In making the determination under sub. (4) (f):

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

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

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

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

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

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

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

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

23 2. Any of the following demonstrate<sup>s</sup> that the expected benefits of the proposed  
24 treatment would be greater than the benefits of any available standard treatment



1 and that the adverse risks of the proposed treatment are not substantially higher  
2 than those of standard treatments:

3 a. Peer reviewed scientific studies published in or accepted for publication by  
4 medical journals that meet nationally recognized requirements for scientific  
5 manuscripts and that submit most of their published articles for review by experts  
6 who are not part of the editorial staff.

7 b. Peer reviewed literature, biomedical compendia and other medical literature  
8 that meet the criteria of the National Library of Medicine for indexing in Index  
9 Medicus, Excerpta Medica, EMBASE, MEDLINE, MEDLARS or HEALTHSTAR.

10 c. Medical journals recognized by the secretary of the federal department of  
11 health and human services under section 1861 (t) (2) of the Social Security Act.

12 d. The American Hospital Formulary Service-Drug Information, the American  
13 Medical Association Drug Evaluation, the American Dental Association Accepted  
14 Dental Therapeutics or the United States Pharmacopoeia-Drug Information for the  
15 Health Care Provider.

16 e. Findings, studies or research conducted by or under the auspices of federal  
17 government agencies or nationally recognized federal research institutes, including  
18 the Agency for Health Care Policy and Research, National Institutes of Health,  
19 National Cancer Institute, National Academy of Sciences, Health Care Financing  
20 Administration, or any national board recognized by the National Institutes of  
21 Health for the purpose of evaluating the medical value of health services.

22 (c) The expert reviewers shall apply prudent professional practices and shall  
23 ensure that at least 2 of the sources specified in par. (b) 2. support the determination.

24 (6) EFFECT OF DETERMINATION. (a) A determination under sub. (4) (f) in favor  
25 of the enrollee is final and binding on the limited service health organization,

1 preferred provider plan or managed care plan, which shall promptly comply with the  
2 determination.

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

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

→ 7 } 6

14 ~~(8)~~ INDEPENDENT REVIEW ORGANIZATIONS; CERTIFICATION. (a) The commissioner  
15 shall certify independent review organizations that may conduct independent  
16 reviews under this section.

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

- 19 1. The names of all owners of more than 5% of any stock or options, if a publicly
- 20 held organization.
- 21 2. The names of all holders of bonds or notes in excess of \$100,000, if any.
- 22 3. The names and types of business of all corporations and organizations that
- 23 the independent review organization controls or is affiliated with and the nature and
- 24 extent of any ownership or control.

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

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

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

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

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

15           2. Hold a nonrestricted license issued by a state of the United States and, for  
16 physicians, a current certification by a recognized American medical specialty board  
17 in the area<sup>er</sup> or areas appropriate to the subject of the review.

18           3. Have no history of disciplinary<sup>er</sup> action or sanctions, including loss of staff  
19 privileges or participation restrictions, taken or pending by any hospital,  
20 government or regulatory body.

→  
\*\*\*\*NOTE: Much of par. (f) is taken verbatim from the Georgia law. It has been  
inserted as a placeholder. Revisions to this language (especially subs. 2. and 3.) will have  
to be made in the next version of the draft, after I am able to consult with Debora Kennedy,  
who is out of the office until August 30.

21           (f) An independent review organization ~~and~~<sup>and</sup> an expert reviewer of the  
22 organization may not have any material professional, familial or financial conflict  
23 of interest with any of the following:

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

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

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

10 4. The institution at which the treatment that is being reviewed was or would  
11 be provided.

12 5. The enrollee or his or her authorized representative.

13 6. The development or manufacture of the treatment that is being reviewed.

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

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

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

23 1. Every limited service health organization, preferred provider plan and  
24 managed care plan, at least quarterly.

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

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

*a.r. added*

4 **SECTION 4. Nonstatutory provisions.**

*Required*

5 (1) RULES REGARDING INDEPENDENT REVIEW. Using the procedure under section  
6 227.24 of the statutes, the commissioner of insurance may promulgate rules  
7 ~~authorized~~ under section 609.16 (9) (a) of the statutes, as created by this act, for the  
8 period before the effective date of the permanent rules promulgated under section  
9 609.16 (9) (a) of the statutes, as created by this act, but not to exceed the period  
10 authorized under section 227.24 (1) (c) and (2) of the statutes. Notwithstanding  
11 section 227.24 (1) (a), (2) (b) and (3) of the statutes, the commissioner is not required  
12 to provide evidence that promulgating a rule under this subsection as an emergency  
13 rule is necessary for the preservation of the public peace, health, safety or welfare  
14 and is not required to provide a finding of emergency for a rule promulgated under  
15 this subsection.

7  
9

16 **SECTION 5. Effective date.** This act takes effect on the first day of the 13th  
17 month beginning after publication, except as follows:

18 (1) SECTION 4 of this act takes effect on the day after publication.

*please check a.r.*

(END)

*D. note*

**DRAFTER'S NOTE  
FROM THE  
LEGISLATIVE REFERENCE BUREAU**

LRB-3357<sup>PI</sup>dn  
PJK.....

cmH

1. Be sure to review this draft carefully. (Notice one note embedded in the draft.) For some of the draft I followed the Georgia law language but do not know if I interpreted the law correctly, since different states have different drafting conventions, terms and phrases have different definitions and usages in different states and different writers use punctuation differently.

2. Because the definition of "managed care plan" in ch. 609 does not include limited service health organizations or every type of preferred provider plan, these two entities are specifically included in the draft separately. Let me know if you do not want to include them, that is, if you want the draft to apply only to managed care plans as defined in ch. 609.

3. There is no limit on how long an enrollee has to request independent review after receiving notification of an unfavorable grievance disposition under s. 609.15. Do you want to specify a time limit?

4. OCI may need an appropriation for its administration. In addition, we will need to add a fee to s. 601.31 for certifying an independent review organization.

5. Note where I used "expert reviewers" instead of "independent review organization". Is this okay?

6. Note that I assumed that the treatment that is the subject of a review, and for which coverage has been denied, may have been either merely proposed or actually provided. Is this okay? 7

7. Note that s. 609.16 (d) in the draft was not discussed at our meeting as being included in this draft. I thought this may have been an oversight, so I included it. You may not want it included, however.

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

**DRAFTER'S NOTE**  
**FROM THE**  
**LEGISLATIVE REFERENCE BUREAU**

LRB-3357/P1dn  
PJK:cmh:jf

August 26, 1999

1. Be sure to review this draft carefully. (Notice one note embedded in the draft.) For some of the draft I followed the Georgia law language but do not know if I interpreted the law correctly, since different states have different drafting conventions, terms and phrases have different definitions and usages in different states and different writers use punctuation differently.

2. Because the definition of "managed care plan" in ch. 609 does not include limited service health organizations or every type of preferred provider plan, these two entities are specifically included in the draft separately. Let me know if you do not want to include them, that is, if you want the draft to apply only to managed care plans as defined in ch. 609.

3. There is no limit on how long an enrollee has to request independent review after receiving notification of an unfavorable grievance disposition under s. 609.15. Do you want to specify a time limit?

4. OCI may need an appropriation for its administration. In addition, we will need to add a fee to s. 601.31 for certifying an independent review organization.

5. Note where I used "expert reviewers" instead of "independent review organization". Is this okay?

6. Note that I assumed that the treatment that is the subject of a review, and for which coverage has been denied, may have been either merely proposed or actually provided. Is this okay?

7. Note that s. 609.16 (7) (d) in the draft was not discussed at our meeting as being included in this draft. I thought this may have been an oversight, so I included it. You may not want it included, however.

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

\$400 for cost ) 601.31  
\$100 for review  
add + review

as to expedited review:

reduce as follows:

3 → 1

5 → 2

5 → 2

15 days → 72 hrs

~~medical & scientific evidence~~  
\* <sup>use</sup> medically & scientifically accepted evidence demonstrates

get rid of laundry list  
(def of med & scien. evid)



Subch II of ch 440

(Nurse Therapists  
& Bodyworkers)

Ch 441 - Nurses

Ch 446 - Chiropractors

Ch 447 - Dentists

Ch 448 - physicians,  
respiratory care practitioners  
physician assistants  
Occupational therapists  
Occupational therapy  
assistants  
physical therapists  
podiatrists  
dietitians

Ch 449 - optometrists

Ch 450 - pharmacists

Ch 451 - acupuncturists

Ch 455 - psychologists

Ch 457 - social workers,  
marriage and family  
therapists,  
professional counselors

Ch. 459 - hearing instrument  
specialists

speech language  
pathologists,  
audiologists

1999-2000 DRAFTING INSERT  
FROM THE  
LEGISLATIVE REFERENCE BUREAU

LRB-3357/P1ins  
PJK:cmh:jf

Debora:

The following subdivision comes from a Georgia law that I have been working from for a bill on independent review of managed care plan grievance decisions. It is one criterion that must be satisfied by a health care provider who is qualified to be an "expert reviewer" in an independent review. Could you please mark it up so that it is consistent with our statutory conventions and language? Thank you very much!

Pam

X  
2. Hold a ~~nonrestricted~~ license issued by a state of the United States and, for  
physicians, <sup>hold</sup> a current certification by a recognized American medical specialty board  
in the area or areas appropriate to the subject of the review.

*certificate, registration or permit  
that is not limited or restricted and  
that is*

440.01(2)(d)

(d) "**Reciprocal** credential" means a credential granted by an examining board, section of an examining board, affiliated credentialing board or the department to an applicant who holds a credential issued by a governmental authority in a jurisdiction outside this state authorizing or qualifying the applicant to perform acts that are substantially the same as those acts authorized by the credential granted by the examining board, section of the examining board, affiliated credentialing board or department.

*2.a. Hold a license, certificate, registration or permit issued under ch. 441, 448 that is not limited or restricted on a license, certificate, registration or permit issued by a governmental authority in a jurisdiction outside this state authorizing or qualifying the applicant to perform acts that are substantially the same as those acts authorized by the license, certificate, registration or permit issued under ch. 441, 448*

*b. For physicians, in addition to the requirement under subd. a., hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the review.*



State of Wisconsin  
1999 - 2000 LEGISLATURE

LRB-3357/94

PJK:cmh:jf

*r m is run*

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

*By Thurs.  
9-9*

*✓  
providing an  
exemption from  
emergency rule  
procedures*

*✓  
regenerate*

1 AN ACT to amend 601.42 (4); and to create 609.15 (3) and 609.16 of the statutes;  
2 relating to: independent review of managed care plan grievance procedure  
3 outcomes and granting rule-making authority.

*✓  
Insert  
A*

**Analysis by the Legislative Reference Bureau**

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

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

*✓  
Insert  
1-4*

4 SECTION 1. 601.42 (4) of the statutes is amended to read:  
5 601.42 (4) REPLIES. Any officer, manager or general agent of any insurer  
6 authorized to do or doing an insurance business in this state, any person controlling  
7 or having a contract under which the person has a right to control such an insurer,  
8 whether exclusively or otherwise, any person with executive authority over or in  
9 charge of any segment of such an insurer's affairs, any individual practice  
10 association or officer, director or manager of an individual practice association, any

1 insurance agent or other person licensed under chs. 600 to 646, any provider of  
2 services under a continuing care contract, as defined in s. 647.01 (2), any  
3 independent review organization certified under s. 609.16 (7) or any health care  
4 provider, as defined in s. 655.001 (8), shall reply promptly in writing or in other  
5 designated form, to any written inquiry from the commissioner requesting a reply.

6 SECTION 2. 609.15 (3) of the statutes is created to read:

7 609.15 (3) Whenever the disposition of a grievance under this section is adverse  
8 to the enrollee, the notice of the grievance disposition under sub. (2) (d) shall include  
9 a written statement that the enrollee may obtain an independent review of the  
10 disposition as provided in s. 609.16, instructions on how to request an independent  
11 review, instructions on what information and documentation are required for  
12 independent review and information about the procedure that will be followed in the  
13 independent review. The limited service health organization, preferred provider  
14 plan or managed care plan shall include with the notice the forms necessary for  
15 requesting independent review.

16 SECTION 3. 609.16 of the statutes is created to read:

17 609.16 Independent review of grievance procedure outcomes. (1)

18 DEFINITION. In this section, "treatment" means a medical service, diagnosis,  
19 procedure, therapy, drug or device.

CRITERIA

20 (2) REQUIREMENT TO ESTABLISH; ELIGIBILITY. Every limited service health  
21 organization, preferred provider plan and managed care plan shall establish an  
22 independent review procedure that is in compliance with this section ~~and~~

Insert 2-22

23 which an enrollee of the plan may request and obtain an independent review of a  
24 grievance determination under s. 609.15. To be eligible for independent review, the

1 determination must be adverse to the enrollee ~~and~~ the value of the treatment that  
2 was the subject of the grievance must be at least \$500.

3 (3) REQUESTING INDEPENDENT REVIEW. (a) To request an independent review, an  
4 enrollee shall submit a written request to the commissioner on forms developed by  
5 the commissioner and provided to the enrollee by the limited service health  
6 organization, preferred provider plan or managed care plan under s. 609.15 (3). An  
7 independent review may be requested on behalf of an enrollee by his or her legal  
8 guardian or representative and on behalf of an enrollee who is a minor by the minor's  
9 parent or guardian.

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

treating

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

23 (d) The enrollee and the limited service health organization, preferred provider  
24 plan or managed care plan shall cooperate fully with the independent review

1 organization to provide the information and documentation necessary for making a  
2 determination, including executing any necessary releases for medical records.

3 (4) PROCEDURE. (a) Within 3 business days after receiving notification of the  
4 name and address of the independent review organization under sub. (3) (b), the  
5 limited service health organization, preferred provider plan or managed care plan  
6 shall submit to the independent review organization copies of all of the following:

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

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

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

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

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

21 (d) Within 5 business days ~~of the receipt of~~ the information under par. (a), the  
22 independent review organization shall request any additional information that it  
23 requires for the review from the enrollee or the limited service health organization,  
24 preferred provider plan or managed care plan. Within 5 business days after  
25 receiving a request for additional information, the enrollee or the limited service

after receiving



1 health organization, preferred provider plan or managed care plan shall submit the  
2 information or an explanation of why the information is not being submitted.

3 (e) The independent review organization shall provide to the limited service  
4 health organization, preferred provider plan or managed care plan any additional  
5 information received from the enrollee under pars. (c) and (d). If, on the basis of the  
6 additional information, the limited service health organization, preferred provider  
7 plan or managed care plan reconsiders the enrollee's grievance and determines that  
8 the treatment that ~~is~~<sup>was</sup> the subject of the grievance should be covered, the independent  
9 review is terminated.

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

18 (g) If, in the judgment of the enrollee's treating health care provider, the health  
19 condition of the enrollee is such that following the procedure outlined in pars. (a) to  
20 (f) would jeopardize the life or health of the enrollee or the enrollee's ability to regain  
21 maximum function, the procedure outlined in pars. (a) to (f) shall be followed except  
22 that the expert reviewers shall make their determination within 72 hours after  
23 receiving all available requested information.

Insert 5-23 →

*all of the following apply*

*that the treatment was medically necessary and appropriate*

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

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

6 (5) STANDARDS FOR REVIEW. In making the determination under sub. (4) (f):

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

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

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

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

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

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

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

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

-7-

Insert 7-1

1 2. ~~that the expert reviewers~~ demonstrates that the expected benefits of the proposed  
 2 treatment would be greater than the benefits of any available standard treatment  
 3 and that the adverse risks of the proposed treatment are not substantially higher  
 4 than those of standard treatments. ← period

5 a. Peer reviewed scientific studies published in or accepted for publication by  
 6 medical journals that meet nationally recognized requirements for scientific  
 7 manuscripts and that submit most of their published articles for review by experts  
 8 who are not part of the editorial staff.  
 9 b. Peer reviewed literature, biomedical compendia and other medical literature  
 10 that meet the criteria of the National Library of Medicine for indexing in Index  
 11 Medicus, Excerpta Medica, EMBASE, MEDLINE, MEDLARS or HEALTHSTAR.  
 12 c. Medical journals recognized by the secretary of the federal department of  
 13 health and human services under section 1861 (t) (2) of the Social Security Act.  
 14 d. The American Hospital Formulary Service-Drug Information, the American  
 15 Medical Association Drug Evaluation, the American Dental Association Accepted  
 16 Dental Therapeutics or the United States Pharmacopoeia-Drug Information for the  
 17 Health Care Provider.  
 18 e. Findings, studies or research conducted by or under the auspices of federal  
 19 government agencies or nationally recognized federal research institutes, including  
 20 the Agency for Health Care Policy and Research, National Institutes of Health,  
 21 National Cancer Institute, National Academy of Sciences, Health Care Financing  
 22 Administration, or any national board recognized by the National Institutes of  
 23 Health for the purpose of evaluating the medical value of health services.

24 (c) The expert reviewers shall apply prudent professional practices and shall  
 25 ensure that ~~all~~ ~~at least 2 of the sources specified in (b) 2~~ ~~support~~ the determination.

medically and scientifically accepted evidence supports



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

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

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

16          (7) INDEPENDENT REVIEW ORGANIZATIONS; CERTIFICATION. (a) The commissioner  
17 shall certify <sup>→ and recertify</sup> independent review organizations that may conduct independent  
18 reviews under this section.

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

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

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

1           3. The names and types of business of all corporations and organizations that  
2 the independent review organization controls or is affiliated with and the nature and  
3 extent of any ownership or control.

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

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

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

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

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

18           2. Hold a nonrestricted license issued by a state of the United States and, for  
19 physicians, a current certification by a recognized American medical specialty board  
20 in the area or areas appropriate to the subject of the review.

21           3. Have no history of disciplinary ~~sanctions~~ sanctions, including loss of staff  
22 privileges ~~or participation restrictions~~ taken or pending by any hospital  
23 government ~~or other regulatory body~~ *Keopromma*

\*\*\*\*NOTE: Much of par. (e) is taken verbatim from the Georgia law. It has been inserted as a placeholder. Revisions to this language (especially subs. 2. and 3.) will have

by the medical examining board or another regulatory body or

treatment

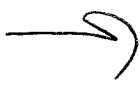
Insert 9-20

15

21

22

23



to be made in the next version of the draft, after I am able to consult with Debra Kennedy, who is out of the office until August 30.

(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 ~~the~~ being reviewed was or would be provided.

5. The enrollee or his or her authorized representative. ✓

6. The development or manufacture of the treatment ~~the~~ 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 independent review organizations.

and recertifying

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

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

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

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

9 **SECTION 4. Nonstatutory provisions.**

10 (1) RULES REGARDING INDEPENDENT REVIEW. Using the procedure under section  
11 227.24 of the statutes, the commissioner of insurance may promulgate rules required  
12 under section 609.16 (8) (a) of the statutes, as created by this act, for the period before  
13 the effective date of the permanent rules promulgated under section 609.16 (8) (a)  
14 of the statutes, as created by this act, but not to exceed the period authorized under  
15 section 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) (a),  
16 (2) (b) and (3) of the statutes, the commissioner is not required to provide evidence  
17 that promulgating a rule under this subsection as an emergency rule is necessary for  
18 the preservation of the public peace, health, safety or welfare and is not required to  
19 provide a finding of emergency for a rule promulgated under this subsection.

20 **SECTION 5. Effective dates.** This act takes effect on the ~~1st~~ after publication,  
21 except as follows:

22 (1) ~~Section~~ 4 of this act takes effect on the day after publication.

23

(END)

→ first day of the 13<sup>th</sup> month  
beginning

→ The treatment of section 609.16(8)(a) of the statutes and SECTION

1999-2000 DRAFTING INSERT  
FROM THE  
LEGISLATIVE REFERENCE BUREAU

LRB-3357/P1ins  
PJK:oml:jf

INSERT A

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 an 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 <sup>from</sup> being owned or controlled by, a health care plan, a trade association of health care plans or a professional association of health care providers and prohibiting an independent review organization or an expert reviewer from having any professional or financial conflict of interest with a plan that is involved in a review being conducted by the organization or reviewer. The bill also provides immunity from liability for determinations made in independent reviews to independent review organizations and employees, 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.

✓  
(END OF INSERT A)

INSERT 1-4

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.

(END OF INSERT 1-4)

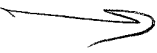
INSERT 2-22

no 9) 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.



was



(b) The value of the treatment that is 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.

(END OF INSERT 2-22)

INSERT 5-23

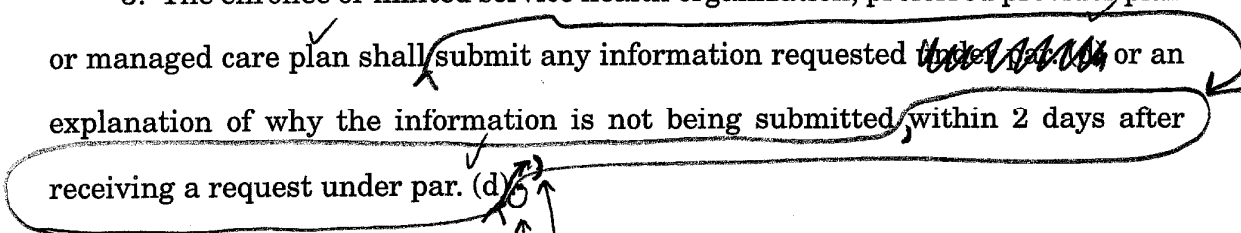
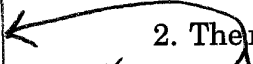
(g) If, in the judgment of the enrollee's treating health care provider, the health condition of the enrollee is such that following the procedure outlined in pars. (a) to (f) would jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, the procedure outlined 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 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 submit any information requested ~~under (a) or~~ or an explanation of why the information is not being submitted, within 2 days after receiving a request under par. (d).

independent



period stays

add comma after "(d)"



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.

(END OF INSERT 5-23)

INSERT 7-1

Medically and scientifically accepted evidence

(END OF INSERT 7-1)

INSERT 9-20

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.

(END OF INSERT 9-20)



State of Wisconsin  
1999 - 2000 LEGISLATURE

LRB-3357/A 2  
PJK:cmh:kjf  
r misun

1999 BILL

SOON  
(9-9)  
✓  
(change on  
P. 5)

reger call

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

**BILL**

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 employees, 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.

**BILL**

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

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

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

2           601.31 (1) (Lp) For certifying as an independent review organization under s.  
3           609.16 (7), \$400.

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

5           601.31 (1) (Lr) For each recertification as an independent review organization  
6           under s. 609.16 (7), \$100.

7           **SECTION 3.** 601.42 (4) of the statutes is amended to read:

8           601.42 (4) **REPLIES.** Any officer, manager or general agent of any insurer  
9           authorized to do or doing an insurance business in this state, any person controlling  
10          or having a contract under which the person has a right to control such an insurer,  
11          whether exclusively or otherwise, any person with executive authority over or in  
12          charge of any segment of such an insurer's affairs, any individual practice  
13          association or officer, director or manager of an individual practice association, any  
14          insurance agent or other person licensed under chs. 600 to 646, any provider of  
15          services under a continuing care contract, as defined in s. 647.01 (2), any  
16          independent review organization certified under s. 609.16 (7) or any health care  
17          provider, as defined in s. 655.001 (8), shall reply promptly in writing or in other  
18          designated form, to any written inquiry from the commissioner requesting a reply.

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

20          609.15 (3) Whenever the disposition of a grievance under this section is adverse  
21          to the enrollee, the notice of the grievance disposition under sub. (2) (d) shall include

**BILL**

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

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

9 **609.16 Independent review of grievance procedure outcomes. (1)**

10 **DEFINITION.** In this section, "treatment" means a medical service, diagnosis,  
11 procedure, therapy, drug or device.

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

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

19 (b) The value of the treatment that was the subject of the grievance is at least  
20 \$500.

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

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

**BILL**

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

5           4. The expert reviewers shall make their determination under par. (f) within  
6 72 hours after the expiration of the time limits under this paragraph that apply in  
7 the matter.

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

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

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

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

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

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

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

**BILL**

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

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

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

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

10          2. Medically and scientifically accepted evidence demonstrates that the  
11 expected benefits of the proposed treatment would be greater than the benefits of any  
12 available standard treatment and that the adverse risks of the proposed treatment  
13 are not substantially higher than those of standard treatments.

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

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

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

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

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

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

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

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

15 3. The names and types of business of all corporations and organizations that  
16 the independent review organization controls or is affiliated with and the nature and  
17 extent of any ownership or control.

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

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

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

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

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

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

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

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

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

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

**BILL**

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

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

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

9           5. The enrollee or his or her authorized representative.

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

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

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

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

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

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

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



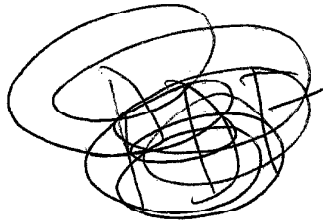


John Sime (Groschmidt)  
SB63 6-7505

include motor files

analysis to Gene Schaeffer  
at Rosenzweig's

3357/2



**1999 DRAFTING REQUEST**

**Assembly Amendment (AA-ASA1-AB133)**

Received: **09/13/1999**

Received By: **kahlepj**

Wanted: **Soon**

Identical to LRB:

For: **Administration 6-1040**

By/Representing: **Schmiedicke**

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

Drafter: **kahlepj**

May Contact:

Alt. Drafters:

Subject: **Econ. Development - bus. dev.**

Extra Copies:

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**Pre Topic:**

No specific pre topic given

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**Topic:**

Establish development opportunity zone in Kenosha

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**Instructions:**

See Attached

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**Drafting History:**

<u>Vers.</u>	<u>Drafted</u>	<u>Reviewed</u>	<u>Typed</u>	<u>Proofed</u>	<u>Submitted</u>	<u>Jacketed</u>	<u>Required</u>
/?	kahlepj			_____			

FE Sent For:

<END>

## Barman, Mike

---

**From:** Barman, Mike  
**Sent:** Wednesday, September 15, 1999 4:37 PM  
**To:** Schaeffer, Gene  
**Cc:** Kahler, Pam  
**Subject:** 99-3357/2 (per your request)



99-3357/2

LRB-3357/2  
Drafter: PJK  
1999 - 2000 LEGISLATURE

## 1999 BILL

**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 employees, 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.

*Mike Barman*

Mike Barman - Program Asst. (PH. 608-266-3561)  
(E-Mail: mike.barman@legis.state.wi.us) (FAX: 608-264-6948)

State of Wisconsin  
Legislative Reference Bureau - Legal Section - Front Office  
100 N. Hamilton Street - 5th Floor  
Madison, WI 53703

**SUBMITTAL  
FORM**

**LEGISLATIVE REFERENCE BUREAU**  
**Legal Section Telephone: 266-3561**  
**5th Floor, 100 N. Hamilton Street**

The attached draft is submitted for your inspection. Please check each part carefully, proofread each word, and sign on the appropriate line(s) below.

Date: 09/09/1999

To: Senator Rosenzweig

Relating to LRB drafting number: LRB-3357

**Topic**

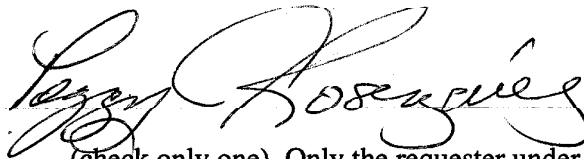
Provide for independent review of managed care plan decisions

**Subject(s)**

Insurance - health

1. **JACKET** the draft for introduction

in the Senate  or the Assembly  (check only one). Only the requester under whose name the drafting request is entered in the LRB's drafting records may authorize the draft to be submitted. Please allow one day for the preparation of the required copies.



2. **REDRAFT.** See the changes indicated or attached \_\_\_\_\_.

A revised draft will be submitted for your approval with changes incorporated.

3. Obtain **FISCAL ESTIMATE NOW**, prior to introduction \_\_\_\_\_.

If the analysis indicates that a fiscal estimate is required because the proposal makes an appropriation or increases or decreases existing appropriations or state or general local government fiscal liability or revenues, you have the option to request the fiscal estimate prior to introduction. If you choose to introduce the proposal without the fiscal estimate, the fiscal estimate will be requested automatically upon introduction. It takes about 10 days to obtain a fiscal estimate. Requesting the fiscal estimate prior to introduction retains your flexibility for possible redrafting of the proposal.

If you have any questions regarding the above procedures, please call 266-3561. If you have any questions relating to the attached draft, please feel free to call me.

Pamela J. Kahler, Senior Legislative Attorney  
Telephone: (608) 266-2682



STEPHEN R. MILLER  
CHIEF

# State of Wisconsin

## LEGISLATIVE REFERENCE BUREAU

100 NORTH HAMILTON STREET  
P. O. BOX 2037  
MADISON, WI 53701-2037

LEGAL SECTION: (608) 266-3561  
LEGAL FAX: (608) 264-8522  
REFERENCE SECTION: (608) 266-0341  
REFERENCE FAX: (608) 266-5648

# ***FISCAL ESTIMATES***

**BILL NUMBER:**

**1999 SENATE BILL 246**

Note: The analysis of this bill states that a fiscal estimate was required for this bill. A request was made through the department of administration to have a fiscal estimate prepared. The agency(s) assigned to prepare a fiscal estimate for this bill did not return an estimate for this bill so none are included in this file.