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:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	[redacted]	Required
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/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: 09-30-99

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LRB-3357

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By/Representing: **Gene Schaeffer**

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

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May Contact: **Dick Sweet**

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

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Subject: **Insurance - health**

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Topic:

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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

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

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

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

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"51-1-48.

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

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

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

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

51-1-49.

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

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

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

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

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

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

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

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

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

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

SECTION 2.

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

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

SECTION 3.

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

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"ARTICLE 2

33-20A-30.

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

33-20A-31.

As used in this article:

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

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

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

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

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

(4) 'Medical and scientific evidence' means:

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

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

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

(C) Medical journals recognized by the United States secretary of health and human services, under Section 1861(t)(2) of the Social Security Act; 42 USC 1861...?

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

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

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

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

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

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

symptoms;

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

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

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

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

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

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

33-20A-32.

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

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

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

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

(B) After exhaustion of standard treatment as provided

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

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

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

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

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

33-20A-33.

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

33-20A-34.

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

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

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

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

33-20A-35.

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

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

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

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

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

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

33-20A-36.

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

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

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

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

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

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

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

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

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

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

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

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33-20A-37.

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

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

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

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

33-20A-38.

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

33-20A-39.

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

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

providers who meet the following minimum requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) The independent review organization shall have a

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

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

33-20A-40.

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

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

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

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

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

33-20A-41.

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

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-13-

HB 732/AP

SECTION 4.

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

SECTION 5.

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

external review → after grievance procedure

review bd (see GA statute)

expedited review p11 (if following usual procedure...)

more

independent review organization

OCI picks organizations
choose 1 or more
" certifies
OCI choose for each case (assigns)

IRO = review who work for/with IRO

(size?) at least 3 for each case
3 individuals
alternate decision made by IRO

$500 threshold for reviewable
MCP pick up cost
include conflict of interest factors (p13)

p5 med necessity appro → standard ~~[redacted]~~
that must be used by IRO
see pp5 & 14

p6 → don't separate out "experimental"

provide written notice of right to IRO

p 9 → wpe MCP provide to IRO

p 8 rotating basis a
choose
OCI 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 stmt –
then 15 days to rebut decision

binding on ncp
rebuttal from enrollee

include liability immunity
as for peer review org → 146, 138 ← cf these in chapter similar provisions

include restrictions on reviews
include p 12, lines 3 to 4 et seq

OCI annual report to gov; leg

med nec / appro

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 thru grievance process first

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

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

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

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

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

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

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

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

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

Pam Kahler
6-2682

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Is it necessary to know if they're current publications

August 24, 1999

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

To: Judith Louer 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

Excerpta Medicus (EMBASE) — refers to electronic form

Medline — MEDLINE (all caps)

Medlars — MEDLARS (my typing mistake)

Health Services Technology Assessment Research (HSTAR) — HEALTHSTAR is the current name (1 word) database put out by Nat Libr of Medicine

databases

The following standard reference compendia:
The American Hospital Formulary Service - Drug Information

The American Medical Association Drug Evaluation — AMA info center (312) 464-5000 — discontinued? old?

The United States Pharmacopeia - ~~Drug Information FOR THE HEALTH CARE PROVIDER~~ — USDI 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–3357/1 P1
PJK...:...:...
cmr

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

D-no to (Friday, if possible)

AN ACT ...; **relating to:** independent review of managed care plan grievance 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:

SECTION 1. 601.42 (4) of the statutes is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Any of the following demonstrate that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions, taken or pending by any hospital, government or regulatory body.

****NOTE: Much of par. (e) is taken verbatim from the Georgia law. It has been inserted as a placeholder. Revisions to this language (especially subds. 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.

(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 that is being reviewed was or would be provided.

5. The enrollee or his or her authorized representative.

6. The development or manufacture of the treatment that is 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) RULEMAKING 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.

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

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

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

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

SECTION 4. Nonstatutory provisions.

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

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

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

(END)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–3357/P1dn
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. Note that s. 609.16 (8) (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.

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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 fn cert
$100 fn review
add + review

601.31

as to expedited review:
reduce as follows:
3 → 1
5 → 2
5 → 2
15 days → 72 hrs

* ~~Medical scientific evidence~~ (medically & scientifically accepted evidence demonstrates)

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

Subch II of ch 440

(Massage therapists & Body wrappers)

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

2. Hold a ~~nonrestricted~~ license, certificate, registration or permit that is not limited or restricted and that is issued by a state of the United States and, for physicians, hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the review.

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.

1. 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/P1
PJK:cmh:jf

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

AN ACT *to amend* 601.42 (4); and *to create* 609.15 (3) and 609.16 of the statutes; **relating to:** independent review of managed care plan grievance 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:

SECTION 1. 601.42 (4) of the statutes is amended to read:

601.42 **(4)** REPLIES. Any officer, manager or general agent of any insurer authorized to do or doing an insurance business in this state, any person controlling or having a contract under which the person has a right to control such an insurer, whether exclusively or otherwise, any person with executive authority over or in charge of any segment of such an insurer's affairs, any individual practice association or officer, director or manager of an individual practice association, any

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

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

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

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

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

(2) REQUIREMENT TO ESTABLISH; ELIGIBILITY. Every limited service health organization, preferred provider plan and managed care plan shall establish an independent review procedure that is in compliance with this section ~~and under~~ which an enrollee of the plan may request and obtain an independent review of a grievance determination under s. 609.15. To be eligible for independent review, the

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

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

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

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

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

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

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

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

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

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

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

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

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

after receiving

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

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

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

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

Insert 5-23 →

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

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

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

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

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

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

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

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

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

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

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

Insert 7-1

2. Any other following demonstrates that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that the adverse risks of the proposed treatment are not substantially higher than those of standard treatments: ~~or~~. ← period

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

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

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

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

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

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

medically and scientifically accepted evidence supports

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Have no history of disciplinary ~~action~~ sanctions, including loss of staff privileges ~~or participation restrictions~~, taken or pending by any hospital or government ~~or regulatory body~~.

****NOTE: Much of par. (e) is taken verbatim from the Georgia law. It has been inserted as a placeholder. Revisions to this language (especially subds. 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.

(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 that is being reviewed was or would be provided.

5. The enrollee or his or her authorized representative.

6. The development or manufacture of the treatment that is 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

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

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

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

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

SECTION 4. Nonstatutory provisions.

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

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

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

(END)

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:~~cmh:if~~

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~~ 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 limts 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 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 employes, agents or contractors of an independent review organization.

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

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

(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

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 par. (d) 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-3357/1 2
PJK:cmh:kjf
r misrun

1999 BILL

SOON (9-9) (change on p. 5)

per call

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

Analysis by the Legislative Reference Bureau

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> Insert 5-4 (see last page)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. The enrollee or his or her authorized representative.

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

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

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

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

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

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

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

SECTION 6. Nonstatutory provisions.

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

SECTION 7. Effective dates. This act takes effect on the first day of the 13th month beginning after publication, except as follows:

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

(END)

Insert 5-4

no ¶ , including an agent under a power of attorney or durable power of attorney or a health care agent under a power of attorney for health care, no ¶

(END OF INSERT)

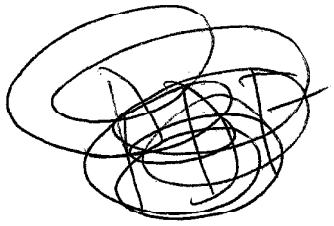
John Sumi (Grobschmidt)

5B63 6-7505

include motorcycles

analysis to Gene Schaffer 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:

Pre Topic:

No specific pre topic given

Topic:

Establish development opportunity zone in Kenosha

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	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 employes, agents or contractors of an independent review organization.

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

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

Mike Barman

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State of Wisconsin
Legislative Reference Bureau - Legal Section - Front Office
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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 Lazer Rosenzweig in the **Senate** X 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

State of Wisconsin

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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 though 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 a estimate for this bill so none are included in this file.