

**SENATE SUBSTITUTE AMENDMENT 1,  
TO 1999 SENATE BILL 258**

January 21, 2000 – Offered by HEALTH, UTILITIES, VETERANS AND MILITARY AFFAIRS.

1     **AN ACT to repeal** 609.15 (title) and (1) (intro.); **to renumber** 609.15 (1) (c), 609.15  
2           (2) (c), 609.15 (2) (d) and 609.15 (2) (e); **to renumber and amend** 609.15 (1) (a),  
3           609.15 (1) (b), 609.15 (2) (intro.), 609.15 (2) (a) and 609.15 (2) (b); **to amend**  
4           40.51 (8), 40.51 (8m), 600.01 (2) (b), 601.42 (4) and 609.655 (4) (b); and **to create**  
5           111.91 (2) (s), 601.31 (1) (Lp), 601.31 (1) (Lr), 632.83 and 632.835 of the statutes;  
6           **relating to:** requiring insurers to establish internal grievance procedures,  
7           independent review of certain coverage determinations made by health benefit  
8           plans and granting rule-making authority.

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

9           **SECTION 1.** 40.51 (8) of the statutes is amended to read:  
10           40.51 **(8)** Every health care coverage plan offered by the state under sub. (6)  
11           shall comply with ss. 631.89, 631.90, 631.93 (2), 632.72 (2), 632.746 (1) to (8) and (10),

1 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (5),  
2 632.895 (5m) and (8) to (13) and 632.896.

3 **SECTION 2.** 40.51 (8m) of the statutes is amended to read:

4 40.51 **(8m)** Every health care coverage plan offered by the group insurance  
5 board under sub. (7) shall comply with ss. 632.746 (1) to (8) and (10), 632.747,  
6 632.748, 632.83, 632.835, 632.85, 632.853, 632.855 and 632.895 (11) to (13).

7 **SECTION 3.** 111.91 (2) (s) of the statutes is created to read:

8 111.91 **(2)** (s) The requirements related to internal grievance procedures under  
9 s. 632.83 and independent review of certain health benefit plan determinations  
10 under s. 632.835.

11 **SECTION 4.** 600.01 (2) (b) of the statutes is amended to read:

12 600.01 **(2)** (b) Group or blanket insurance described in sub. (1) (b) 3. and 4. is  
13 not exempt from ss. 632.745 to 632.749, 632.83 or 632.835 or ch. 633 or 635.

14 **SECTION 5.** 601.31 (1) (Lp) of the statutes is created to read:

15 601.31 **(1)** (Lp) For certifying as an independent review organization under s.  
16 632.835, \$400.

17 **SECTION 6.** 601.31 (1) (Lr) of the statutes is created to read:

18 601.31 **(1)** (Lr) For each biennial recertification as an independent review  
19 organization under s. 632.835, \$100.

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

21 601.42 **(4)** REPLIES. Any officer, manager or general agent of any insurer  
22 authorized to do or doing an insurance business in this state, any person controlling  
23 or having a contract under which the person has a right to control such an insurer,  
24 whether exclusively or otherwise, any person with executive authority over or in  
25 charge of any segment of such an insurer's affairs, any individual practice

1 association or officer, director or manager of an individual practice association, any  
2 insurance agent or other person licensed under chs. 600 to 646, any provider of  
3 services under a continuing care contract, as defined in s. 647.01 (2), any  
4 independent review organization certified or recertified under s. 632.835 (4) or any  
5 health care provider, as defined in s. 655.001 (8), shall reply promptly in writing or  
6 in other designated form, to any written inquiry from the commissioner requesting  
7 a reply.

8 **SECTION 8.** 609.15 (title) and (1) (intro.) of the statutes are repealed.

9 **SECTION 9.** 609.15 (1) (a) of the statutes is renumbered 632.83 (2) (a) and  
10 amended to read:

11 632.83 (2) (a) Establish and use an internal grievance procedure that is  
12 approved by the commissioner and that complies with sub. ~~(2)~~ (3) for the resolution  
13 of enrollees' insureds' grievances with the ~~limited service health organization,~~  
14 ~~preferred provider plan or managed care~~ health benefit plan.

15 **SECTION 10.** 609.15 (1) (b) of the statutes is renumbered 632.83 (2) (b) and  
16 amended to read:

17 632.83 (2) (b) Provide ~~enrollees~~ insureds with complete and understandable  
18 information describing the internal grievance procedure under par. (a).

19 **SECTION 11.** 609.15 (1) (c) of the statutes is renumbered 632.83 (2) (c).

20 **SECTION 12.** 609.15 (2) (intro.) of the statutes is renumbered 632.83 (3) (intro.)  
21 and amended to read:

22 632.83 (3) (intro.) The internal grievance procedure established under sub. ~~(1)~~  
23 ~~(2)~~ (a) shall include all of the following elements:

24 **SECTION 13.** 609.15 (2) (a) of the statutes is renumbered 632.83 (3) (a) and  
25 amended to read:

1           632.83 (3) (a) The opportunity for an enrollee insured to submit a written  
2 grievance in any form.

3           **SECTION 14.** 609.15 (2) (b) of the statutes is renumbered 632.83 (3) (b) and  
4 amended to read:

5           632.83 (3) (b) Establishment of a grievance panel for the investigation of each  
6 grievance submitted under par. (a), consisting of at least one individual authorized  
7 to take corrective action on the grievance and at least one enrollee insured other than  
8 the grievant, if an enrollee insured is available to serve on the grievance panel.

9           **SECTION 15.** 609.15 (2) (c) of the statutes is renumbered 632.83 (3) (c).

10          **SECTION 16.** 609.15 (2) (d) of the statutes is renumbered 632.83 (3) (d).

11          **SECTION 17.** 609.15 (2) (e) of the statutes is renumbered 632.83 (3) (e).

12          **SECTION 18.** 609.655 (4) (b) of the statutes is amended to read:

13          609.655 (4) (b) Upon completion of the review under par. (a), the medical  
14 director of the managed care plan shall determine whether the policy or certificate  
15 will provide coverage of any further treatment for the dependent student's nervous  
16 or mental disorder or alcoholism or other drug abuse problems that is provided by  
17 a provider located in reasonably close proximity to the school in which the student  
18 is enrolled. If the dependent student disputes the medical director's determination,  
19 the dependent student may submit a written grievance under the managed care  
20 plan's internal grievance procedure established under s. ~~609.15~~ 632.83.

21          **SECTION 19.** 632.83 of the statutes is created to read:

22          **632.83 Internal grievance procedure. (1)** In this section, "health benefit  
23 plan" has the meaning given in s. 632.745 (11), except that "health benefit plan"  
24 includes the coverage specified in s. 632.745 (11) (b) 10. and includes a policy,

1 certificate or contract under s. 632.745 (11) (b) 9. that provides only limited–scope  
2 dental or vision benefits.

3 (2) Every insurer that issues a health benefit plan shall do all of the following:

4 **SECTION 20.** 632.835 of the statutes is created to read:

5 **632.835 Independent review of adverse and experimental treatment**

6 **determinations. (1) DEFINITIONS.** In this section:

7 (a) “Adverse determination” means a determination by or on behalf of an  
8 insurer that issues a health benefit plan to which all of the following apply:

9 1. An admission to a health care facility, the availability of care, the continued  
10 stay or other treatment that is a covered benefit has been reviewed.

11 2. Based on the information provided, the treatment under subd. 1. does not  
12 meet the health benefit plan’s requirements for medical necessity, appropriateness,  
13 health care setting, level of care or effectiveness.

14 3. Based on the information provided, the insurer that issued the health benefit  
15 plan reduced, denied or terminated the treatment under subd. 1. or payment for the  
16 treatment under subd. 1.

17 4. Subject to sub. (5) (c), the amount of the reduction or the cost or expected cost  
18 of the denied or terminated treatment or payment exceeds, or will exceed during the  
19 course of the treatment, \$200.

20 (b) “Experimental treatment determination” means a determination by or on  
21 behalf of an insurer that issues a health benefit plan to which all of the following  
22 apply:

23 1. A proposed treatment has been reviewed.

24 2. Based on the information provided, the treatment under subd. 1. is  
25 determined to be experimental under the terms of the health benefit plan.

1           3. Based on the information provided, the insurer that issued the health benefit  
2 plan denied the treatment under subd. 1. or payment for the treatment under subd.  
3 1.

4           4. Subject to sub. (5) (c), the cost or expected cost of the denied treatment or  
5 payment exceeds, or will exceed during the course of the treatment, \$200.

6           (c) “Health benefit plan” has the meaning given in s. 632.745 (11), except that  
7 “health benefit plan” includes the coverage specified in s. 632.745 (11) (b) 10.

8           (d) “Treatment” means a medical service, diagnosis, procedure, therapy, drug  
9 or device.

10           **(2) REVIEW REQUIREMENTS; WHO MAY CONDUCT.** (a) Every insurer that issues a  
11 health benefit plan shall establish an independent review procedure whereby an  
12 insured under the health benefit plan, or his or her authorized representative, may  
13 request and obtain an independent review of an adverse determination or an  
14 experimental treatment determination made with respect to the insured.

15           (b) Whenever an adverse determination or an experimental treatment  
16 determination is made, the insurer involved in the determination shall provide  
17 notice to the insured of the insured’s right to obtain the independent review required  
18 under this section, how to request the review and the time within which the review  
19 must be requested. The notice shall include a current listing of independent review  
20 organizations certified under sub. (4). An independent review under this section  
21 may be conducted only by an independent review organization certified under sub.  
22 (4) and selected by the insured.

23           (c) Except as provided in par. (d), an insured must exhaust the internal  
24 grievance procedure under s. 632.83 before the insured may request an independent  
25 review under this section. Except as provided in sub. (9), an insured who uses the

1 internal grievance procedure must request an independent review as provided in  
2 sub. (3) (a) within 4 months after the insured receives notice of the disposition of his  
3 or her grievance under s. 632.83 (3) (d).

4 (d) An insured is not required to exhaust the internal grievance procedure  
5 under s. 632.83 before requesting an independent review if any of the following  
6 apply:

7 1. The insured and the insurer agree that the matter may proceed directly to  
8 independent review under sub. (3).

9 2. Along with the notice to the insurer of the request for independent review  
10 under sub. (3) (a), the insured submits to the independent review organization  
11 selected by the insured a request to bypass the internal grievance procedure under  
12 s. 632.83 and the independent review organization determines that the health  
13 condition of the insured is such that requiring the insured to use the internal  
14 grievance procedure before proceeding to independent review would jeopardize the  
15 life or health of the insured or the insured's ability to regain maximum function.

16 **(3) PROCEDURE.** (a) To request an independent review, an insured or his or her  
17 authorized representative shall provide timely written notice of the request for  
18 independent review, and of the independent review organization selected, to the  
19 insurer that made or on whose behalf was made the adverse or experimental  
20 treatment determination. The insurer shall immediately notify the commissioner  
21 and the independent review organization selected by the insured of the request for  
22 independent review. For each independent review in which it is involved, an insurer  
23 shall pay a fee to the independent review organization.

1 (b) Within 3 business days after receiving written notice of a request for  
2 independent review under par. (a), the insurer shall submit to the independent  
3 review organization copies of all of the following:

4 1. Any information submitted to the insurer by the insured in support of the  
5 insured's position in the internal grievance under s. 632.83.

6 2. The contract provisions or evidence of coverage of the insured's health benefit  
7 plan.

8 3. Any other relevant documents or information used by the insurer in the  
9 internal grievance determination under s. 632.83.

10 (c) Within 5 business days after receiving the information under par. (b), the  
11 independent review organization shall request any additional information that it  
12 requires for the review from the insured or the insurer. Within 5 business days after  
13 receiving a request for additional information, the insured or the insurer shall  
14 submit the information or an explanation of why the information is not being  
15 submitted.

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

19 (e) In addition to the information under pars. (b) and (c), the independent  
20 review organization may accept for consideration any typed or printed, verifiable  
21 medical or scientific evidence that the independent review organization determines  
22 is relevant, regardless of whether the evidence has been submitted for consideration  
23 at any time previously. The insurer and the insured shall submit to the other party  
24 to the independent review any information submitted to the independent review  
25 organization under this paragraph and pars. (b) and (c). If, on the basis of any



1 additional information, the insurer reconsiders the insured's grievance and  
2 determines that the treatment that was the subject of the grievance should be  
3 covered, the independent review is terminated.

4 (f) If the independent review is not terminated under par. (e), the independent  
5 review organization shall, within 30 business days after the expiration of all time  
6 limits that apply in the matter, make a decision on the basis of the documents and  
7 information submitted under this subsection. The decision shall be in writing,  
8 signed on behalf of the independent review organization and served by personal  
9 delivery or by mailing a copy to the insured or his or her authorized representative  
10 and to the insurer. A decision of an independent review organization is binding on  
11 the insured and the insurer.

12 (g) If the independent review organization determines that the health  
13 condition of the insured is such that following the procedure outlined in pars. (b) to  
14 (f) would jeopardize the life or health of the insured or the insured's ability to regain  
15 maximum function, the procedure outlined in pars. (b) to (f) shall be followed with  
16 the following differences:

17 1. The insurer shall submit the information under par. (b) within one day after  
18 receiving the notice of the request for independent review under par. (a).

19 2. The independent review organization shall request any additional  
20 information under par. (c) within 2 business days after receiving the information  
21 under par. (b).

22 3. The insured or insurer shall, within 2 days after receiving a request under  
23 par. (c), submit any information requested or an explanation of why the information  
24 is not being submitted.

1           4. The independent review organization shall make its decision under par. (f)  
2 within 72 hours after the expiration of the time limits under this paragraph that  
3 apply in the matter.

4           **(3m)** STANDARDS FOR DECISIONS. (a) A decision of an independent review  
5 organization regarding an adverse determination must be consistent with the terms  
6 of the health benefit plan under which the adverse determination was made.

7           (b) A decision of an independent review organization regarding an  
8 experimental treatment determination is limited to a determination of whether the  
9 proposed treatment is experimental. The independent review organization shall  
10 determine that the treatment is not experimental and find in favor of the insured  
11 only if the independent review organization finds all of the following:

12           1. The treatment has been approved by the federal food and drug  
13 administration, if the treatment is subject to the approval of the federal food and  
14 drug administration.

15           2. Medically and scientifically accepted evidence clearly demonstrates that the  
16 treatment meets all of the following criteria:

17           a. The treatment is proven safe.

18           b. The treatment can be expected to produce greater benefits than the standard  
19 treatment without posing a greater adverse risk to the insured.

20           c. The treatment meets the coverage terms of the health benefit plan and is not  
21 specifically excluded under the terms of the health benefit plan.

22           **(4)** CERTIFICATION OF INDEPENDENT REVIEW ORGANIZATIONS. (a) The commissioner  
23 shall certify independent review organizations. An independent review  
24 organization must demonstrate to the satisfaction of the commissioner that it is  
25 unbiased, as defined by the commissioner by rule. An organization certified under

1 this paragraph must be recertified on a biennial basis to continue to provide  
2 independent review services under this section.

3 (ag) An independent review organization shall have in operation a quality  
4 assurance mechanism to ensure the timeliness and quality of the independent  
5 reviews, the qualifications and independence of the clinical peer reviewers and the  
6 confidentiality of the medical records and review materials.

7 (ap) An independent review organization shall establish reasonable fees that  
8 it will charge for independent reviews and shall submit its fee schedule to the  
9 commissioner for a determination of reasonableness and for approval. An  
10 independent review organization may not change any fees approved by the  
11 commissioner more than once per year and shall submit any proposed fee changes  
12 to the commissioner for approval.

13 (b) An organization applying for certification or recertification as an  
14 independent review organization shall pay the applicable fee under s. 601.31 (1) (Lp)  
15 or (Lr). Every organization certified or recertified as an independent review  
16 organization shall file a report with the commissioner in accordance with rules  
17 promulgated under sub. (5) (a) 4.

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

22 (d) The commissioner may revoke, suspend or limit in whole or in part the  
23 certification of an independent review organization, or may refuse to recertify an  
24 independent review organization, if the commissioner finds that the independent  
25 review organization is unqualified or has violated an insurance statute or rule or a

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

6 (e) The commissioner shall keep an up-to-date listing of certified independent  
7 review organizations and shall provide a copy of the listing to all of the following:

- 8 1. Every insurer that is subject to this section, at least quarterly.
- 9 2. Any person who requests a copy of the listing.

10 **(5) RULES; REPORT; ADJUSTMENTS.** (a) The commissioner shall promulgate rules  
11 for the independent review required under this section. The rules shall include at  
12 least all of the following:

13 1. The application procedures for certification and recertification as an  
14 independent review organization.

15 2. The standards that the commissioner will use for certifying and recertifying  
16 organizations as independent review organizations, including standards for  
17 determining whether an independent review organization is unbiased.

18 3. Procedures and processes, in addition to those in sub. (3), that independent  
19 review organizations must follow.

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

22 5. Standards for the practices and conduct of independent review  
23 organizations.

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

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

5 (c) To reflect changes in the consumer price index for all urban consumers, U.S.  
6 city average, as determined by the U.S. department of labor, the commissioner shall  
7 at least annually adjust the amounts specified in sub. (1) (a) 4. and (b) 4.

8 **(6) CONFLICT OF INTEREST STANDARDS.** (a) An independent review organization  
9 may not be affiliated with any of the following:

10 1. A health benefit plan.

11 2. A national, state or local trade association of health benefit plans, or an  
12 affiliate of any such association.

13 3. A national, state or local trade association of health care providers, or an  
14 affiliate of any such association.

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

19 1. The insurer that issued the health benefit plan that is the subject of the  
20 independent review.

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

23 3. The health care provider that recommended or provided the health care  
24 service or treatment that is the subject of the independent review, or the health care  
25 provider's medical group or independent practice association.

1           4. The facility at which the health care service or treatment that is the subject  
2 of the independent review was or would be provided.

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

5           6. The insured or his or her authorized representative.

6           **(6m) QUALIFICATIONS OF CLINICAL PEER REVIEWERS.** A clinical peer reviewer who  
7 conducts a review on behalf of a certified independent review organization must  
8 satisfy all of the following requirements:

9           (a) Be a health care provider who is expert in treating the medical condition  
10 that is the subject of the review and who is knowledgeable about the treatment that  
11 is the subject of the review through current, actual clinical experience.

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

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

20           (d) Have no history of disciplinary sanctions, including loss of staff privileges  
21 but excluding temporary suspension of staff privileges due to incomplete records,  
22 taken or pending by the medical examining board or another regulatory body or by  
23 any hospital or government.

24           **(7) IMMUNITY.** (a) A certified independent review organization is immune from  
25 any civil or criminal liability that may result because of an independent review

1 determination made under this section. An employe, agent or contractor of a  
2 certified independent review organization is immune from civil liability and criminal  
3 prosecution for any act or omission done in good faith within the scope of his or her  
4 powers and duties under this section.

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

9 **(8) NOTICE OF SUFFICIENT INDEPENDENT REVIEW ORGANIZATIONS.** The  
10 commissioner shall make a determination that at least one independent review  
11 organization has been certified under sub. (4) that is able to effectively provide the  
12 independent reviews required under this section and shall publish a notice in the  
13 Wisconsin Administrative Register that states a date that is 2 months after the  
14 commissioner makes that determination. The date stated in the notice shall be the  
15 date on which the independent review procedure under this section begins operating.

16 **(9) APPLICABILITY.** The independent review required under this section shall be  
17 available to an insured who receives notice of the disposition of his or her grievance  
18 under s. 632.83 (3) (d) on or after the first day of the 7th month beginning after the  
19 effective date of this subsection .... [revisor inserts date]. Notwithstanding sub. (2)  
20 (c), an insured who receives notice of the disposition of his or her grievance under s.  
21 632.83 (3) (d) on or after the first day of the 7th month beginning after the effective  
22 date of this subsection .... [revisor inserts date], but before the date stated in the  
23 notice published by the commissioner in the Wisconsin Administrative Register  
24 under sub. (8) .... [revisor inserts date], must request an independent review no later

1 than 4 months after the date stated in the notice published by the commissioner in  
2 the Wisconsin Administrative Register under sub. (8) ... [revisor inserts date].

3 **SECTION 21. Nonstatutory provisions.**

4 (1) RULES REGARDING INDEPENDENT REVIEW. The commissioner of insurance shall  
5 submit in proposed form the rules required under section 632.835 (5) (a) of the  
6 statutes, as created by this act, to the legislative council staff under section 227.15  
7 (1) of the statutes no later than the first day of the 7th month beginning after the  
8 effective date of this paragraph.

9 **SECTION 22. Effective dates.** This act takes effect on the day after publication,  
10 except as follows:

11 (1) The treatment of sections 609.15 (title), (1) (intro.), (a), (b) and (c) and (2)  
12 (intro.), (a), (b), (c), (d) and (e), 609.655 (4) (b) and 632.83 of the statutes takes effect  
13 on the first day of the 7th month beginning after publication.

14 (2) The treatment of section 632.835 (2), (3), (3m) and (5) (b) and (c) of the  
15 statutes takes effect on the date stated in the notice published by the commissioner  
16 of insurance in the Wisconsin Administrative Register under section 632.835 (8) of  
17 the statutes, as created by this act.

18 (END)