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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott McCallum, Governor
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HONORABLE JUDITH ROBSON
SENATE CO-CHAIRPERSON
JOINT COMM FOR REVIEW OF ADM RULES
SOUTH STATE CAPITOL RM 15
MADISON WI 53702

Re: Chapter Ins 18, Wis. Adm. Code, relating to health benefit plan grievance requirements and independent review organizations

Clearinghouse Rule No. 00-169

Dear Senator Welch:

I am enclosing a copy of this proposed rule that has been submitted to the presiding officers of the legislative houses under s. 227.19 (2), Wis. Stat. A copy of the report required under s. 227.19 (3), Wis. Stat., is also enclosed.

Sincerely,

Connie L. O'Connell
Commissioner

CLO:JW

Attachment: 1 copy rule & legislative report

**PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE REPEALING AND
RECREATING AND CREATING A RULE**

The Wisconsin Office of the Commissioner of Insurance proposes an order to repeal and recreate s. Ins 9.33; and to create ch. Ins 18, Wis. Adm. Code, relating to health benefit plan grievance requirements and independent review organizations.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 600.01(2), 601.41(3), 601.42, 628.34(12), 632.81, 632.835 (5), Stats.

Statutes interpreted: ss. 600.01, 628.34 (12), 632.83, and 632.835, Stats.

The creation of ch. Ins 18, Wis. Adm. Code, reflects the provisions of 1999 Wisconsin Act 155 that introduced the use of Independent Review Organizations in the State as a means for policyholders and claimants of health benefit plans to challenge certain decisions made by such plans. In addition, 1999 Wisconsin Act 155 renumbered portions of ch. 609, Stats., to relate in sequence the utilization of independent review with established grievance procedures.

The definition of health benefit plan has been expanded to meet new statutory requirements. The definitions of health benefit plan that are used within 1999 Wisconsin Act 155 encompass the vast majority of insurers that offer health insurance products including Medicare Select and Medicare Cost plans. All health benefit plans are required to provide insureds the right to access the grievance process that has previously been required only for managed care plans including limited service health plans and preferred provider plans.

The grievance procedures for health benefit plans have been expanded to meet new statutory requirements and to improve the review process. Access to the grievance process includes the ability to grieve all matters considered by definition to be a grievance including administrative matters. In compliance with 1999 Wisconsin Act 155, the notice to the insureds has been expanded to incorporate reference to, and procedures for, independent review by a certified independent review organization.

All insurers offering health benefit plans must provide insureds with clear and timely explanations for the insurers benefit determinations or denial of experimental treatment determinations. The grievance and appeal procedures must be provided to the insured and shall also include a notice of the right for independent review when applicable. An expedited process both for the internal grievance process and independent review process must be established and notice of the same provided to insureds.

For implementation of 1999 Wisconsin Act 155, the Office developed certification requirements and approval procedures with which independent review organizations will need to comply. Requirements were derived from national standards in light of statutory requirements. Reporting requirements are established for both independent review organizations and insurers to track utilization and outcomes of independent reviews.

Independent review organizations are required by 1999 Wisconsin Act 155 to submit fee schedules to the office.

SECTION 1. Ins 9.33 is repealed.

SECTION 2. Chapter Ins 18 is created to read:

CHAPTER INS 18 (title)

**HEALTH BENEFIT PLAN GRIEVANCES AND INDEPENDENT REVIEW ORGANIZATIONS
CERTIFICATION AND REVIEW PROCEDURES**

SECTION 3. Subchapter I is created to read:

SUBCHAPTER I – DEFINITIONS

Ins 18.01 DEFINITIONS. In this chapter:

(1) "Commissioner" means the "commissioner of insurance" of this state or the commissioner's designee.

(2) "Complaint" means any expression of dissatisfaction expressed to the insurer by the insured, or an insured's authorized representative, about an insurer or its providers with whom the insurer has a direct or indirect contract.

(3) "Expedited grievance" means a grievance where any of the following applies:

(a) The duration of the standard resolution process will result in serious jeopardy to the life or health of the insured or the ability of the insured to regain maximum function.

(b) In the opinion of a physician with knowledge of the insured's medical condition, the insured is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.

(c) A physician with knowledge of the insured's medical condition determines that the grievance shall be treated as an expedited grievance.

(4) "Grievance" means any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured.

(5) "Independent review organizations" means an organization certified under s. 632.835 (4), Stats.

(6) "Independent review" means a review conducted by a certified independent review organization.

(7) "Insured" has the meaning provided in s. 600.03 (23), Stats.

(8) "OCI complaint" means any complaint received by the office of the commissioner of insurance by, or on behalf of, an insured of an insurer offering coverage under a health benefit plan.

(7) "Office" means the "office of the commissioner of insurance."

SECTION 4. Ins subchapter II is created to read:

SUBCHAPTER II – GRIEVANCE PROCEDURES

Ins 18.02 DEFINITIONS. In addition to the definitions in s. 632.83, Stats., in this subchapter:

(1) "Health benefit plan" has the meaning provided in s. 632.83, Stats., and includes Medicare supplement and replacement plans as defined in ss. 600.03 (28p) and (28r), Stats., and ss. Ins 3.39 (3) (f) and (g). Health benefit plan includes Medicare Cost and Select plans but does not include Medicare + Choice plans.

Ins 18.03 GRIEVANCES. (1) DEFINITION AND EXPLANATION OF THE GRIEVANCE PROCEDURE.

(a) Each insurer offering a health benefit plan shall incorporate within its policies, certificates and outlines of coverage the definition of a grievance as stated in s. Ins 18.01 (4).

(b) An insurer offering a health benefit plan shall develop an internal grievance and expedited grievance procedure that shall be described in each policy and certificate issued to insureds at the time of enrollment or issuance.

(c) In accordance with s. 632.83 (2) (a), Stats., an insurer that offers a health benefit plan shall investigate each grievance.

(2) NOTIFICATION OF RIGHT TO APPEAL DETERMINATIONS. (a) In addition to the requirements under sub. (1), each time an insurer offering a health benefit plan denies a claim or benefit or initiates disenrollment proceedings, the health benefit plan shall notify the affected insured of the right to file a grievance. For purposes of this subchapter, denial or refusal of an insured's request of the insurer for a referral shall be considered a denial of a claim or benefit.

(b) When notifying the insured of their right to grieve the denial, determination, or initiation of disenrollment, an insurer offering a health benefit plan shall either direct the insured to the policy or certificate section that delineates the procedure for filing a grievance or shall describe, in detail, the grievance procedure to the insured. The notification shall also state the specific reason for the denial, determination or initiation of disenrollment.

(c) An insurer offering a health benefit plan shall include in each contract between it and its providers, provider networks, and within each agreement governing the administration of provider services, a provision that requires the contracting entity to identify complaints and grievances and to promptly forward these complaints and grievances to the insurer for recording and resolution. An insurer

offering a health benefit plan shall require contracted entities that subcontract for the provision of services, including subcontracts with health care providers, to incorporate within their contracts a requirement that the providers promptly identify complaints and grievances and forward these complaints and grievances to the insurer promptly for recording and resolution. Any insurer offering a health benefit plan shall maintain records and reports reasonably necessary to monitor compliance with the contractual provisions required under this paragraph and shall take prompt action under the contract to compel correction of non-compliance.

(d) If the insurer offering a health benefit plan is either a health maintenance organization as defined in s. 609.01 (2), Stats., or a limited service health organization as defined by s. 609.01 (3), Stats., and the insurer initiates disenrollment proceedings, the insurer shall additionally comply with s. Ins 9.39.

(3) GRIEVANCE PROCEDURE. The grievance procedure utilized by an insurer offering a health benefit plan shall include all of the following:

(a) A method whereby the insured who filed the grievance, or the insured's authorized representative, has the right to appear in person before the grievance panel to present written or oral information. The insurer shall permit the grievant to submit written questions to the person or persons responsible for making the determination that resulted in the denial, determination, or initiation of disenrollment unless the insurer permits the insured or insured's authorized representative to meet with and question the decision maker or makers.

(b) A written notification to the insured of the time and place of the grievance meeting at least 7 calendar days before the meeting.

(c) Reasonable accommodations to allow the insured, or the insured's authorized representative, to participate in the meeting.

(d) The grievance panel shall comply with the requirements of s. 632.83 (3) (b), Stats., and shall not include the person who ultimately made the initial determination. If the panel consists of at least three persons, the panel may then include no more than one subordinate of the person who ultimately made the initial determination. The panel may, however, consult with the ultimate initial decision-maker.

(e) The insured member of the panel shall not be an employee of the plan, to the extent possible.

(f) Consultation with a licensed health care provider with expertise in the field relating to the grievance, if appropriate.

(g) The panel's written decision to the insured as described in s. 632.83 (3) (d), Stats., shall be signed by one voting member of the panel and include a written description of position titles of panel members involved in making the decision.

(4) RECEIPT OF GRIEVANCE ACKNOWLEDGMENT. An insurer offering a health benefit plan shall, within 5 business days of receipt of a grievance deliver or deposit in the mail a written acknowledgment to the insured or the insured's authorized representative confirming receipt of the grievance.

(5) AUTHORIZATION FOR RELEASE OF INFORMATION. An insurer offering a health benefit plan shall not require the insured to sign a release in order to have an authorized representative act on the insured's behalf. An insurer may require the insured, or the insured's authorized representative, legal guardian or court appointed representative, to provide a written release to the insurer to share the insured's personal medical information with the insurer's grievance panel, independent review organization and the insured's authorized representative if that individual is not a legally recognized representative. The insurer must include the release form with the acknowledgment of receipt of the grievance as described in sub. (4). The release form shall contain information describing the scope, duration and purpose for the release of personal medical information. The insurer shall notify the insured that failing to sign and return the release form may limit the information reviewed by the grievance panel to information in the possession of the insurer. The insurer shall not refuse to proceed with the grievance review solely due to the lack of a signed release form.

(6) RESOLUTION OF A GRIEVANCE. An insurer offering a health benefit plan shall resolve a grievance:

(a) For a grievance that is a review of a benefit determination that is subject to 29 CFR 2560.503-1, within the time provided under 29 CFR 2560-503-1 (i).

(b) For any grievance not subject to par. (a), within 30 calendar days of receiving the grievance. If the insurer is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days, if the insurer provides a written notification to the insured and the insured's authorized representative, if applicable, of all of the following:

1. That the insurer has not resolved the grievance.
2. When resolution of the grievance may be expected.
3. The reason additional time is needed.

Ins 18.04 RIGHT OF THE COMMISSIONER TO REQUEST OCI COMPLAINTS BE HANDLED AS GRIEVANCES. The commissioner may require an insurer offering a health benefit plan to treat and process an OCI complaint as a grievance. The insurer shall process the OCI complaint as a grievance in compliance with s. 18.03.

Ins 18.05 EXPEDITED GRIEVANCE PROCEDURE. Sections 18.03 (2) to (4) and (6) do not apply to situations where the normal duration of the grievance resolution process could have adverse health effects for the insured. For these situations, an insurer offering a health benefit plan shall develop a separate expedited grievance procedure. An expedited grievance shall be resolved as expeditiously as the insured's health condition requires but not more than 72 hours after receipt of the grievance.

Ins 18.06 REPORTING REQUIREMENTS. An insurer offering a health benefit plan shall comply with all of the following requirements:

(1) Each record of each complaint and grievance submitted to the insurer shall be kept and retained for a period of at least 3 years. These records shall be maintained at the insurer's home or principal office and shall be available for review during examinations by or on request of the commissioner or office.

(2) Submit a grievance experience report required by s. 632.83 (2) (c), Stats., to the commissioner by March 1 of each year. The report shall provide information on all grievances received during the previous calendar year. The report shall be in a form prescribed by the commissioner and, at a minimum, shall classify grievances into the following categories:

(a) Plan administration including plan marketing, policyholder service, billing, underwriting and similar administrative functions.

(b) Benefit services including denial of a benefit, denial of experimental treatment, quality of care, refusal to refer insureds or to provide requested services.

Note: A copy of the grievance experience report form OCI26-007, required under par. (2), may be obtained from the Office of the Commissioner of Insurance, P. O. Box 7873, Madison WI 53707-7873.

SECTION 5. Ins 18.10 and Subchapter III is created to read:

SUBCHAPTER III – INDEPENDENT REVIEW PROCEDURES

Ins 18.10 DEFINITIONS. In addition to the definitions in s. 632.835 (1), Stats., in this subchapter:

(1) "Adverse determination" has the meaning as defined in s. 632.835 (1) (a), Stats. This includes the denial of a request for a referral for out-of-network services when the insured requests health care services from a provider that does not participate in the insurer's provider network because the clinical expertise of the provider may be medically necessary for treatment of the insured's medical condition and that expertise is not available in the insurer's provider network.

(2) "Health benefit plan" has the meaning provided in s. 632.835 (1) (c), Stats., and includes Medicare supplement and replacement plans as defined in ss. 600.03 (28p) and (28r), Stats., and ss. 3.39 (3) (f) and (g). Health benefit plan including Medicare Cost and Select plans but does not include Medicare + Choice plans.

(3) "Medical or scientific evidence" means information from any of the following sources:

(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 medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR).

(c) Medical journals recognized by the Secretary of Health and Human Services under 42 USC1320c et. seq. of the federal Social Security Act.

(d) Any of the following standard reference compendia:

1. The American Hospital Formulary Service – Drug Information.
2. The American Medical Association of Drug Evaluation.
3. The American Dental Association Accepted Dental Therapeutics.

4. The United States Pharmacopoeia – Drug Information.

(e) Findings, studies or research conducted by, or under the auspices of, federal governmental agencies and nationally recognized federal research institutes, including:

1. The federal Agency for Healthcare Research and Quality.

2. The National Institutes of Health.

3. The National Cancer Institute.

4. The National Academy of Sciences.

5. The Health Care Financing Administration.

6. Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services.

7. Any other medical or scientific evidence that is comparable to the sources listed in this paragraph.

(4) "Unbiased" means an independent review organization that complies with all of the following:

(a) Section 632.835 (6), Stats.

(b) The independent review organization does not provide incentives of any kind, including financial incentives, to providers or consumers as inducements for selection as the independent review organization.

(c) The independent review organization does not directly or indirectly receive any compensation, in any form, related to a review, other than the compensation permitted under this subchapter and s. 632.835, Stats.

(d) The independent review organization does not promote, to providers, consumers or insurers any of the following:

1. A pattern of favorable results or a pattern of favorable results on a particular treatment or subject.

2. An association with a class of providers, consumers or insurers.

3. A bias favorable to a class of providers, consumers or insurers.

(e) The independent review organization does not have a pattern of decisions that are unsupported by substantial evidence.

Ins 18.11 INDEPENDENT REVIEW. (1) INDEPENDENT REVIEW PROCEDURES. Each insurer offering a health benefit plan shall establish procedures to ensure compliance with this section and s. 632.835, Stats.

(2) NOTIFICATION OF RIGHT TO INDEPENDENT REVIEW. In addition to the requirements of s. 632.835 (2) (b), Stats., and s. 18.03, each time an insurer offering a health benefit plan makes an adverse determination or an experimental treatment determination the insurer shall provide all of the following in the notice to insureds:

(a) A notice to an insured of the right to request an independent review. The notice shall comply with s. 632.835 (2) (b), Stats., and be accompanied by the informational brochure developed by the office, or in a form substantially similar, describing the independent review process. The notice shall be sent when the insurer makes an adverse determination or experimental treatment determination. In addition, the notice shall contain all of the following information:

1. In accordance with s. 632.835 (9), Stats., for adverse determinations or experimental treatment determinations occurring on or after December 1, 2000, but prior to the effective date of this section, the notice to an insured shall state that the insured, or the insured's authorized representative, must request the independent review within 4 months from the effective date of this section.

2. For adverse determinations or experimental treatment determinations occurring subsequent to the effective date of this section, the notice to an insured shall state that the insured, or the insured's authorized representative, must request independent review within 4 months from the date of the adverse determination or experimental treatment determination by the insurer or from the date of the grievance panel decision, whichever is later.

3. The notice shall state that the insured, or the insured's authorized representative, shall select the independent review organization from the list of certified independent review organizations, accompanying the notice, as compiled by the commissioner and available from the insurer.

Note: The commissioner maintains a current listing, revised at least quarterly, of certified independent review organizations and posts the current list on the office website:

http://badger.state.wi.us/agencies/oci/oci_home.htm.

4. The notice shall state that the insured's, or the insured's authorized representative's, request for an independent review must be made in writing, contain the name of the selected independent review organization and be accompanied with the \$25 fee payable to the independent review organization. The notice shall also state that the insured's, or the insured's authorized representative, written request be submitted to the insurer and must contain the address and name of the person or position to whom the request is to be sent. The notice shall state that if the insured or insured's authorized representative prevails in the review, either in whole or in part, the \$25 fee paid to the independent review organization will be refunded to the insured by the insurer.

5. The notice shall include a statement that references s. 632.835 (3) (f), Stats., informing the insured that once the independent review organization makes a determination, the determination is binding upon the insurer and insured.

6. The notice shall include a statement that references s. 632.835 (2) (d), Stats., informing the insured, or the insured's authorized representative, that they need not exhaust the internal grievance procedure if either of the following conditions are met:

a. Both the insurer and insured, or the insured's authorized representative, agree that the appeal should proceed directly to independent review.

b. The independent review organization determines that an expedited review is appropriate upon receiving a request from an insured or the insured's authorized representative that is simultaneously sent to the insurer.

(3) INDEPENDENT REVIEW TIMEFRAMES. In addition to the requirements set forth in s. 632.835 (3), Stats., the following procedures shall be followed:

(a) The insurer, upon receipt of a request for independent review, shall provide written notice of the request to the commissioner and to the independent review organization selected by the insured or the insured's authorized representative within 2 business days of receipt.

(b) The insurer shall provide the information required in s. 632.835 (3) (b), Stats., to the independent review organization without requiring a written release from the insured in accordance with s. 610.70 (5) (f), Stats.

(c) Information submitted to the independent review organization at the request of the independent review organization by either the insurer or the insured, or the insured's authorized representative, shall also be promptly provided to the other party to the review.

(d) Subdivisions (a) to (c) do not apply to situations where the normal duration of the independent review process could result in adverse health effects for the insured. For these situations, the independent review organization shall develop a separate expedited review procedure for expedited situations which complies with s. 632.835 (3) (g), Stats. An expedited review shall be conducted in accordance with s. 632.835 (3) (g) 1. to 4., Stats., and shall be resolved as expeditiously as the insured's health condition requires.

Ins 18.12 INDEPENDENT REVIEW ORGANIZATION PROCEDURES. (1) Independent review organizations shall have, and demonstrate compliance with, written policies and procedures governing all aspects of both the standard review and expedited review processes as described in s. 632.835, Stats., including all of the following:

(a) A regulatory compliance program that does all of the following:

1. Tracks applicable independent review laws and regulations.
2. Ensures the organization's compliance with applicable laws.
3. Maintains a current list of potential conflicts of interest updated on no less than a quarterly basis in addition to conducting a conflict review at the time of each case referral to the organization.

(b) A procedure to determine, upon receipt of the referral for review, all of the following:

1. Whether a conflict of interest exists. If a conflict exists, the independent review organization shall provide an written notification to the insurer, the commissioner and the insured within 3 business days stating that a conflict exists and that a different independent review organization will need to be selected by the insured.
2. The type of case for which review is sought. The independent review organization shall determine if the case relates to an adverse determination, experimental treatment determination or an

administrative issue. If the independent review organization determines that the review is not related to an adverse determination or experimental treatment determination, the independent review organization shall provide written notification to the commissioner, the insured and the insurer of its determination within 2 business days.

3. The specific question or issue that is to be resolved by the independent review process.

4. Whether the cost of treatment or course of treatment is at least \$250. In determining the cost of treatment or cost of the course of treatment, the independent review organization shall calculate the amount as the actual cost charged the insured if the treatment is denied, without deduction for cost sharing or contractual agreements with providers.

5. Whether the case merits standard review or expedited review.

(c) Criteria for the number and qualification of reviewers. The criteria must meet the requirements of sub. (4).

(d) Procedures to ensure that, upon selection of the reviewer, a file which includes all information necessary to consider the case is provided to the reviewer. In cases where more than one reviewer is assigned to the case by the independent review organization, the independent review organization shall provide an opportunity for the reviewers to discuss the case with one another and shall accept the majority decision of the reviewers.

(e) Procedures for consideration of pertinent information for cases referred to independent review organizations regarding an adverse determination, including all of the following:

1. The insured's medical records.

2. The attending provider's recommendation.

3. The terms of coverage under the insured's health benefit plan.

4. Information accumulated regarding the case prior to its referral to independent review, including the rationale for prior review determinations.

5. Information submitted to the independent review organization by the referring entity, insured or attending provider.

6. Clinical review criteria developed and used by the insurer.

7. Medical or scientific evidence, as appropriate.

(f) Procedures for consideration of pertinent information for cases referred to the independent review organization regarding experimental treatment determinations including all information required in par. (e) and existing medical or scientific evidence regarding the proposed treatment with respect to effectiveness and efficacy.

(g) Policies and procedures to request and accept any additional information that may assist in rendering a determination. Information received by the independent review organization from the insured or attending provider shall be provided to the insurer in order to provide the insurer with the opportunity to reverse its decision.

(h) Procedures to ensure that within 2 business days of rendering a determination, the independent review organization shall, in addition to the requirements of s. 632.835 (3) (f), Stats., send to the insurer, the insured, or the insured's authorized representative a written notice of the determination that includes all of the following:

1. The question or issue that was referred for review.
2. A description of the qualifications of the reviewer or reviewers.
3. A clinical rationale or explanation for the independent review organization's determination, including supporting evidence.

(i) Procedures to ensure expedited reviews are completed in accordance with s. 632.835 (3) (g), Stats., and take into account the insured's health condition. Upon completion of the review, the independent review organization shall provide its decision within one hour, or as expeditiously as practicable, to the insured, or the insured's authorized representative, and the insurer.

(2) QUALITY ASSURANCE PROCEDURES. Independent review organizations shall establish, maintain and demonstrate compliance with written quality assurance procedures that promote objective and systematic monitoring and evaluation of the independent review process and that includes, at a minimum, all procedures to ensure the following:

(a) That the independent reviews are conducted within the specified time frames and that required notices are provided in a timely manner.

(b) That the selection of qualified and impartial clinical peer reviewers to conduct independent reviews on behalf of the independent review organization is achieved, including that the matching of reviewers to specific cases is suitable.

(c) The independent review organization shall conduct appropriate training, monitor performance on an ongoing basis and evaluate, no less than annually, each of the reviewers and non-clinical staff.

(d) That the confidentiality of personal medical information is maintained in accordance with state and federal law. Access to personal medical information shall be limited to only the information necessary for review of the services under independent review, used solely for the purpose of independent review and shared only with the selected reviewers, the insurer and the insured or the insured's authorized representative.

(e) That any person employed by, or under contract with, the independent review organization adheres to the requirements of this section.

(f) That management reports are adequate to track and monitor matters described in pars. (a) to (e).

(3) ACCESSIBILITY. (a) The independent review organization shall establish a toll-free telephone service to receive information on a 24-hour, 7-days per week, basis. The telephone service selected shall be capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours.

(b) The independent review organization shall establish policies and procedures to ensure that services are provided during times other than normal business hours to ensure that the independent review organization meets its obligation under sub. (1) (i).

(4) REVIEWER QUALIFICATIONS. In addition to the requirements of s. 632.835 (6m), Stats., the independent review organization shall require all clinical peer reviewers assigned to conduct independent reviews to be physicians or other appropriate health care providers whose qualifications are verified at least every 2 years.

(5) CONFLICT OF INTEREST. In addition to the requirements in s. 632.835 (6), Stats., all clinical peer reviewers shall, at least quarterly, provide to the independent review organization a list of potential conflicts of interest.

(6) DIRECTOR. (a) Except as provided in par. (b), an independent review organization shall employ or contract with a medical director with professional post-residency experience in direct patient care who holds a current license to practice medicine and who has a clinical specialty appropriate to the type of reviews conducted by the independent review organization.

(b) An independent review organization that limits its reviews to matters related to a particular type of health care may employ or contract with a clinical director. The clinical director shall be trained and hold a current license in a medical or health care specialty appropriate to the full scope of the organization's review.

(c) The independent review organization shall require the medical director or clinical director to oversee the medical or health care aspects of quality assurance and credentialing programs.

(7) DELEGATED FUNCTIONS. The independent review organization may delegate or subcontract review functions. Nevertheless, the independent review organization is responsible for the delegated or subcontracted functions, including any violation of law, policy or procedure. In addition, an independent review organization that delegates or subcontracts independent review functions shall provide documentation and verification of all of the following:

(a) Written contracts with the subcontractor that delineates with specificity all duties and responsibilities.

(b) A review by the independent review organization, on at least an annual basis, of the subcontractor's policies, procedures, and quality assurance program, if relevant to the subcontracted functions.

(c) A review by the independent review organization, on at least an annual basis, of the subcontractor's performance and compliance, monitored by the independent review organization, with stated policies, procedures, quality assurance programs and applicable laws.

(d) A review by the independent review organization, on at least an annual basis, of the effectiveness of communication and coordination of processes between the independent review organization and the subcontractor.

(8) UNBIASED. An independent review organization shall be unbiased. An independent review organization shall establish and maintain procedures to ensure that it is unbiased.

Section 4. Section Ins 18.14 is created to read:

Ins 18.14 APPROVAL OF INDEPENDENT REVIEW ORGANIZATIONS. (1) In addition to meeting the requirements established s. 632.835 (4) (a), Stats., any independent review organization seeking approval to conduct independent reviews shall submit an application for approval on a form prescribed by the commissioner and include with the form all documentation and information necessary for the commissioner to determine if the independent review organization is unbiased and satisfies s. Ins 18.12.

(2) The independent review organization shall submit informational materials to the commissioner as part of the application. Materials will be maintained in the office for public review.

(3) The independent review organization shall submit the application fee in accordance with s. 601.31 (1) (Lp), Stats., at the time of the application to an identified lock box address.

Section 5. Section Ins 18.16 is created to read:

Ins 18.16 INDEPENDENT REVIEW ORGANIZATION REPORTING REQUIREMENTS. (1) An independent review organization shall maintain records on all independent review activity during each calendar year and submit a report to the commissioner, on a form prescribed by the commissioner, by March 1 of each year for the prior calendar year's experience. Records shall be maintained so that, at a minimum, they satisfy the reporting requirements to the commissioner and shall be retained for at least 3 years.

(2) The annual report shall include all of the following information on an aggregate basis, by insurer and by insurer and by insurance product name:

(a) The total number of requests for independent review received.

(b) The total number of requests for independent review declined and the reason for the declination, including whether the request was a qualified request or within the scope of the health benefit plan policy.

(c) The total number of requests for expedited independent review that the independent review organization declined to handle in an expedited timeframe, including whether the request was a qualified request or within the scope of the health benefit plan policy.

(d) The number of independent reviews that were done in an expedited manner and the results of those reviews.

(e) The number of requests for independent review resolved and, of those resolved, the number resolved upholding the adverse determination or experimental treatment determination by the insurer and the number resolved reversing the adverse determination or experimental treatment determination by the insurer.

(f) The average length of time for resolution.

(g) A detailed summary of cases including a synopsis of facts, rationale for decision and key evidence relied upon to reach the reviewer's decision. The summary shall also include the types of cases or coverage for which an independent review was sought.

(h) The cost of reviews both in the aggregate and on a case by case basis.

(i) The number of independent reviews that were terminated as the result of reconsideration by the insurer of its adverse determination or experimental treatment determination after the receipt of additional information from the insured, the insured's authorized representative, or other appropriate sources.

(j) Any other information the commissioner requests.

Section 6. Section Ins 18.18 is created to read:

INS 18.18 INDEPENDENT REVIEW ORGANIZATION FEES. (1) A certified independent review organization shall submit its fee schedule in accordance with s. 632.835 (4) (ap), Stats., to the commissioner for review and approval.

(2) Fee schedules shall be based on prevailing rates in the industry demonstrated by supporting credible documentation including actual costs for conducting the reviews. Fee schedules shall

be on a per case basis according to categories established by the commissioner. The fee schedule shall include a category for the fee payable for a review that is terminated because the insurer voluntarily reverses its decision because of information first received by the insurer after the review is requested.

(3) An insurer offering a health benefit plan shall pay the fee submitted by the independent review organization within 30 days of receipt of a written invoice or billing record from the independent review organization.

(4) The independent review organization may only charge the fees in accordance with the fee schedule that is approved by the commissioner.

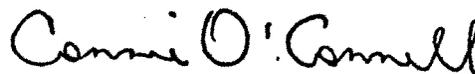
(5) An independent review organization is required to charge the insured a \$25 filing fee in accordance with s. 632.835 (3) (a), Stats., that shall be refunded by the insurer if the insured prevails in the review. The \$25 filing fee shall be considered a part of the overall cost for a qualified review. The independent review organization may not bill the insured for the cost of the review.

(6) If an independent review organization determines the matter is not within its authority to review, it may charge no more than the filing fee for that determination.

SECTION 7. These changes will take effect on the first day of the month after publication, as provided in s. 227.22 (2) (intro.), Stats.

SECTION 8. The application of s. 18.03 (1) (a), and the definition of grievance in s. 18.01 (4), applies to policies, certificates and outlines of coverage issued or renewed on the first day of the month following publication.

Dated at Madison, Wisconsin, this 24th day of May 2001.



Connie L. O'Connell
Commissioner of Insurance



State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott McCallum, Governor
Connie L. O'Connell, Commissioner

May 24, 2001

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REPORT ON Chapter Ins 18, Wis. Adm. Code, relating to health benefit plan grievance requirements and independent review organizations

Clearinghouse Rule No 00-169
Submitted Under s. 227.19 (3), Stats.
The proposed rule-making order is attached.

(a) Statement of need for the proposed rule

The creation of chapter Ins 18, Wis. Adm. Code, implements the provisions of 1999 Act 155 that expanded the types of health benefit plans that are required to provide insured's with access to an internal grievance process to resolve disputes. The Act also introduced the use of independent review organizations. The rule delineates the requirements for internal grievances and establishes requirements of independent review organizations.

(b) Modifications made in proposed rule based on testimony at public hearing:

The final draft of chapter Ins 18, Wis. Adm. Code, reflects significant changes to the noticed form of the rule based upon testimony received at the public hearing as well as numerous written comments received during the comment period. The rule now contains three subchapters, separating internal grievance procedures from independent review organization requirements, although timing of notices to insureds overlap.

(c) Persons who appeared or registered regarding the proposed rule:

Appearances For:

Ron Stark, MD, Medical Society of Milwaukee County

Appearances Against:

Pat Osborne, The Wisconsin Association of Life and Health Insurers
Carol Rubin, WEA Insurance Trust & Corp.
Ed Blume, The Wisconsin Association of Health Underwriters
Russ Leonard, Wisconsin Chiropractic Association

Appearances For Information:

Joe Kachelski, Wisconsin Association of Health Plans
Peter Weidenheim, Security Health Plan of Wisconsin, Inc.

Registrations For:

Betsy Adrian, Medical Society of Milwaukee County
Barbara Matthews, AARP
Sandra Lonergan, Rep. Gregg Underheim Office

Registrations Against:

Lynn Retan, Greater LaCrosse Health Plan, Inc.
Andrea Delwig, Humana
Dan Schwartz, Wisconsin Association of Provider Networks

Ann Jablonski, Humana
Carol Trounski, Midwest Security Ins. Companies
Christine Duval, Midwest Security Ins. Companies
Coreen Dicus-Johnson, Blue Cross & Blue Shield United of Wisconsin and UWS
John Lauders, American Family Mutual Ins. Co.
Patrick Essie, Wisconsin Chiropractic Association

Registrations Neither for nor against:

Katie Boyce, Dental Associates, LTD, Care Plus, Dental Ins.
Dismas Becker, Golden Rule Ins.
Eric Jensen, State Medical Society of Wisconsin
Louis Schubert, Wisconsin Association of Health Plans
Claudia Sanders, Darcy Parkey, Debbie Heinrich, Dean Health Plan, Inc.
Jackie Seversen, Wisconsin Association of Health Underwriters
Ann Blanquist, Wisconsin Association of Health Underwriters
JP Wiske, American Medical Security

Letters received:

Wisconsin Chiropractic Association dated December 15, 2000
Collaboration for healthcare consumer protection dated January 10, 2001
Wisconsin Association of Health Plans dated January 9, 2001
Wisconsin Association of Life and Health Insurers dated January 10, 2001
Wisconsin Association of Health Underwriters dated January 10, 2001
Wisconsin Association of Health Plans dated January 9, 2001
Security Health Plan dated January 11, 2001
Security Health Plan dated January 19, 2001
Senator Rodney Moen dated January 23, 2001
Delta Dental dated January 25, 2001
Wisconsin Association of Provider Networks dated January 31, 2001
Atrium Health Plan, Inc. dated February 6, 2001
American Medical Security dated February 7, 2001
State Medical Society of Wisconsin dated February 8, 2001
URAC, American Accreditation of HealthCare Commission dated February 8, 2001
Humana dated February 9, 2001
Collaboration for healthcare consumer protection dated February 9, 2001
WEA Trust dated February 9, 2001
WPS dated February 8, 2001
Wisconsin Association of Health Plans dated February 5, 2001
Blue Cross & Blue Shield United of Wisconsin dated February 8, 2001
Midwest Security Ins. Cos. dated February 7, 2001

(d) Response to Legislative Council staff recommendations

All comments were complied with and corrected unless revisions were rendered mute due to redrafting of the rule.

(e) Regulatory flexibility analysis

1. No issues were raised by small businesses during the hearing on the proposed rule.
2. The proposed rule does not impose any additional reporting requirements on small businesses.
3. The proposed rule does not require any additional measures or investments by small businesses.

(f) Fiscal Effect

See fiscal estimate attached to proposed rule.

Enclosure: Legislative Council Staff Recommendations
CH18 Rule Legislative Report 1.Doc