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CLEARINGHOUSE REPORT TO AGENCY

[THIS REPORT HAS BEEN PREPARED PURSUANT TO S. 227.15, STATS. THIS IS A REPORT ON A RULE AS ORIGINALLY PROPOSED BY THE AGENCY; THE REPORT MAY NOT REFLECT THE FINAL CONTENT OF THE RULE IN FINAL DRAFT FORM AS IT WILL BE SUBMITTED TO THE LEGISLATURE. THIS REPORT CONSTITUTES A REVIEW OF, BUT NOT APPROVAL OR DISAPPROVAL OF, THE SUBSTANTIVE CONTENT AND TECHNICAL ACCURACY OF THE RULE.]

CLEARINGHOUSE RULE **00–169**

AN ORDER to repeal and recreate Ins 9.33; and to create chapter Ins 18, relating to health benefit plan grievance requirements and independent review organizations.

Submitted by **OFFICE OF THE COMMISSIONER OF INSURANCE**

01–02–01 REPORT SENT TO AGENCY.
12–01–00 RECEIVED BY LEGISLATIVE COUNCIL.

GAA:tlu;rv

LEGISLATIVE COUNCIL RULES CLEARINGHOUSE REPORT

This rule has been reviewed by the Rules Clearinghouse. Based on that review, comments are reported as noted below:

1. STATUTORY AUTHORITY [s. 227.15 (2) (a)]

   Comment Attached YES ☑ NO ☐

2. FORM, STYLE AND PLACEMENT IN ADMINISTRATIVE CODE [s. 227.15 (2) (c)]

   Comment Attached YES ☑ NO ☐

3. CONFLICT WITH OR DUPLICATION OF EXISTING RULES [s. 227.15 (2) (d)]

   Comment Attached YES ☐ NO ☑

4. ADEQUACY OF REFERENCES TO RELATED STATUTES, RULES AND FORMS [s. 227.15 (2) (e)]

   Comment Attached YES ☑ NO ☐

5. CLARITY, GRAMMAR, PUNCTUATION AND USE OF PLAIN LANGUAGE [s. 227.15 (2) (f)]

   Comment Attached YES ☑ NO ☐

6. POTENTIAL CONFLICTS WITH, AND COMPARABILITY TO, RELATED FEDERAL REGULATIONS [s. 227.15 (2) (g)]

   Comment Attached YES ☐ NO ☑

7. COMPLIANCE WITH PERMIT ACTION DEADLINE REQUIREMENTS [s. 227.15 (2) (h)]

   Comment Attached YES ☐ NO ☑

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CLEARINGHOUSE RULE 00–169

Comments

[NOTE: All citations to "Manual" in the comments below are to the Administrative Rules Procedures Manual, prepared by the Revisor of Statutes Bureau and the Legislative Council Staff, dated September 1998.]

1. Statutory Authority

a. Sections 632.83 (1) and 632.835 (1) (c), Stats., define the term "health benefit plan" in two different ways. Section Ins 18.01 (7) defines the term "health benefit plan" as a combination of the statutory definitions and includes specifically "Medicare + Choice, Medicare supplement and replacement plans." The statutory definitions should be used with respect to their applicable subjects; that is, the definition in s. 632.83, Stats., should be used with respect to internal grievance procedure requirements and the definition in s. 632.835, Stats., should be used with respect to independent review of adverse and experimental treatment determinations. Reference to Medicare plans only should be used if those plans can be included in the phrase "any hospital or medical policy or certificate" as used in s. 632.745 (11) (a), Stats.

b. Section Ins 18.02 (1) (a) and (8), refer to an "expedited grievance procedure." Presumably, the authority for requiring an expedited grievance procedure is derived from s. 632.83 (2) (a), Stats., which provides that every insurer must establish and use an internal grievance procedure that is approved by the commissioner. However, the rule should make clear that the expedited grievance procedure may be avoided under s. 632.835 (2) (d) 2., Stats., which provides that the internal grievance procedure is not necessary when an independent review organization determines that the health condition of an insured is such that requiring the insured to use the internal grievance procedure before proceeding to independent review would jeopardize the life or health of the insured or the insured's ability to regain maximum function.

c. Section Ins 18.02 (2) (c) provides that a notice to an insured must contain a statement that the grievance or independent review process need not be exhausted in order for an insurer to use some other unstated procedures. The rule should make clear that s. 632.835 (2) (c), Stats., generally provides that an insured must exhaust the internal grievance procedure before the insured may request an independent review. [See also s. Ins 18.04.]

d. Under s. 632.835 (5) (a), Stats., the commissioner is required to promulgate rules which include six specific items. Included are standards for determining whether an independent review organization is unbiased and standards addressing conflicts of interest by independent review organizations. [See s. 632.835 (5) (a) 2. and 6., Stats.] There appear to be no provisions in the rules addressing these requirements.

e. Section Ins 18.10 (1) (i) states that expedited review shall in no case take longer than 72 hours from the time of review. However, s. 632.835 (3), Stats., describes the length of time within which an independent review organization must undertake an expedited review. The statute provides different time periods in the event that following the ordinary procedure would jeopardize the life or health of the insured or the insured's ability to regain maximum function. Under that provision, the insurer must submit the information required within one day after receiving the notice of the request for independent review. The independent review organization must request any additional information within two business days within receiving the information and the insurer shall, within two days after receiving a request, submit any information requested or an explanation of why the information is not being submitted. Finally, the independent review organization must make its decision within 72 hours after the expiration of the time limits that apply in the matter. Allowing only a maximum of 72 hours from the time of the request conflicts with the statute.

2. Form, Style and Placement in Administrative Code

a. SECTION 1 of the rule should read: "Ins 9.33 is repealed." The treatment clause of SECTION 2 should read: "Chapter Ins 18 is created to read:". A chapter title should be created and the three following subchapters should be created: Definitions, Grievance Procedures and Independent Review Organizations.

b. Since s. Ins 18.01 includes all of the definitions in s. 632.835, Stats., the introduction simply should read: "In this chapter:".

c. In s. Ins 18.01 (4) (b), the phrase "would subject the insured" should be replaced by the phrase "the insured may be subject."

d. In s. Ins 18.01 (6), the phrase "as defined in this chapter" is unnecessary and should be deleted.

e. In s. Ins 18.01 (11) (e) 7., it appears that the word "above" should be replaced by the phrase "in this paragraph."

f. In s. Ins 18.02 (6), par. (b) should conclude with a period.

g. In ss. Ins 18.02 (8) and 18.10 (2) (e), the word "through" should be replaced by the word "to."

h. In s. Ins 18.10 (4), par. (e) does not follow grammatically from the introduction and should be placed elsewhere in the rule.

4. Adequacy of References to Related Statutes, Rules and Forms

a. Section Ins 18.01 (8) should provide a more specific cross-reference.

b. Section Ins 18.10 (1) (h) refers to s. 632.835 (2) (e), Stats. The citation is incorrect.

c. Section Ins 18.12 refers to a form. The agency should ensure that the requirements of s. 227.14 (3), Stats., are met.

5. Clarity, Grammar, Punctuation and Use of Plain Language

a. In the second sentence of the second paragraph in the analysis, the comma after the word "includes" should be deleted and a comma should be inserted after the word "insurers."

b. Section Ins 18.01 (4) (c) does not seem to add anything to the definition and probably should be deleted.

c. In s. Ins 18.01 (11) (f), the word "shall" should be replaced by the word "does." Also, what does the phrase "significant extent" mean?

d. In s. Ins 18.01 (12), a comma should be inserted after the word "by."

e. Section Ins 18.02 (2) (c) begins with an incomplete sentence. Presumably, the sentence refers to other alternative procedures. What are these alternative procedures? [See, also, sub. (3) (b).]

f. In s. Ins 18.04, "impose" should be inserted prior to "other requirements."

g. In s. Ins 18.10 (1) (i), the second sentence is an incomplete sentence.

h. Section Ins 18.10 (3) (a) is awkward and should be rewritten.

i. Section Ins 18.10 (4) appears to be a restatement of s. 632.835 (6m), Stats. Why is the statutory language not used? For example, compare s. Ins 18.10 (4) (d) to s. 632.835 (6m) (d).

j. Why do the provisions of the rule, such as ss. Ins 18.10 (1) (e) and 18.14 (2) (e) and (i), not refer to experimental treatment determinations?

k. Section Ins 18.16 (5) provides that an independent review organization may not bill the insured for the cost of the review. Perhaps a note should be included stating that s. 632.835 (3) (a) requires an insured to pay a $25 fee to an independent review organization and that the fee may be refunded if the insured prevails in a proceeding.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Connie L. O'Connell
Commissioner

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Rec'd 12/1/00

TO: Ron Sklansky, Director, Legislative Council
1 East Main Street, Suite 401, Madison, WI 53701

FROM: Fred Nepple, General Counsel
Office of the Commissioner of Insurance

DATE: November 30, 2000

SUBJECT: Chapter Ins 18, Wis. Adm. Code, relating to Grievance Procedures and Independent Review Organizations

NOTICE OF SUBMITTAL TO LEGISLATIVE COUNCIL STAFF

Rule Submittal Date

In accordance with ss. 227.14 and 227.15, Stats., the Office of the Commissioner of Insurance is submitting a proposed rule to the Wisconsin Legislative Council Rules Clearinghouse on November 30, 2000.

Analysis

These changes will create Chapter Ins 18, Wis. Adm. Code, relating to Grievance Procedures and Independent Review Organizations.

Agency Procedure for Promulgation

The date for the public hearing is January 10, 2001.

Contact Person

A copy of the proposed rule may be obtained from the OCI internet WEB site at **http://www.state.wi.us/agencies/oci/ocirules.htm** or by contacting Patrick Bass at (608) 264-6232 in OCI Administrative Services. For additional information, please contact Julie E. Walsh at 264-8101 or e-mail at Julie.Walsh@oci.state.wi.us in the OCI Legal Unit.

This Notice of Submittal to Legislative Council Staff is prepared under s. 227.135, Stats., and approved on November 29, 2000.

Connie L. O'Connell

Connie L. O'Connell, Commissioner

FN:JW
Attachment: 1 copy rule

STATE OF WISCONSIN OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

★★★ NOTICE OF RULEMAKING HEARING ★★★

NOTICE IS HEREBY GIVEN that pursuant to the authority granted under s. 601.41(3), Stats., and the procedure set forth in under s. 227.18, Stats., OCI will hold a public hearing to consider the adoption of the attached proposed rulemaking order creating Chapter Ins 18, Wis. Adm. Code, relating to Grievance Requirements and Independent Review Organizations.

HEARING INFORMATION

Date: **January 10, 2001**
Time: **9:30 a.m., or as soon thereafter as the matter may be reached**
Place: **Room 6, OCI, 121 East Wilson Street, Madison, WI**

Written comments on the proposed rule will be accepted into the record and receive the same consideration as testimony presented at the hearing if they are received at OCI within 30 days following the date of the hearing. Written comments should be addressed to: Julie E. Walsh, OCI, PO Box 7873, Madison WI 53707

SUMMARY OF PROPOSED RULE & FISCAL ESTIMATE

For a summary of the rule see the analysis contained in the attached proposed rulemaking order. There will be no state or local government fiscal effect. The full text of the proposed changes and the fiscal estimate are attached to this Notice of Hearing.

INITIAL REGULATORY FLEXIBILITY ANALYSIS

This rule does not impose any additional requirements on small businesses.

CONTACT PERSON

A copy of the full text of the proposed rule changes and fiscal estimate may be obtained from the OCI internet WEB site at **http://www.state.wi.us/agencies/oci/ocirules.htm** or by contacting Patrick Bass, Administrative Services Section, Office of the Commissioner of Insurance, at (608) 264-6232 or at 121 East Wilson Street, PO Box 7873, Madison WI 53707-7873.

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), 632.835 (5), Stats.

Statutes interpreted: ss. 600.01, and 628.34 (12), 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. 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 definition of health benefit plan that is used within 1999 Wisconsin Act 155 includes all insurers, including Medicare + Choice, Medicare Select and Medicare replacement plans, that offer health insurance products with few exceptions. 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. In compliance with 1999 Wisconsin Act 155, the notice to the insureds have been expanded to incorporate reference to, and procedures for, independent review by a certified independent review organization. Notices to insureds will also include information on alternative resolution options.

All health benefit plans must provide enrollees with clear and timely explanations if experimental treatment is denied. The grievance and appeal procedures must be provided to the insured including a notice of independent review. 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. This rule establishes requirements to comply with the Act.

SECTION 1. ~~**Repeal s.**~~ **Ins 9.33** Section is repealed

SECTION 2. Chapter Ins 18, ~~**Subchapter I – Definitions and Grievance Procedures and Section Ins 18.01 are created to read:**~~ is created to read ch. 18 title

SUBCHAPTER I – DEFINITIONS AND GRIEVANCE PROCEDURES

Ins 18.01 DEFINITIONS. ~~In~~ addition to the ~~definitions in s. 632.835~~, Stats., in this chapter:

(1) "Adverse determination" has the meaning provided in s. 632.835 (1) (a), Stats.

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

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

(4) "Expedited grievance" means a grievance where the standard resolution process may include any of the following:

(a) 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, ~~would~~ may be subject the insured to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.

(c) It is determined to be an expedited grievance by a physician with knowledge of the insured's medical condition.

(5) "Experimental treatment determination" has the meaning provided in s. 632.835 (1) (b), Stats.

(6) "Grievance" means any written expression of dissatisfaction with the administration, claims practices or provision of services by an insurer offering a health benefit plan ~~as defined in this chapter.~~

(7) "Health benefit plan" has the meaning provided in s. 632.745 (11), Stats., except that health benefit plan includes; the coverage specified in s. 632.745 (11)(b) 9. and 10., Stats., Medicare + Choice, Medicare supplement and replacement plans as defined in ss. 600.03 (28q) and (28r), Stats., and ss. Ins 3.39 (3) (f) and (g).

(8) "Independent review organizations" means a certified organization that meets the criteria established within this chapter.

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

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

(11) "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 CFR s. 1861(t)(2) 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 government 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 above.

(f) "Medical or scientific evidence" shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer.

(12) "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 a health benefit plan.

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

(14) "Treatment" has the meaning provided in s.632.835 (1)(d), Stats.

Section 3. Section Ins 18.02 is created to read:

Ins 18.02 GRIEVANCE PROCEDURE. (1) (a) DEFINITION AND EXPLANATION OF THE GRIEVANCE PROCEDURE. Each insurer offering a health benefit plan shall incorporate within its policies, certificates and outlines of coverage the definition of a grievance in s. Ins 18.01 (6). The 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. In

accordance with s. 632.83 (2) (a), Stats., insurers offering a health benefit plan shall investigate each grievance.

(b) Insurers issuing Medicare + Choice plans shall follow the Medicare + Choice grievance and appeal procedures in accordance with 42 CFR s. 422.561 (1998), unless the insurer determines that a grievance or appeal is not subject to 42 CFR s. 422.561 (1998) and then the insurer shall follow the procedures set forth in this section.

stat. auth

(2) NOTIFICATION OF RIGHT TO APPEAL AN ADVERSE OR AN EXPERIMENTAL TREATMENT DETERMINATION. In addition to the requirements under sub. (1), each time an insurer offering a health benefit plan makes an adverse determination or denies an experimental treatment request the insurer shall notify the affected insureds of their right to file a grievance and request an independent review. For purposes of this subsection, denial or refusal of an insured's request for a referral from the insurer shall be considered an adverse determination. Insurers offering health benefit plans shall provide the all of the following notices to insureds:

(a) The notice to insureds of their right to grieve under this subsection 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 state the specific reason for the adverse determination or denial of experimental treatment.

632.835 (2)(b)(6)?

(b) The notice to insureds of their right to request an independent review shall comply with s. 632.835 (2), Stats., and shall be accompanied by the informational brochure developed by the office describing the independent review process. The notice shall state that the insured may select the independent review organization from a list of certified independent review organizations provided by the commissioner and shall provide instructions to the insured on how the independent review process operates.

(c) The notice to insureds shall also contain a statement that the grievance or independent review process need not be exhausted in order for insured to use other. However, the notice shall include a statement that references s. 632.835 (3) (f), Stats., informing insureds that once the independent review organization makes a determination, the determination is binding upon the insurer and insured.

(3) 2. (2) (c) (d)? stat. auth.

(3) NOTIFICATION OF RIGHT TO GRIEVE MATTERS OTHER THAN ADVERSE, EXPERIMENTAL TREATMENT DETERMINATIONS. In addition to other notices and provisions, including s. Ins 9.39, each time an insurer offering a health benefit plan receives complaints concerning administrative matters or makes other determinations affecting coverage, or when a health benefit plan that is either a health maintenance organization as defined by s. 609.01 (2), Stats., or a limited service health organization as defined by s. 609.01 (3), Stats., and initiates disenrollment proceedings, the insurer shall notify the affected insured of the right to file a grievance. The insurer shall provide the following notices to insureds:

(a) Their right to grieve the initiation of disenrollment, administrative matters or other determinations affecting coverage 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 state the specific reason for the administrative dispute, initiation of disenrollment or other determination affecting coverage.

(b) A statement that the insured need not exhaust the grievance process in order to utilize other remedies.

(4) GRIEVANCE PROCEDURE. A grievance procedure for insurers offering health benefit plans 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 grievance unless the insurer permits the grievant 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 who filed the grievance, or the insured's authorized representative, to participate in the meeting.

(d) In addition to the requirements of s. 632.83 (3) (b), Stats., the grievance panel shall not include the person who ultimately made the initial determination. The panel may include no more than one subordinate of the person who ultimately made

the initial determination only if the panel consists of at least three persons. 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 grievant as described in s. 632.83 (3) (d), Stats., which 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.

(5) ACKNOWLEDGMENT OF RECEIPT OF GRIEVANCE. 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 grievant confirming receipt of the grievance.

(6) TIMELINESS OF NOTIFICATION AND RESOLUTION OF GRIEVANCE. An insurer offering a health benefit plan shall resolve a grievance 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 notifies, in writing, the person who filed the grievance of all of the following:

(a) That the insurer has not resolved the grievance.

(b) When resolution of the grievance may be expected.

(c) The reason additional time is needed.

(7) 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 including but not limited to, the notice contained in subs. (2) and (3) as appropriate. The insurer shall then follow its grievance procedure in compliance with sub. (4).

(8) EXPEDITED GRIEVANCE PROCEDURE. Subs. (2) ~~through~~ to (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 for

expedited grievance situations. 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.

(9) REPORTING REQUIREMENTS. An insurer offering a health benefit plan, other than a Medicare + Choice plan, shall comply with all of the following requirements:

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

(b) The records maintained for requests received for independent review shall include the date that the insurer notified the insured of the right to request independent review, the date and time a request for independent review or expedited independent review was received, and the date and time the request and required documentation in accordance with s. 632.835 (3), Stats., was provided to the independent review organization.

(c) Any provider providing services to the health benefit plan, either directly or indirectly, shall be required, by the insurer, to promptly identify complaints and grievances and forward complaints and grievances to the insurer in a timely manner for recording and resolution. Any insurer offering a health benefit plan shall require all direct or indirect contracts for provider or administrative services to include a provision to promptly identify complaints and grievances and forward these complaints and grievances in a timely manner to the insurer for recording and resolution.

(d) 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:

forms o.k.

1. Plan administration including plan marketing, policyholder service, billing, underwriting, or similar administrative functions.

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

(e) Maintain, at its home or principal office, all records on complaints, grievances and requests for independent review.

(10) MEDICARE + CHOICE REPORTING REQUIREMENTS. Medicare + Choice plans shall report to the commissioner the number of appeal requests received as required by the Health Care Financing Administration and any other information the commissioner may request.

Note: A copy of the grievance experience report form OCI26-007, required under par. (9) (d), may be obtained from the Office of the Commissioner of Insurance, P. O. Box 7873, Madison WI 53707-7873.

Section 4. Section Ins 18.04 is created to read:

Ins 18.04 PROHIBITED ACTIONS BY INSURERS. Insurers offering a health benefit plan may not require binding arbitration or other requirements that restrict an insured's right to seek alternative remedies. Insurers may not require an insured to exhaust internal grievance or independent review prior to utilizing alternative sources for resolution of complaints. An insured may seek an alternative remedy at any time.

Section 5. Subchapter II-Independent Review Organizations and Section Ins 18.10 are created to read:

SUBCHAPTER II-INDEPENDENT REVIEW ORGANIZATIONS

Ins 18.10 MINIMUM QUALIFICATIONS. **(1)** Independent review organizations shall have and demonstrate compliance with written policies and procedures governing all aspects of both the standard 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. If a conflict exists, the independent review organization shall notify the insured in a timely manner and in writing that a different independent review organization will need to be selected.

2. Whether the case relates to a clinical issue or an administrative issue.

3. Whether the case relates to an adverse determination or denial of experimental treatment.

4. The specific question or issue to be resolved by the independent review process.

5. Whether the case merits standard or expedited review.

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

(d) Upon selection of the reviewer, provision of a file that includes all information necessary to consider the case. In cases where more than one reviewer is used 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) For cases referred to independent review organizations regarding an adverse determination, the independent review organization and its reviewer shall consider information pertinent to the case 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. As appropriate, medical or scientific evidence.

(f) For cases regarding experimental treatment, the independent review organization and its reviewer shall consider all information required in par. (e) and

existing medical or scientific evidence regarding the proposed treatment with respect to effectiveness and efficacy.

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

(h) A process so that within two business days of rendering a determination, the independent review organization shall, in addition to the requirements of s. 632.835 (2) (e), Stats., be able to send to the insured, or the insured's authorized representative, and the insurer 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 reviewer's determination, including supporting evidence.

(i) A process so that expedited reviews shall be completed as quickly as necessary given the insured's health condition, but in no case shall it take longer than 72 hours from the time of the request for review. Upon completion of the review, a process so that notice is provided within one hour to the insured, or the insured's authorized representative, and the insurer.

(2) 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 of the following:

(a) That the independent reviews are conducted within the specified time frames and 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 and suitable matching of reviewers to specific cases is achieved. On a periodic basis, the independent review organization shall conduct training, and on-going monitoring and evaluation of the reviewers and non-clinical staff.

(c) That the confidentiality of medical and treatment records and clinical review criteria in accordance with state and federal law is ensured. Access to medical and treatment records 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.

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

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

(3) (a) Independent review organizations shall establish a toll-free telephone service to receive ~~information~~ on a 24-hour, 7-days per week, basis related to ~~independent reviews and~~ is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during ~~other than~~ normal business hours. rewrite

(b) To ensure that the independent review organization meets its obligation under sub. (1)(i), the independent review organization shall establish adequate means to provide services during times other than normal business hours.

(4) Independent review organizations shall require all clinical peer reviewers assigned to conduct independent reviews to be physicians or other appropriate health care providers who meet the following minimum qualifications verified at least every 2 years:

(a) Be an expert in the treatment of the insured's medical condition that is the subject of the independent review.

(b) Be knowledgeable about the recommended health care service or treatment through recent or current actual ~~clinical~~ experience treating patients with the same or similar medical condition of the insured.

(c) Hold a non-restricted license in 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 independent review.

(d) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial

question as to the clinical peer reviewer's physical, mental or professional competence or moral character.

(e) Provide to the independent review organization a list, updated at least quarterly, of potential conflicts of interest.

(5) The independent review organization shall have a medical director or clinical director with professional post-residency experience in direct patient care who holds a current license to practice medicine, has a clinical specialty appropriate to the type of reviews conducted and oversees the medical aspects of the quality assurance and credentialing program.

(6) If the independent review organization delegates or subcontracts independent review functions, it is responsible for the delegated functions, nevertheless, including any violation of law, policy or procedure. In addition, independent review organizations that delegate or subcontract 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 sub-contracted functions.

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

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

Section 7. Section Ins 18.12 is created to read:

Ins 18.12 APPROVAL OF INDEPENDENT REVIEW ORGANIZATIONS. (1) Any independent review organization seeking approval to conduct independent reviews shall, in addition to meeting the requirements established s. 632.835 (4), Stats., 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 satisfies s. Ins

18.10. The independent review organization shall also submit the application fee in accordance with s. 601.31 (1) (Lp), Stats.

Section 8. Section Ins 18.14 is created to read:

INS 18.14 INDEPENDENT REVIEW ORGANIZATION REPORTING REQUIREMENTS. (1) An independent review organization shall maintain records on all requests for independent review for which it conducted an independent review during that 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 aforementioned 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 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 organizations 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 by the insurer and the number resolved reversing the adverse 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 after the receipt of additional information from the insured or the insured's authorized representative.

(j) Any other information the commissioner requests.

Section 9. Section Ins 18.16 is created to read:

INS 18.16 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.

(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.

(3) Insurers offering health benefit plans shall pay the fee submitted by the independent review organization within twenty days of receipt of the charges from the independent review organization.

(4) Independent review organizations may only charge fees that have received prior approval from the commissioner.

(5) An independent review organization may not bill the insured for the cost of the review.

SECTION 10. These changes will take effect on the first day of the month after publication, as provided in s. 227.22(2)(intro.), Stats.

SECTION 11. These changes first apply to _____.

Dated at Madison, Wisconsin, this 30 day of November 2000.

Connie L. O'Connell

Connie L. O'Connell