Chapter Ins 18

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

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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.

(2m) "Coverage denial determination" has the meaning as defined in s. 632.835 (1) (ag), Stats., and includes, for individual insurance products, a policy reformation or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

(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 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 including any of the following:

(a) Provision of services.

(b) Determination to reform or rescind a policy.

(c) Determination of a diagnosis or level of service required for evidence−based treatment of autism spectrum disorders.

(d) Claims practices.

(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.

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

(10) "Rescission" or "reformation" of a policy means a determination by an insurer offering health benefit plan, subject to s. 628.34 (3), Stats., to withdraw the coverage back to the initial date of coverage, modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by the insurer to all similar individual policy forms is not a rescission or reformation of a policy.

History: CR 00−169: cr. Register November 2001 No. 551, eff. 12−1−01; **CR 10−023: cr. (2m), (10), am. (4) Register September 2010 No. 657, eff. 10−1−10.**

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 Medicare replacement plans as defined in s. 600.03 (28p) and (28r), Stats., and s. Ins 3.39 (3) (v) and (w). Health benefit plan includes Medicare cost and select plans but does not include Medicare Advantage plans.

History: CR 00−169: cr. Register November 2001 No. 551, eff. 12−1−01; CR 04−121: am. (1) Register June 2005 No. 594, eff. 7−1−05.

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) 1. An insurer offering a health benefit plan that is a defined network plan as defined in s. 609.01 (1b), Stats., other than a preferred provider plan as defined in s. 609.01 (4), Stats., shall do all of the following:

a. 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 promptly respond to complaints and grievances filed with the insurer to facilitate resolution.

b. 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 respond to complaints and grievances filed with the insurer to facilitate resolution.

c. Maintain records and reports reasonably necessary to monitor compliance with the contractual provisions required under this paragraph.

d. Take prompt action to compel correction of non−compliance with contractual provisions required under this paragraph.

2. An insurer offering a health benefit plan that is a preferred provider plan as defined in s. 609.01 (4), Stats., shall do all of the following:

a. 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 promptly provide the insurer the information necessary to permit the insurer to respond to complaints or grievances described under subd. 2. c.

b. Require contracted entities that subcontract for the provision of services, to incorporate within their contracts, including subcontracts with health care providers, a requirement that the subcontractor promptly provide the insurer with the information necessary to respond to complaints or grievances described under subd. 2. c.

c. Include in its description of the grievance process required under sub. (1), a clear statement that an insured may submit to the insurer offering a health benefit plan a complaint or grievance relating to covered services provided by a participating health care provider.

d. Process and respond to a complaint or grievance described under subd. 2. c.

e. Maintain records and reports reasonably necessary to monitor compliance with the contractual provisions required under this paragraph.

f. Take prompt action to compel correction of non−compliance with contractual provisions required under this paragraph.

(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. (a) An insurer offering a health benefit plan may require a written expression of authorization for representation from a person acting as the insured's authorized representative unless any of the following applies:

1. The person is authorized by law to act on behalf of the insured.

2. The insured is unable to give consent and the person is a spouse, family member or the treating provider.

3. The grievance is an expedited grievance and the person represents that the insured has verbally given authorization to represent the insured.

(b) An insurer offering a health benefit plan shall process a grievance without requiring written authorization unless the insurer, in its acknowledgement to the person under sub. (4), clearly and prominently does all of the following:

1. Notifies the person that, unless an exception under par. (a) applies, the grievance will not be processed until the insurer receives a written authorization.

2. Requests written authorization from the person.

3. Provides the person with a form the insured may use to give written authorization. An insured may, but is not required to, use the insurer's form to give written authorization.

(c) An insurer offering a health benefit plan shall accept under par. (a) any written expression of authorization without requiring specific form, language or format.

(d) An insurer offering a health benefit plan shall include in its acknowledgement of receipt of a grievance filed by an authorized representative a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law. The acknowledgement shall state that unless otherwise permitted under applicable law, including the Health Insurance Portability and Accountability Act of 1996, U.S. PL 104−191, ss. 51.30, 146.82 to 146.84, and 610.70, Stats., and ch. Ins 25, informed consent is required and the acknowledgement shall include an informed consent form for that purpose. An insurer offering a health benefit plan may withhold health care information or medical records from an authorized representative, including information contained in its resolution of the grievance, but only if disclosure is prohibited by law. An insurer offering a health benefit plan shall process a grievance submitted by an authorized representative regardless of whether health care information or

medical records may be disclosed to the authorized representative under applicable law.

(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 offering a health benefit plan 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.

(7) COMMISSIONER ANNUAL REPORT. The commissioner shall by June 1 of each year prepare a report that summarizes grievance experience reports received by the commissioner from insurers offering health benefit plans. The report shall also summarize OCI complaints involving the insurer offering health benefit plans that were received by the office during the previous calendar year.

History: CR 00−169: cr. Register November 2001 No. 551, eff. 12−1−01; corrections in (2) (c) 1. and (5) (d) made under s. 13.93 (2m) (b) 7., Stats., Register December 2004 No. 588; CR 05−059: am. (2) (c) 1. Register February 2006 No. 602, eff. 3−1−06.

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 as appropriate, if the commissioner provides a written description of the complaint to the insurer. The insurer shall process the OCI complaint as a grievance in compliance with s. Ins 18.03.

History: CR 00−169: cr. Register November 2001 No. 551, eff. 12−1−01.

Ins 18.05 Expedited grievance procedure. Section Ins 18.03 (2) to (4) and (6) does not apply to expedited grievances. 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. An insurer offering a health benefit plan, upon written request, shall mail or electronically mail a copy of the insured's complete policy to the insured or the insured's authorized representative as expeditiously as the grievance is handled.

History: CR 00−169: cr. Register November 2001 No. 551, eff. 12−1−011; **CR 10−023: am. Register September 2010 No. 657, eff. 10−1−10.**

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.

History: CR 00−169: cr. Register November 2001 No. 551, eff. 12−1−01.

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) "Experimental treatment determination" means a determination by or on behalf of an insurer that issues a health benefit plan to which all of the following apply:

(a) A proposed treatment has been reviewed.

(b) Based on the information provided, the treatment under par. (a) is determined to be experimental under the terms of the health benefit plan.

(c) Based on the information provided, the insurer that issued the health benefit plan denied the treatment under par. (a) or payment for the treatment under par. (a).

(d) Pursuant to s. 632.835 (5) (c), Stats., the cost or expected cost of the denied treatment or payment exceeds, or will exceed during the course of the treatment, the amount published in accordance with s. Ins 18.105.

(3) "Health benefit plan" has the meaning provided in s. 632.835 (1) (c), Stats., and includes Medicare supplement and replacement plans as defined in s. 600.03 (28p) and (28r), Stats., and s. Ins 3.39 (3) (v) and (w). Health benefit plan includes Medicare cost and select plans but does not include Medicare Advantage plans.

(4) "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 most current edition in publication at the time of the dispute:

1. The American Hospital Formulary Service — Drug Information.
2. The Center for Drug Evaluation and Research History.
3. The ADA/PDR Guide to Dental Therapeutics, current edition.
4. The United States Pharmacopeia — National Formulary.

(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.

(4e) "Preexisting condition exclusion denial determination" has the meaning as defined in s. 632.835 (1) (cm), Stats.

(4m) "Legal basis" means information from any of the following sources:

(a) The most current version of The American Journal of Jurisprudence.

(b) United States 7th Judicial Circuit Court decisions.

(c) Wisconsin statutory and common law.

(d) The terms of the insurance contract applicable for the period of coverage in dispute.

(5) "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.

History: CR 00−169: cr. Register November 2001 No. 551, eff. 12−1−01; CR 04−079: am. (2) (d) Register December 2004 No. 588, eff. 1−1−05; CR 04−121: am. (3) Register June 2005 No. 594, eff. 7−1−05; **CR 10−023: am. (4) (d), cr. (4e) and (4m) Register September 2010 No. 657, eff. 10−1−10**.

Ins 18.105 Annual CPI adjustment for independent review eligibility. (1) PUBLICATION AND EFFECTIVE DATE. The commissioner shall publish to the office of the commissioner of insurance website on or before December 1 of each year the consumer price index for urban consumers as determined by the U.S. Department of Labor and publish the adjusted dollar amount in accordance with s. 632.835 (5) (c), Stats. The adjusted dollar amount published each December shall be used by insurers offering health benefit plans when complying with s. Ins 18.10 (2) (d) and s. 632.835 (1) (a) 4., Stats., effective the following January 1.

(2) DETERMINATION OF ADJUSTED RATES. Insurers offering health benefit plans shall apply the adjusted dollar amount published annually by the commissioner that is required to be met in accordance with s. 632.835 (1) (a) 4. and (b) 4., Stats., as follows:

(a) For adverse determinations when treatment was received by the insured, the insurer shall use the date treatment was received to determine the proper adjusted dollar amount that is required to be met in accordance with s. 632.835 (1) (a) 4., Stats.

(b) For adverse determinations when a course of treatment was received by the insured or terminated by the insurer, the insurer shall use later of the following dates to determine the proper adjusted dollar amount that is required to be met in accordance with s. 632.835 (1) (a) 4., Stats.:

1. The last date treatment was received by the insured; or,

2. The date the insurer mailed written notification to the insured, or the insured's authorized representative, that the course of treatment was terminated or denied.

(c) For experimental treatment determinations the insurer shall use the date the insurer mailed written notification to the insured, or the insured's authorized representative, that for the proposed treatment the insurer has either denied the treatment or denied payment for the treatment, to determine the proper adjusted dollar amount that is required to be met in accordance with s. 632.835 (1) (b) 4., Stats., and s. Ins 18.10 (2) (d).

Note: Office website address: http://oci.wi.gov.

History: CR 04−079: cr. Register December 2004 No. 588, eff. 1−1−05.

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) or (2) (bg), Stats., and s. Ins 18.03, each time an insurer offering a health benefit plan makes a coverage denial determination the insurer shall provide all of the following in the notice to the 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) or (2) (bg), Stats., and when required, to be accompanied by the informational brochure developed by the office or in a form substantially similar, describe the independent review process. The notice shall be sent when the insurer offering a health benefit plan makes a coverage denial determination. In addition, the notice shall contain all of the following information:

2. For coverage denial determinations occurring after June 15, 2002, the notice to an insured shall, in accordance with s. 632.835 (2) (c), Stats., state that the insured, or the insured's authorized representative, must request independent review within 4 months from the date of the coverage denial determination by the insurer or from the date of receipt of notice 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://oci.wi.gov.

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 and contain the name of the selected 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.

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 may be binding upon the insurer and insured. For preexisting condition exclusion and rescission denial determinations, the notice shall indicate that the independent review organization determination is not binding on the 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 offering a health benefit plan and the 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 offering a health benefit plan.

7. The notice shall include a brief summary statement regarding Health Insurance Risk Sharing Plan eligibility as required in s. 632.785, Stats., when the coverage denial determination involved a policy rescission.

(b) 1. For preexisting condition exclusion denial and rescission determinations that occur on or after January 1, 2010, but prior to the date stated in the notice published by the commissioner in the Wisconsin Administrative Register under s. 632.835 (8) (b), Stats., 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 date stated in the notice published by the commissioner in the Wisconsin Administrative Register under s. 632.835 (8) (b), Stats.

2. For preexisting condition exclusion denial and rescission determinations occurring subsequent to the date stated in the notice published by the commissioner in the Wisconsin Administrative Register under s. 632.835 (8) (b), Stats., the notice to an insured shall comply with sub. (2) (a), state that the insured, or the insured's authorized representative, must request the independent review within 4 months from the date of the preexisting condition exclusion denial or rescission determination by the insurer or from the date of receipt of notice of the grievance panel decision, whichever is later.

(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 offering a health benefit plan, 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 offering a health benefit plan 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.

(bm) The insurer offering a health benefit plan shall provide, upon written request from the insurer or the insured's authorized representative, a complete copy of the insured's policy. The insurer offering a health benefit plan shall respond to the written request within 3 business days of the request by mailing or electronically mailing the copy to the insured or the insured's authorized representative in the format requested.

(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) Paragraphs (a) to (c) do not apply to situations where the independent review organization determines that the normal duration of the independent review process would jeopardize the life or health of the insured or the insured's ability to regain maximum function. 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.

(4) DISPUTES. (a) A dispute between an insured and an insurer regarding eligibility for independent review shall be considered a coverage denial determination and the insured may seek independent review of the determination in accordance with this section.

(b) Disputes that are related to administrative matters, including enrollment eligibility, not related to treatment or services are not eligible for independent review determinations.

History: CR 00−169: cr. Register November 2001 No. 551, eff. 12−1−01; CR 04−079: am. (2) (a) 3. Register December 2004 No. 588, eff. 1−1−05; **CR 10−023: am. (2) (intro.), (a) (intro.), 2., 4., 5., r. (2) (a) 1., cr. (2) (a) 7., (b), (3) (bm), (4) Register September 2010 No. 657, eff. 10−1−10.**

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 a written notification to the insurer, the commissioner and the insured, or the insured's authorized representative, within 3 business days stating that a conflict exists and declining to take the review, indicating that a different independent review organization will need to be selected by the insured, or the insured's authorized representative.

2. The type of case for which review is sought. The independent review organization shall determine if the case relates to a coverage denial determination or an administrative issue. If the independent review organization determines that the review is not related to a coverage denial determination, the independent review organization shall provide written notification to the commissioner, the insured, or the insured's authorized representative, 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 amount published in accordance with s. Ins 18.105, has been met based upon the type of determination the insurer made. The independent review organization shall calculate the amount that is required to be met, in accordance with s. 632.835 (1) (a) 4. and (b) 4., Stats., and s. Ins 18.10 (2) (d), as adjusted in accordance with s. 632.835 (5) (c), Stats., and s. Ins 18.105, using the actual cost charged the insured 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 including evidence that is determined to be an efficacious treatment or strategy as defined at s. Ins 3.36 (3) (c), as appropriate.

8. Legal basis, 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 offering a health benefit plan 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 offering a health benefit plan, 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 and a clear statement of the decision.

4. The decision shall be signed by the case reviewer or, in cases where more than one reviewer is assigned to review the case, the signature of at least one of the reviewers.

(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.

(j) Procedures to ensure that the decision of the independent review organization is consistent with s. 632.835 (3m), Stats.

(k) Procedures for determining when the inclusion of an attorney or actuary as a member of a review panel or the advice of an attorney and actuary would provide appropriate and necessary assistance in the review.

(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. (a) 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.

(b) For coverage denial determinations that include a legal review, the independent review organization shall require legal reviewers assigned to conduct independent reviews be attorneys licensed and in good standing in this state and whose qualifications are verified at least every 2 years.

(c) For coverage denial determinations that include review of an underwriting determination, the independent review organization shall require actuaries be assigned to assist in the review and be a member in good standing of the American academy of actuaries and 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, legal and actuary 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.

(6m) An independent review organization may employ or contract with a law firm, experienced attorney, actuarial entity or experienced actuary to assist in the review of matters related to reformations, rescissions and preexisting condition denial determinations. The independent review organization shall oversee aspects of quality assurance, licensing and expertise of the legal or actuarial reviewer.

(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.

History: CR 00−169: cr. Register November 2001 No. 551, eff. 12−1−01; CR 04−079: am. (1) (b) Register December 2004 No. 588, eff. 1−1−05; **CR 10−023: am. (1) (b) 1., 2., (e) 7., (4), (5), cr. (1) (e) 8., (k), (6m) Register September 2010 No. 657, eff. 10−1−10.**

Ins 18.13 Standards of independent review. (1) For coverage denial determinations other than experimental treatment determinations, independent review organizations shall consider any of the following:

(a) Medical or scientific evidence including evidence that is determined to be an efficacious treatment or strategy as defined at s. Ins 3.36 (3) (c).

(b) Legal basis.

(c) The applicable insurance contract.

(2) Independent review organizations shall include as members or advisors an attorney or actuary when the dispute involves a rescission, reformation or the dispute includes a legal dispute. The addition of an attorney or actuary to a review panel is at the discretion of the independent review organization or reviewers and need only be considered when the independent review organization or reviewers determine additional expertise would provide appropriate and necessary assistance in the review.

History: CR 10−023: cr. Register September 2010 No. 657, eff. 10−1−10.

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.

History: CR 00−169: cr. Register November 2001 No. 551, eff. 12−1−01.

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 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 coverage denial determination by the insurer and the number resolved reversing the coverage denial determination by the insurer.

(em) The names and specialty of the reviewers participating in reviews conducted during the year. The listing shall include the name of any attorney or actuary or the respective firm, who participated in the reviews.

(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 offering a health benefit plan of its coverage denial 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.

History: CR 00−169: cr. Register November 2001 No. 551, eff. 12−1−01; **CR 10−023: am. (2) (e), (i), cr. (2) (em) Register September 2010 No. 657, eff. 10−1−10.**

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.

(6) If an independent review organization determines the matter is not within its authority to review, it may not charge for that determination.

History: CR 00−169: cr. Register November 2001 No. 551, eff. 12−1−01; **CR 10−023: r. (5), am. (6) Register September 2010 No. 657, eff. 10−1−10.**