HOUSE BILL NO. 129

INTRODUCED BY G. MACLAREN

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT ADOPTING AND REVISING PROCESSES THAT PROVIDE FOR UTILIZATION REVIEW, GRIEVANCE, AND EXTERNAL REVIEW OF HEALTH INSURANCE ISSUERS' ACTIONS; AMENDING HEALTH INSURANCE UTILIZATION REVIEW; ESTABLISHING INDEPENDENT REVIEW ORGANIZATIONS FOR EXTERNAL REVIEW; LIMITING LIABILITY FOR INDEPENDENT REVIEW ORGANIZATIONS FOR DECISIONS MADE IN EXTERNAL REVIEWS; REQUIRING HEALTH INSURANCE ISSUERS TO PAY THE COSTS OF AN EXTERNAL REVIEW; EXTENDING RULEMAKING; AMENDING SECTIONS 33-32-101, 33-32-102, 33-32-103, 33-32-104, 33-32-105, AND 33-33-103, MCA; REPEALING SECTIONS 33-32-201, 33-32-203, 33-37-101, 33-37-102, 33-37-103, 33-37-104, 33-37-105, AND 33-37-106, MCA; AND PROVIDING AN EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-32-101, MCA, is amended to read:

"33-32-101. Purpose. The legislature finds and declares that it is the purpose of this chapter to:

(1) promote the delivery of quality health care in a cost-effective manner;

(2) foster greater coordination between health care providers, third-party payors, and others who conduct utilization review activities;

(3) ensure access to health care services; ~~and~~

(4) protect patients, employers, and health care providers by ensuring that utilization review activities result in informed decisions on the appropriateness of medical care made by those best qualified to be involved in the utilization review process; and

(5) establish standards and criteria for the structure and operation of utilization review and benefit determination processes designed to facilitate ongoing assessment and management of health care services."

Section 2. Section 33-32-102, MCA, is amended to read:

"33-32-102. Definitions. As used in this chapter, the following definitions apply:

~~(1) "Commissioner" means the commissioner of insurance provided for in 2-15-1903.~~

~~(2) "Health care provider" means a person, corporation, facility, or institution licensed by the state to provide or otherwise lawfully providing health care services, including but not limited to:~~

~~(a) a physician, health care facility as defined in 50-5-101, osteopath, dentist, nurse, optometrist, chiropractor, podiatrist, physical therapist, psychologist, licensed social worker, speech pathologist, audiologist, licensed addiction counselor, or licensed professional counselor; and~~

~~(b) an officer, employee, or agent of a person described in subsection (2)(a) acting in the course and scope of employment.~~

~~(3) "Health care services" means the health care and services provided by health care providers, including drugs, medicines, ambulance services, and other therapeutic and rehabilitative services and supplies.~~

(1) "Adverse determination", except as provided in [section 25], means:

(a) a determination by a health insurance issuer or its designated utilization review organization that, based on the provided information and after application of any utilization review technique, a requested benefit under the health insurance issuer's health plan is denied, reduced, or terminated or that payment is not made in whole or in part for the requested benefit because the requested benefit does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or level of effectiveness or is determined to be experimental or investigational;

(b) a denial, reduction, termination, or failure to provide or make payment in whole or in part for a requested benefit based on a determination by a health insurance issuer or its designated utilization review organization of a covered person's eligibility to participate in the health insurance issuer's health plan;

(c) any prospective review or retrospective review of a benefit determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit; or

(d) a rescission of coverage determination.

(2) "Ambulatory review" means a utilization review of health care services performed or provided in an outpatient setting.

(3) "Authorized representative" means:

(a) a person to whom a covered person has given express written consent to represent the covered person in an external review;

(b) a person authorized by law to provide substituted consent for a covered person; or

(c) a family member of the covered person or the covered person's treating health care provider only

when the covered person is unable to provide consent.

(4) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

(5) "Certification" means a determination by a health insurance issuer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, and level of effectiveness.

(6) "Clinical peer" means a physician or other health care provider who:

(a) holds a nonrestricted license in a state of the United States; and

(b) is trained or works in the same or a similar specialty to the specialty that typically manages the medical condition, procedure, or treatment under review.

(7) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health insurance issuer to determine the necessity and appropriateness of health care services.

(8) "Concurrent review" means a utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

(9) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health plan.

(10) "Covered person" means a policyholder, certificate holder, member, subscriber, enrollee, or other individual participating in a health plan.

(11) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives after discharge from a facility.

(12) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect to see from the absence of immediate medical attention a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or serious jeopardy to the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child.

(13) "Emergency services" means, with respect to an emergency medical condition:

(a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency

medical condition; and

(b) further medical examination and treatment needed to stabilize a patient to the extent they are within the capability of the staff and facilities available at a hospital.

(14) "External review" describes the set of procedures in [sections 24 through 38].

(15) "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health insurance issuer or its designated utilization review organization, at the completion of the health insurance issuer's internal grievance process, as provided in [sections 16 through 23].

(16) "Grievance" means a written complaint or oral complaint if the complaint involves an urgent care request submitted by or on behalf of a covered person regarding:

(a) availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) claims payment, handling, or reimbursement for health care services; or

(c) matters pertaining to the contractual relationship between a covered person and a health insurance issuer.

(17) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(18) "Health insurance issuer" means an insurer, a health service corporation, or a health maintenance organization.

(19) "Medical care" means:

(a) the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(b) transportation primarily for and essential to medical care referred to in subsection (19)(a); or

(c) insurance covering medical care referred to in subsections (19)(a) and (19)(b).

(20) "Network" means the group of participating providers providing services to a managed care plan.

(21) "Participating provider" means a provider who, under a contract with a health insurance issuer or with its contractor or subcontractor, has agreed to provide health care services to covered persons with the expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health insurance issuer.

(22) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, or any similar entity or combination of entities in this

subsection (13).

(23) "Prospective review", except as provided in [section 19], means a utilization review conducted prior to an admission or a course of treatment.

(24) (a) "Rescission" means a cancellation or the discontinuance of coverage under a health plan that has a retroactive effect.

(b) The term does not include a cancellation or discontinuance of coverage under a health plan if:

(i) the cancellation or discontinuance of coverage has only a prospective effect; or

(ii) the cancellation or discontinuance of coverage is effective retroactively to the extent that it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(25) (a) "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient.

(b) The term does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

(26) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

(27) "Stabilize" means, with respect to an emergency medical condition, that no material deterioration of the condition is, within a reasonable medical probability, likely to result from or occur during the transfer of the individual from a facility.

(28) (a) "Urgent care request" means a request for a health care service or course of treatment with respect to which the time periods for making a nonurgent care request determination could:

(i) seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(ii) subject the covered person, in the opinion of a physician with knowledge of the covered person's medical condition, to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

(b) Except as provided in subsection (28)(c), in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health insurance issuer shall apply the judgment of a prudent lay person who possesses an average knowledge of health and medicine.

(c) Any request that a physician with knowledge of the covered person's medical condition determines

is an urgent care request within the meaning of subsection (28)(a) must be treated as an urgent care request.

~~(4)~~(29) ~~(a)~~ "Utilization review" means a ~~system for review of health care services for a patient to determine the~~ set of formal techniques designed to monitor the use of or to evaluate the clinical necessity~~,~~ ~~or~~ appropriateness, efficacy, or efficiency of health care services, procedures, or settings. ~~whether that review is prospective, concurrent, or retrospective, when the review will be used directly or indirectly in order to determine whether the health care services will be paid, covered, or provided~~ Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

~~(b) Utilization review does not include routine claim administration or determination that does not include determinations of medical necessity or appropriateness.~~

(30) "Utilization review organization" means an entity that conducts utilization review, other than a health insurance issuer performing a review for its own health plans."

Section 3. Section 33-32-103, MCA, is amended to read:

"33-32-103. Utilization review plan. ~~A person~~ An entity covered under the provisions of this chapter may not conduct a utilization review of health care services provided or to be provided to a patient covered under a contract or plan for health care services issued in this state unless that ~~person~~ entity, at all times, maintains with the commissioner a current utilization review plan that includes:

(1) a description of review criteria, standards, and procedures to be used in evaluating proposed or delivered health care services that, to the extent possible, must:

(a) be based on nationally recognized criteria, standards, and procedures;

(b) reflect community standards of care, except that a utilization review plan for health care services under the medicaid program provided for in Title 53 need not reflect community standards of care;

(c) ensure quality of care; and

(d) ensure access to needed health care services;

~~(2) the provisions by which patients or providers may seek reconsideration or appeal of adverse decisions by the person conducting the utilization review;~~

~~(3) the type and qualifications of the personnel either employed or under contract to perform the utilization review;~~

~~(4)~~(2) policies and procedures to ensure that a representative of the ~~person~~ entity conducting the

utilization review is reasonably accessible to patients and health care providers at all times;

~~(5)~~(3) policies and procedures to ensure compliance with all applicable state and federal laws to protect the confidentiality of individual medical records;

~~(6)~~(4) a copy of the materials designed to inform applicable patients and health care providers of the requirements of the utilization review plan; and

~~(7)~~(5) any other information ~~as~~ that may be required by the commissioner and that is necessary to implement this chapter."

Section 4. Section 33-32-104, MCA, is amended to read:

"33-32-104. Preemption by federal law. If any provision of this chapter is preempted ~~or duplicated~~ by federal law or regulations as applied to any specific health care service, then the provision of this chapter that is preempted ~~or duplicated~~ by federal law or regulations does not apply to that health care service but only to the extent of the preemption ~~or duplication~~."

Section 5. Section 33-32-105, MCA, is amended to read:

"33-32-105. Application -- exemptions. (1) The provisions of this chapter apply to:

~~a person or entity performing utilization reviews who is, or is affiliated with, under contract with, or acting on behalf of:~~

~~(a) a Montana business entity; or~~

~~(b) a third party that provides or administers health care benefits to citizens of this state, including:~~

~~(i) a health insurer, nonprofit health service plan, health service corporation, employees' health and welfare fund, or preferred provider organization authorized to offer health insurance policies or contracts;~~

~~(ii) a health maintenance organization issued a certificate of authority in accordance with Title 33, chapter 31; or~~

~~(iii) a state agency.~~

(a) a health insurance issuer that offers a health plan and provides or performs utilization review services;

(b) any designee of the health insurance issuer or utilization review organization that performs utilization review functions on the health insurance issuer's behalf;

(c) a health insurance issuer or its designated utilization review organization that provides or performs

prospective review or retrospective review benefit determinations; and

(d) the state employee group insurance program, the university system employee group insurance program, any employee group insurance program of a city, town, school district, or other political subdivision of this state, and any self-funded multiple employer welfare arrangement that is subject to licensing requirements under Title 33, chapter 35.

(2) A general in-house utilization review for a health care provider, including an in-house utilization review that is conducted by or for a long-term care facility and that is required by regulations for medicare or medicaid ~~regulations~~, is exempt from the provisions of this chapter as long as the review does not directly result in the approval or denial of payment for health care services for a particular case.

(3) A peer review procedure conducted by a professional society or association of providers is exempt from the provisions of this chapter."

Section 6. Section 33-33-103, MCA, is amended to read:

"33-33-103. Definitions. As used in this chapter, the following definitions apply:

(1) "Utilization review" ~~means the same as~~ has the meaning provided in 33-32-102~~(4)~~.

(2) "Utilization review organization" means an entity that provides utilization review services."

NEW SECTION. **Section 7. Corporate oversight of utilization review program.** A health insurance issuer is responsible for:

(1) monitoring all utilization review activities carried out by or on behalf of the health insurance issuer;

(2) ensuring that all requirements of [sections 7 through 15] and rules adopted pursuant to [sections 7 through 15] are met; and

(3) ensuring that appropriate personnel have operational responsibility for the conduct of the health insurance issuer's utilization review program.

NEW SECTION. **Section 8. Contracting.** Whenever a health insurance issuer contracts with a utilization review organization or other entity to perform the utilization review functions required by [sections 7 through 15] or rules adopted pursuant to [sections 7 through 15], the commissioner shall hold the health insurance issuer responsible for monitoring the activities of the utilization review organization or the entity with which the health insurance issuer has contracted and for ensuring that the requirements of [sections 7 through

15] are met.

NEW SECTION. **Section 9. Health insurance issuer duties regarding utilization review program.** (1) A health insurance issuer that requires a request for benefits under the covered person's health plan to be subjected to utilization review shall implement a utilization review program with written documentation describing all review activities and procedures, both delegated and nondelegated, for:

(a) the filing of benefit requests;

(b) the notification of utilization review and benefit determinations; and

(c) the review of adverse determinations in accordance with [sections 16 through 38].

(2) The written documentation must describe the following:

(a) procedures to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;

(b) data sources and clinical review criteria used in decisionmaking;

(c) mechanisms to ensure consistent application of clinical review criteria and compatible decisions;

(d) data collection processes and analytical methods used in assessing utilization of health care services;

(e) provisions for ensuring confidentiality of clinical and proprietary information;

(f) the organizational structure that periodically assesses utilization review activities and reports to the health insurance issuer's governing body. This organizational structure may include but is not limited to the utilization review committee or a quality assurance committee.

(g) the staff position functionally responsible for day-to-day program management.

(3) A health insurance issuer shall:

(a) file an annual summary report of its utilization review program activities with the commissioner in the format specified by the commissioner;

(b) maintain records for a minimum of 6 years of all benefit requests and claims and notices associated with utilization review and benefit determinations made in accordance with [sections 11 and 12]; and

(c) make the records maintained under subsection (3)(b) available, upon request, for examination by covered persons, the commissioner, and appropriate federal agencies.

NEW SECTION. **Section 10. Operational requirements.** (1) A utilization review program must use clinical review criteria that have been documented to be based on sound clinical evidence and are evaluated

periodically to ensure ongoing efficacy. A health insurance issuer may develop its own clinical review criteria or may purchase or license clinical review criteria from qualified vendors.

(2) A health insurance issuer shall, upon request, make available its clinical review criteria to authorized government agencies, including the commissioner.

(3) Qualified health care professionals shall administer the utilization review program and oversee utilization review decisions. A clinical peer shall evaluate the clinical appropriateness of adverse determinations.

(4) A health insurance issuer shall issue utilization review and benefit determinations in a timely manner pursuant to the requirements of [sections 11 and 12].

(5) (a) Whenever a health insurance issuer fails to strictly adhere to the requirements of [section 11 or 12], as applicable, with respect to conducting a utilization review and making benefit determinations of a benefit request or claim, the covered person is considered to have exhausted the provisions of [sections 7 through 15] and may take action under subsection (5)(b), regardless of whether the health insurance issuer asserts that it substantially complied with the requirements of [section 11 or 12], as applicable, or that any error the health insurance issuer committed was minor.

(b) A covered person may file a request for external review in accordance with the procedures outlined in [sections 16 through 38]. In addition to filing a request, a covered person is entitled to pursue any available remedies under state or federal law if the health insurance issuer failed to provide a reasonable internal claims and appeals process designed to yield a decision on the merits of the claim.

(6) A health insurance issuer shall maintain a process to ensure that utilization reviewers apply clinical review criteria in conducting utilization review consistently.

(7) A health insurance issuer shall routinely assess the effectiveness and efficiency of its utilization review program.

(8) A health insurance issuer's data systems must be sufficient to support utilization review program activities and to generate management reports to enable the health insurance issuer to monitor and manage health care services effectively.

(9) If a health insurance issuer delegates any utilization review activities to a utilization review organization, the health insurance issuer shall maintain adequate oversight, which includes:

(a) a written description of the utilization review organization's activities and responsibilities, including reporting requirements;

(b) evidence of formal approval of the utilization review organization's program by the health insurance

issuer; and

(c) a process by which the health insurance issuer evaluates the performance of the utilization review organization.

(10) The health insurance issuer shall coordinate its utilization review program with other medical management activity conducted by the health insurance issuer, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction, and risk management.

(11) A health insurance issuer shall provide covered persons and participating providers with access to the health insurance issuer's review staff through a toll-free number or collect-call telephone line.

(12) When conducting a utilization review, the health insurance issuer shall collect only the information necessary, including pertinent clinical information, to conduct the utilization review or make the benefit determination.

(13) (a) In conducting a utilization review, the health insurance issuer shall ensure that the review is conducted in a manner that ensures the independence and impartiality of the individuals involved in conducting the utilization review or making the benefit determination.

(b) In ensuring the independence and impartially of individuals involved in the utilization review or benefit determination, the health insurance issuer may not make decisions regarding hiring, compensation, termination, promotion, or other similar matters based upon the likelihood that the individual involved in the utilization review or benefit determination will support the denial of benefits.

NEW SECTION. **Section 11. Procedures for standard utilization review and benefit determinations -- notices.** (1) A health insurance issuer shall establish written procedures, as provided in this section, for conducting standard utilization reviews and making benefit determinations on requests for benefits submitted to the health insurance issuer by covered persons or their authorized representatives. The written procedures must also include provisions for notifying covered persons and their authorized representatives of the health insurance issuer's determinations with respect to these requests within the timeframes specified in this section.

(2) (a) Subject to subsection (2)(c), for prospective review determinations, a health insurance issuer shall make the determination and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether the health insurance issuer certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but not later than

15 days after the date the health insurance issuer receives the request.

(b) Whenever the determination is an adverse determination, the health insurance issuer shall provide notification of the adverse determination in accordance with subsection (8).

(c) The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative of the determination pursuant to subsection (2)(a) may be extended once by the health insurance issuer for up to 15 days if the health insurance issuer:

(i) determines that an extension is necessary due to matters beyond the health insurance issuer's control; and

(ii) notifies the covered person or, if applicable, the covered person's authorized representative, prior to the expiration of the initial 15-day time period, of the circumstances requiring the extension of time and of the date by which the health insurance issuer expects to make a determination.

(d) If the extension under subsection (2)(c) is necessary because of the failure of the covered person or the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension must:

(i) describe specifically the required information necessary to complete the request; and

(ii) give the covered person or, if applicable, the covered person's authorized representative at least 45 days from the date of receipt of the notice to provide the specified information.

(3) (a) Whenever the health insurance issuer receives from a covered person or the covered person's authorized representative a prospective review request that fails to meet the health insurance issuer's filing procedures, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative of this failure and provide in the notice any information regarding the proper procedures to be followed for filing a request.

(b) The notice required under subsection (3)(a) must be provided as soon as possible but no later than 5 days following the date of the failure. The health insurance issuer may provide the notice orally or, if requested by the covered person or the covered person's authorized representative, in writing or electronically.

(c) To qualify for the provisions of this subsection (3) related to a failed filing procedure, the communication must:

(i) have been sent by a covered person or the covered person's authorized representative and received by a person or organizational unit of the health insurance issuer responsible for handling benefit matters; and

(ii) refer to a specific covered person, a specific medical condition or symptom, and a specific health care

service, treatment, or provider for which certification is being requested.

(4) For concurrent review determinations, if a health insurance issuer has certified an ongoing course of treatment to be provided over a period of time or a specified number of treatments:

(a) any reduction or termination by the health insurance issuer during the course of treatment before the end of the period or the specified number of treatments, other than by health plan amendment or termination of the health plan, constitutes an adverse determination; and

(b) the health insurance issuer shall notify the covered person of the adverse determination in accordance with subsection (8) at a time sufficiently in advance of the reduction or termination to allow the covered person or, if applicable, the covered person's authorized representative to:

(i) file a grievance;

(ii) request a review of the adverse determination pursuant to [sections 16 through 38]; and

(iii) obtain a determination with respect to the review of the adverse determination before the benefit is reduced or terminated.

(5) The health care service or treatment that is the subject of the adverse determination must be continued without liability to the covered person pending a determination under the internal review request made pursuant to [sections 16 through 38].

(6) (a) For retrospective review determinations, a health insurance issuer shall make the determination no later than 30 days after the date of receiving the benefit request.

(b) If the determination is an adverse determination, the health insurance issuer shall provide notice of the adverse determination to the covered person or, if applicable, the covered person's authorized representative in accordance with subsection (8).

(c) The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative of the determination pursuant to subsection (6)(a) may be extended one time by the health insurance issuer for up to 15 days if the health insurance issuer:

(i) determines that an extension is necessary due to matters beyond the health insurance issuer's control; and

(ii) notifies the covered person or, if applicable, the covered person's authorized representative, prior to the expiration of the initial 30-day time period, of the circumstances requiring the extension of time and of the date by which the health insurance issuer expects to make a determination.

(d) If the extension under subsection (6)(c) is necessary because of the failure of the covered person or,

if applicable, the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension must:

(i) describe specifically the information required to complete the request; and

(ii) give the covered person or, if applicable, the covered person's authorized representative at least 45 days from the date of receipt of the notice to provide the specified information.

(7) (a) For purposes of this section, the time period within which a determination must be made begins on the date the request is received by the health insurance issuer in accordance with the health insurance issuer's procedures, established pursuant to [section 9], for filing a request. The date of the original request must be counted, without regard to whether all of the information necessary to make the determination accompanies the filing of the request.

(b) If the time period for making the determination under this section is extended due to the failure of the covered person or, if applicable, the covered person's authorized representative to submit the information necessary to make the determination, the time period for making the determination is tolled from the date on which the health insurance issuer sends the notification of the extension to the covered person or, if applicable, the covered person's authorized representative until the earlier of:

(i) the date on which the covered person or, if applicable, the covered person's authorized representative responds to the request for additional information; or

(ii) the date on which the specified information was to have been submitted.

(c) If the covered person or the covered person's authorized representative fails to submit the information before the end of the extension period, as specified in this section, the health insurance issuer may deny the certification of the requested benefit.

(8) A notification of an adverse determination under this section must, in a manner calculated to be understood by the covered person, set forth:

(a) information sufficient to identify the benefit request or claim involved and, if applicable, the date of service, the health care provider, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(b) the specific rationale behind the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health insurance issuer's standard, if any, that was used in denying the benefit request or claim;

(c) a reference to the specific plan provisions on which the determination is based;

(d) a description of any additional material or information necessary for the covered person to complete the benefit request, including an explanation of why the material or information is necessary to complete the request;

(e) a description of the health insurance issuer's grievance procedures established pursuant to [sections 16 through 23], including any time limits applicable to those procedures;

(f) any internal rule, guideline, protocol, or other similar criteria that the health insurance issuer may have relied upon to make the adverse determination or a statement that a specific rule, guideline, protocol, or other similar criteria was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criteria will be provided free of charge to the covered person upon request;

(g) an explanation of the scientific or clinical judgment for making the adverse determination if the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit. Alternatively, the health insurance issuer may provide a statement that an explanation will be provided to the covered person free of charge upon request. The explanation under this subsection (8)(g) must apply the terms of the health plan to the covered person's medical circumstances.

(h) a copy of the rule, guideline, protocol, or other similar criteria relied upon in making the adverse determination, as provided in subsection (8)(f), or the written statement of the scientific or clinical rationale for the adverse determination, as provided in subsection (8)(g); and

(i) a statement explaining the availability of further assistance and the right of the covered person to contact the commissioner's office at any time for assistance or, upon completion of the health insurance issuer's grievance procedure process as provided under [sections 16 through 38], to file a civil suit in a court of competent jurisdiction. The statement must include contact information for the commissioner's office.

(9) (a) A health insurance issuer shall provide the notice required under this section in a culturally and linguistically appropriate manner as required in accordance with federal regulations, including 45 CFR 147.136(e), and rules adopted pursuant to [sections 16 through 23].

(b) To satisfy the provisions of subsection (9)(a), the health insurance issuer shall, at a minimum:

(i) include in the English version of the notice a prominently displayed statement offering the provision of the notice in a language other than English;

(ii) provide all subsequent notices to the covered person in the language requested by the covered person, if applicable; and

(iii) provide further assistance in the language requested by the covered person, if applicable, to the

extent the health insurance issuer maintains a consumer assistance process, such as a telephone hotline used to answer questions or provide assistance with filing claims and appeals.

(10) If the adverse determination is a rescission, the health insurance issuer shall provide, in addition to any applicable disclosures required under this section, in a notice sent at least 30 days in advance of implementing the rescission decision:

(a) clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;

(b) an explanation for why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;

(c) the date when the advance notice period ends and the date to which the coverage is to be retroactively rescinded;

(d) notice that the covered person or the covered person's authorized representative may immediately file a grievance with the health insurance issuer requesting a review of the rescission; and

(e) a description of the health insurance issuer's grievance procedures, including any time limits applicable to those procedures.

(11) A health insurance issuer may provide the notices required under this section in writing or electronically.

NEW SECTION. **Section 12. Procedures for expedited utilization review and benefit determinations.** (1) With respect to urgent care requests and concurrent review urgent care requests, a health insurance issuer shall establish written procedures for receiving benefit requests from covered persons or their authorized representatives, for conducting an expedited utilization review and making benefit determinations, and for notifying the covered persons or their authorized representatives of the expedited utilization review and benefit determinations.

(2) (a) The procedures established under subsection (1) must include a requirement for the health insurance issuer to provide that, in the case of a failure by a covered person or the covered person's authorized representative to follow the health insurance issuer's procedures for filing an urgent care request, the covered person or the covered person's authorized representative must be notified of the failure and the proper procedures to be following for filing the request.

(b) The notice required under subsection (2)(a):

(i) must be provided to the covered person or the covered person's authorized representative, as appropriate, not later than 24 hours after receipt of the request; and

(ii) may be made orally, unless the covered person or the covered person's authorized representative requests the notice in writing or electronically.

(c) To qualify for the provisions of this subsection (2) related to a failed filing procedure, the communication must:

(i) be sent by a covered person or, if applicable, the covered person's authorized representative and received by a person or organizational unit of the health insurance issuer responsible for handling benefit matters; and

(ii) contain a reference to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment, or provider for which approval is being requested.

(3) (a) For an urgent care request, unless the covered person or the covered person's authorized representative has failed to provide sufficient information for the health insurance issuer to determine whether or to what extent the benefits requested are covered benefits or payable under the health insurance issuer's health plan, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative as soon as possible, taking into account the medical condition of the covered person, but no later than 24 hours after the receipt of the request by the health insurance issuer.

(b) With respect to the request, the health insurance issuer shall state in the notification whether or not the determination is an adverse determination. If the health insurance issuer's determination is an adverse determination, the notice must comply with the provisions of subsection (8).

(4) (a) If the covered person or, if applicable, the covered person's authorized representative has failed to provide sufficient information for the health insurance issuer to make a determination, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative either orally or, if requested by the covered person or the covered person's authorized representative, in writing or electronically of this failure and identify what specific information is needed as soon as possible, but not later than 24 hours after receipt of the request.

(b) The health insurance issuer shall, taking into account the circumstances, provide the covered person or, if applicable, the covered person's authorized representative with a reasonable period of time to submit the necessary information. The reasonable period may not be less than 48 hours after the health insurance issuer notifies the covered person or the covered person's authorized representative of the failure to submit sufficient

information as provided in subsection (4)(a).

(c) A health insurance issuer shall, in cases in which more information is required as provided in subsection (4)(a), notify the covered person or, if applicable, the covered person's authorized representative of its determination with respect to the urgent care request as soon as possible but no more than 48 hours after the earlier of:

(i) the health insurance issuer's receipt of the requested information; or

(ii) the end of the period provided for the covered person or, if applicable, the covered person's authorized representative to submit the requested information.

(d) If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in subsection (4)(b), the health insurance issuer may deny the certification of the requested benefit.

(e) If the health insurance issuer's determination is an adverse determination, the health insurance issuer shall provide notice of the adverse determination in accordance with subsection (8).

(5) For concurrent review urgent care requests involving a request by the covered person or the covered person's authorized representative to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the health insurance issuer shall make a determination with respect to the request and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but no more than 24 hours after the health insurance issuer's receipt of the request.

(6) If the health insurance issuer's determination is an adverse determination, the health insurance issuer shall provide notice of the adverse determination as provided in subsection (8).

(7) For the purposes of this section, the time period within which a determination must be made begins on the date the request is filed with the health insurance issuer in accordance with the health insurance issuer's procedures established pursuant to [section 9] for filing a request. The date of the original request must be counted, without regard to whether all of the information necessary to make the determination accompanies the filing of the request.

(8) A notification of an adverse determination under this section must, in a manner calculated to be understood by the covered person, set forth:

(a) information sufficient to identify the benefit request or claim involved and, if applicable, the date of

service, the health care provider, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(b) the specific rationale behind the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health insurance issuer's standard, if any, that was used in denying the benefit request or claim;

(c) a reference to the specific plan provisions on which the determination is based;

(d) a description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(e) a description of the health insurance issuer's internal review procedures established pursuant to [sections 16 through 23], including any time limits applicable to those procedures;

(f) a description of the health insurance issuer's expedited grievance procedures established pursuant to [sections 16 through 23], including any time limits applicable to those procedures;

(g) any internal rule, guideline, protocol, or other similar criteria that the health insurance issuer may have relied upon to make the adverse determination or a statement that a specific rule, guideline, protocol, or other similar criteria was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criteria will be provided free of charge to the covered person upon request;

(h) an explanation of the scientific or clinical judgment for making the adverse determination if the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, applying the terms of the health plan to the covered person's medical circumstances. Alternatively, the health insurance issuer may provide a statement that an explanation will be provided to the covered person free of charge upon request.

(i) a list of instructions for requesting:

(i) a copy of the rule, guideline, protocol, or other similar criteria relied upon in making the adverse determination in accordance with subsection (8)(g); or

(ii) the written statement of the scientific or clinical rationale for the adverse determination in accordance with subsection (8)(h); and

(j) a statement explaining the availability of assistance from the commissioner's office and the right of the covered person to contact the commissioner's office at any time for assistance or, upon completion of the health insurance issuer's grievance procedure process as provided under [sections 16 through 23], to file a civil suit in a court of competent jurisdiction. The statement must include contact information for the commissioner's

office.

(9) A health insurance issuer shall provide the notice required under this section in the manner provided in [section 11(9)].

(10) (a) A health insurance issuer may provide the notice required under this section orally, in writing, or electronically.

(b) If notice of the adverse determination is provided orally, the health insurance issuer shall provide written or electronic notice of the adverse determination within 3 days following the oral notification.

NEW SECTION. **Section 13. Emergency services.** (1) When conducting a utilization review or making a benefit determination for emergency services, a health insurance issuer that provides benefits for services in an emergency department of a hospital shall follow the provisions of this section.

(2) A health insurance issuer shall cover emergency services that screen and stabilize a covered person:

(a) without the need for prior authorization of the emergency services if a prudent lay person would have reasonably believed that an emergency medical condition existed even if the emergency services are provided on an out-of-network basis;

(b) without regard to whether the health care provider furnishing the services is a participating provider with respect to the emergency services;

(c) if the emergency services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from network providers;

(d) if the emergency services are provided out-of-network, by complying with the cost-sharing requirements in subsection (4); and

(e) without regard to any other term or condition of coverage, other than:

(i) the exclusion of or coordination of benefits;

(ii) an affiliation or waiting period as permitted under 42 U.S.C. 300gg-19a; or

(iii) cost-sharing, as provided in subsection (4)(a) or (4)(b), as applicable.

(3) For in-network emergency services, coverage of emergency services is subject to applicable copayments, coinsurance, and deductibles.

(4) (a) Except as provided in subsection (4)(b), for out-of-network emergency services, any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a covered person

may not exceed the cost-sharing requirement for a covered person if the services were provided in-network.

(b) A covered person may be required to pay, in addition to the in-network cost-sharing expenses, the excess amount the out-of-network provider charges that exceeds the amount the health insurance issuer is required to pay under this subsection (4).

(c) A health insurance issuer complies with the requirements of this section by paying for emergency services provided by an out-of-network provider in an amount not less than the greatest of the following and taking into account exceptions in subsections (4)(d) and (4)(e):

(i) the amount negotiated with in-network providers for emergency services, excluding any in-network copayment or coinsurance imposed with respect to the covered person;

(ii) the amount of the emergency service calculated using the same method the plan uses to determine payments for out-of-
network services but using the in-network cost-sharing provisions instead of the out-of-network cost-sharing provisions; or

(iii) the amount that would be paid under medicare for the emergency services, excluding any in-network copayment or coinsurance requirements.

(d) For capitated or other health plans that do not have a negotiated charge for each service for in-network providers, subsection (4)(c)(i) does not apply.

(e) If a health plan has more than one negotiated amount for in-network providers for a particular emergency service, the amount in subsection (4)(c)(i) is the median of those negotiated amounts.

(5) (a) Any cost-sharing requirement, other than a copayment or coinsurance requirement such as a deductible or out-of-pocket maximum, may be imposed with respect to emergency services that are provided out-of-network if the cost-sharing requirement generally applies to out-of-network benefits.

(b) A deductible may be imposed with respect to out-of-network emergency services only as part of a deductible that generally applies to out-of-network benefits.

(c) If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-network maximum must apply to out-of-network emergency services.

(6) For an immediately required postevaluation or poststabilization services review, a health insurance issuer shall provide access to a designated representative 24 hours a day, 7 days a week, to facilitate the review.

NEW SECTION. **Section 14. Confidentiality.** A health insurance issuer and its designee shall comply

with all applicable state and federal laws establishing confidentiality and reporting requirements with regard to its utilization review program, including the provisions of Title 33, chapter 19, and 45 CFR, parts 160 and 164.

NEW SECTION. **Section 15. Disclosure.** (1) In the certificate of coverage or member handbook provided to covered persons, a health insurance issuer shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations, and a statement of the rights and responsibilities of covered persons with respect to those procedures.

(2) A health insurance issuer shall include a summary of its utilization review procedures and benefit determination procedures in materials intended for prospective covered persons.

(3) A health insurance issuer shall print on its membership cards a toll-free telephone number to call for utilization review and benefit decisions.

NEW SECTION. **Section 16. Short title.** [Sections 16 through 38] may be cited as the "Health Insurance Issuer Grievance Procedures and External Review Act".

NEW SECTION. **Section 17. Applicability and scope.** (1) Except as provided in subsection (2), [sections 16 through 38] apply to all health insurance issuers, the state employee group insurance program, the university system employee group insurance program, any employee group insurance program of a city, town, school district, or other political subdivision of this state, and any self-funded multiple employer welfare arrangement that is subject to the licensing requirements under Title 33, chapter 35.

(2) The provisions of [sections 16 through 38] do not apply to:

(a) a policy or certificate that provides coverage only for a specified disease or specified accident, accident-only coverage, credit insurance as described in 33-1-206, dental, disability income, or hospital indemnity insurance, long-term care insurance as defined by 33-22-1107, vision care insurance, or any other limited supplemental benefit;

(b) a medicare supplement policy as defined by 33-22-903;

(c) coverage under a plan through medicare or medicaid or any coverage issued under Title 10, chapter 55, of the United States Code and any coverage issued as supplement to that coverage;

(d) any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, or any insurance under which benefits are payable with or

without regard to fault, whether written on a group blanket basis or an individual basis.

NEW SECTION. **Section 18. Purpose.** The purpose of [sections 16 through 23] is to provide standards for the establishment and maintenance of procedures by health insurance issuers to ensure that covered persons have the opportunity for the appropriate resolution of grievances.

NEW SECTION. **Section 19. Definitions for grievance procedures.** For the purposes of [sections 16 through 23], the following definitions apply:

(1) "Adverse determination" has the meaning provided in 33-32-102.

(2) "Closed plan" means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan.

(3) "Health indemnity plan" means a health plan that is not a managed care plan.

(4) "Managed care plan" means a health plan that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by a health insurance issuer. The term includes a closed plan and an open plan.

(5) "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

(6) "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health insurance issuer's requirement that the health care service or course of treatment, in whole or in part, be approved prior to the admission, service, or treatment.

(7) "Register" means the written record of grievances received by a health insurance issuer that includes the notices and claims associated with the grievances as required by [section 20].

NEW SECTION. **Section 20. Grievance reporting and recordkeeping requirements.** (1) A health insurance issuer shall maintain within a register all written records that document grievances received during a calendar year, including the notices and claims associated with the grievances.

(2) Retention of the records in the register must be as provided in subsection (6), except that a health insurance issuer shall maintain for at least 6 years those records specified by the commissioner by rule.

(3) A health insurance issuer shall:

(a) maintain the records in a manner that is reasonably clear and accessible to the commissioner; and

(b) make the records available for examination, upon request, by covered persons, the commissioner, and any appropriate federal oversight agency.

(4) A request for a review of a grievance involving an adverse determination must be processed in compliance with [section 22] and must be included in the register.

(5) For each grievance, the register must contain, at a minimum, the following information:

(a) a general description of the reason for the grievance;

(b) the date received;

(c) the date of each review or, if applicable, review meeting;

(d) a report on the resolution of the grievance, if applicable;

(e) the date of the resolution, if applicable; and

(f) the name of the covered person for whom the grievance was filed.

(6) Subject to the provisions of subsection (2), a health insurance issuer shall retain the register compiled for a calendar year for 3 years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year, whichever is longer.

(7) (a) At least annually, a health insurance issuer shall submit to the commissioner a report in the format specified by the commissioner.

(b) The report must include for each type of health plan offered by the health insurance issuer:

(i) the certificate of compliance required by [section 21(3)(b)];

(ii) the number of covered persons;

(iii) the total number of grievances;

(iv) the number of grievances resolved, if applicable, and their resolution;

(v) the number of grievances of which the health insurance issuer has been informed that were appealed to the commissioner;

(vi) the number of grievances referred to an alternative dispute resolution procedure or resulting in litigation; and

(vii) a synopsis of actions taken or being taken to correct problems that have been identified.

NEW SECTION. **Section 21. Grievance review procedures.** (1) Except as specified in [section 23], a health insurance issuer shall use written procedures for receiving and resolving grievances from covered

persons as provided in [section 22].

(2) (a) Whenever a health insurance issuer fails to strictly adhere to the requirements of [section 22 or 23], as applicable, with respect to receiving and resolving grievances involving an adverse determination or waives the review of the grievance, the covered person is considered to have exhausted the provisions of [sections 16 through 23] and may take action under subsection (2)(b) regardless of whether the health insurance issuer asserts that it substantially complied with the requirements of [section 22 or 23], as applicable, or that any error the health insurance issuer committed was minor.

(b) (i) A covered person may file a request for external review in accordance with the procedures outlined in [sections 24 through 38].

(ii) In addition to filing a request under subsection (2)(b)(i), a covered person is entitled to pursue any available remedies under state or federal law on the basis that the health insurance issuer failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

(3) A health insurance issuer shall file with the commissioner:

(a) a copy of the procedures required under subsection (1), including all forms used to process requests made pursuant to [section 22]. Any subsequent material modifications to the documents must also be filed.

(b) as part of the annual report required by [section 20(7)], a certificate of compliance stating that the health insurance issuer has established and maintains for each of its health plans a set of grievance procedures that fully comply with the provisions of [sections 16 through 23]; and

(c) a description of the grievance procedures required under this section, which must be included in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons. The grievance procedure documents must include a statement of a covered person's right to contact the commissioner's office for assistance at any time. The statement must include the telephone number and address of the commissioner's office.

(4) The commissioner may disapprove a filing received in accordance with subsection (3) if the filing fails to comply with [sections 16 through 23] or applicable federal regulations.

NEW SECTION. **Section 22. Grievances involving an adverse determination.** (1) Within 180 days after the date of receipt of a notice of an adverse determination sent pursuant to [sections 7 through 15], a covered person or the covered person's authorized representative may file a grievance with the health insurance issuer requesting a review of the adverse determination.

(2) The health insurance issuer shall provide the covered person with the name, address, and telephone number of a person or organizational unit designated to coordinate the review on behalf of the health insurance issuer.

(3) (a) In providing for a review under this section, the health insurance issuer shall ensure that the review meets the requirements of this section and is conducted in a manner that ensures the independence and impartiality of the individuals involved in making the review decision.

(b) To ensure the independence and impartially of individuals involved in making the review decision, the health insurance issuer may not make hiring, compensation, termination, promotion, or other similar decisions related to any of those individuals based upon the likelihood that the individual will support the denial of benefits.

(4) (a) In the case of an adverse determination involving utilization review, the health insurance issuer shall designate one or more appropriate clinical peers to review the adverse determination. A clinical peer may not have been involved in the initial adverse determination.

(b) In designating an appropriate clinical peer pursuant to subsection (4)(a), the health insurance issuer shall ensure that if more than one clinical peer is involved in the review, a majority of the individuals reviewing the adverse determination are health care professionals who have appropriate expertise.

(5) In conducting a review under subsection (4), each clinical reviewer shall take into consideration all comments, documents, records, and other information regarding the request for services submitted by the covered person or the covered person's authorized representative without regard to whether the information was submitted or considered in making the initial adverse determination.

(6) (a) A covered person does not have the right to attend or to have a representative in attendance at the review, but the covered person or, if applicable, the covered person's authorized representative is entitled to:

(i) submit written comments, documents, records, and other material relating to the request for benefits for the reviewer or reviewers to consider when conducting the review; and

(ii) receive from the health insurance issuer, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the covered person's request for benefits.

(b) For the purposes of subsections (6)(a) and (11)(e)(iii), the term "relevant" in relation to a document, record, or other information related to a covered person's request for benefits means the document, record, or other information:

(i) was relied upon in making the benefit determination;

(ii) was submitted, considered, or generated in the course of making the adverse determination without

regard to whether the document, record, or other information was relied upon in making the benefit determination;

(iii) was used to demonstrate that in making the benefit determination, the health insurance issuer or its designated representatives consistently applied to the covered person the required administrative procedures and safeguards used for other similarly situated covered persons; or

(iv) constituted a statement of policy or guidance with respect to the health plan concerning the denied health care service or treatment for the covered person's diagnosis without regard to whether the advice or statement was relied upon in making the benefit determination.

(7) The health insurance issuer shall make the provisions of subsection (6) known to the covered person or, if applicable, the covered person's authorized representative within 3 working days after the date of receipt of the grievance.

(8) For the purposes of calculating the time periods within which a determination must be made and noticed under subsection (9), the time period begins on the date the request for a grievance review is filed with the health insurance issuer in accordance with the health insurance issuer's procedures for filing requests established pursuant to [section 21] without regard to whether all of the information necessary to make the determination accompanies the filing.

(9) A health insurance issuer shall notify and issue a decision in writing or electronically to the covered person or, if applicable, the covered person's authorized representative within the applicable timeframe provided below:

(a) with respect to a grievance requesting a review of an adverse determination involving a prospective review request, the health insurance issuer shall issue a decision and send notification as provided in this section within a reasonable period of time that is appropriate considering the covered person's medical condition but no later than 30 days after the date on which the health insurance issuer received the grievance request for the review made pursuant to subsection (1); or

(b) with respect to a grievance requesting a review of an adverse determination involving a retrospective review request, the health insurance issuer shall issue a decision and send notification as provided in this section within a reasonable period of time but no later than 60 days after the date on which the health insurance issuer received the grievance request for the review made pursuant to subsection (1).

(10) Prior to issuing a decision or final adverse determination in accordance with the timeframes provided in subsection (9) and sufficiently in advance of the required date for a decision or final adverse determination to allow the covered person or the covered person's authorized representative a reasonable opportunity to respond

prior to the date of the decision or final adverse determination, the health insurance issuer shall provide free of charge to the covered person or the covered person's authorized representative:

(a) any new or additional relevant evidence relied upon or generated by the health insurance issuer or at the health insurance issuer's direction in connection with the grievance;

(b) in relation to the issuance and notice of a final adverse determination based on new or additional rationale, the new or additional rationale.

(11) The decision issued pursuant to subsection (9) must specify in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative, the following:

(a) the titles and qualifying credentials of each person participating in the review process;

(b) information sufficient to identify the claim involved with respect to the grievance, including as applicable the date of service, the health care provider, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(c) a statement from the persons participating in the review of their understanding of the covered person's grievance;

(d) the decision of the persons conducting the review, provided in clear terms, and the contract basis or medical rationale on which the decision was based, provided in sufficient detail for the covered person to respond further to the health insurance issuer's position;

(e) a reference to the evidence or documentation used as the basis for the decision. The information required under this subsection (11)(e) must also include for a review decision issued pursuant to subsection (9) that upholds an adverse determination:

(i) all specific reasons that uphold the final internal adverse determination, including the denial code and its corresponding meaning, as well as a description of the health insurance issuer's standard, if any, that was used in reaching the denial;

(ii) the reference to the specific plan provisions on which the adverse determination is based;

(iii) a statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the covered person's benefit request;

(iv) a copy of any specific rule, guideline, protocol, or other similar criteria if relied upon by the health insurance issuer to make the final adverse determination or a statement that a specific rule, guideline, protocol, or other similar criteria was relied upon to make the final adverse determination and that a copy of the rule,

guideline, protocol, or other similar criteria is available free of charge to the covered person upon request;

(v) an explanation of the scientific or clinical judgment used for making the adverse determination if the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit. The explanation must apply the terms of the health plan to the covered person's medical circumstances. Alternatively, the health insurance issuer may provide a statement that an explanation is available to the covered person free of charge upon request.

(vi) instructions for requesting all of the following that are applicable:

(A) a copy of the rule, guideline, protocol, or other similar criteria relied upon in making the final adverse determination, as provided in subsection (11)(e)(iv); and

(B) the written statement of the scientific or clinical rationale for the determination, as provided in subsection (11)(e)(v);

(vii) a statement, if applicable, indicating:

(A) a description of the procedures for obtaining an independent external review of the final adverse determination pursuant to [sections 24 through 38]; and

(B) the covered person's right to bring a civil action in a court of competent jurisdiction;

(viii) the following statement, if applicable:

"You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state insurance commissioner."

(ix) notice of the covered person's right to contact the commissioner's office for assistance on any claim, grievance, or appeal at any time, including the telephone number and address of the commissioner's office. The notice under this subsection (11)(e)(ix) must be provided in accordance with federal regulations and as provided in [section 11(9)].

NEW SECTION. **Section 23. Expedited review of grievance involving an adverse determination.** (1) A health insurance issuer shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination.

(2) A health insurance issuer shall provide an expedited review of a grievance involving an adverse determination with respect to a concurrent review of an urgent care request involving an admission, availability of care, continued stay, or health care service for a covered person who has received emergency services but has not been discharged from a facility. The procedures in subsection (1) must also specify the process for the

concurrent review of urgent care requests under this subsection (2).

(3) The procedures under this section must provide that a covered person or the covered person's authorized representative may request an expedited review orally, in writing, or electronically.

(4) Upon receipt of a request for an expedited review, a health insurance issuer shall appoint one or more appropriate clinical peers to review the adverse determination. An appointed clinical peer may not have been involved in making the initial adverse determination.

(5) In an expedited review, all necessary information, including the health insurance issuer's decision, must be transmitted between the health insurance issuer and the covered person or, if applicable, the covered person's authorized representative in the most expeditious method available, whether by telephone, facsimile, or other method.

(6) (a) The timeframe for making a decision under an expedited review and notification, as provided in subsection (8), must be as expeditious as the covered person's medical condition requires but may take no more than 72 hours after the receipt of the request for the expedited review.

(b) If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review urgent care request, the health insurance issuer shall continue the health care service without liability to the covered person until the covered person has been notified of the determination.

(7) For purposes of calculating the timeframe within which a decision is required to be made under subsection (6), the time period within which the decision must be made begins on the date the request is filed with the health insurance issuer in accordance with the health insurance issuer's procedures for filing requests established under [section 21] without regard to whether all of the information necessary to make the determination accompanies the filing.

(8) A notification of a decision under this section must be in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative, and if necessary meet the requirements of subsection (9). The notification must include:

(a) the titles and qualifying credentials of each person participating in the expedited review process;

(b) information sufficient to identify the claim involved with respect to the grievance, including as applicable the date of service, the health care provider, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(c) a statement of the reviewers' understanding of the covered person's grievance;

(d) a description in clear terms of the decision of the reviewers and the contract basis or medical

rationale in sufficient detail for the covered person to respond further to the health insurance issuer's position;

(e) a reference to the evidence or documentation used as the basis for the decision. If the decision involves an adverse determination, the notice must provide:

(i) all specific reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health insurance issuer's standard, if any, that was used in reaching the denial;

(ii) the reference to the specific plan provisions on which the determination is based;

(iii) if the adverse determination is based on incomplete documentation, a description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(iv) a copy of any internal rule, guideline, protocol, or other similar criteria if relied upon by the health insurance issuer to make the adverse determination or a statement that a specific rule, guideline, protocol, or other similar criteria was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criteria is available free of charge to the covered person upon request;

(v) an explanation of the scientific or clinical judgment used for making the adverse determination if the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit. The explanation must apply the terms of the health plan to the covered person's medical circumstances. Alternatively, the health insurance issuer may provide a statement that an explanation is available to the covered person free of charge upon request.

(vi) instructions for requesting all of the following that are applicable:

(A) a copy of the rule, guideline, protocol, or other similar criteria relied upon in making the adverse determination in accordance with subsection (8)(e)(iv); or

(B) the written statement of the scientific or clinical rationale for the adverse determination in accordance with subsection (8)(e)(v);

(vii) a statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to [sections 24 through 38];

(viii) the following statement:

"You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state insurance commissioner."

(ix) a statement indicating the covered person's right to bring a civil action in a court of competent

jurisdiction; and

(x) a notice of the covered person's right to contact the commissioner's office for assistance at any time, including the telephone number and address of the commissioner's office.

(9) The notice under subsection (8)(e) must be provided in accordance with federal regulations and as provided in [section 11(9)].

(10) (a) A health insurance issuer may provide the notice required under this section orally, in writing, or electronically.

(b) If notice of the adverse determination is provided orally, the health insurance issuer shall provide written or electronic notice of the adverse determination within 3 days of the oral notification.

NEW SECTION. **Section 24. Purpose.** The purpose of [sections 24 through 38] is to provide uniform standards for the establishment and maintenance of external review procedures to ensure that covered persons have the opportunity for an independent review of an adverse determination or a final adverse determination.

NEW SECTION. **Section 25. Definitions for external review.** For the purposes of [sections 24 through 38], the following definitions apply:

(1) "Adverse determination" means a determination by a health insurance issuer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or level of effectiveness and as a result the requested service or payment for the service has been denied, reduced, or terminated.

(2) "Best evidence" means evidence based on:

(a) randomized clinical trials;

(b) a cohort study or case-control study if randomized clinical trials are not available;

(c) a case series if information for subsection (2)(a) or (2)(b) is unavailable; or

(d) an expert opinion if information from subsection (2)(a), (2)(b), or (2)(c) is unavailable.

(3) "Case-control study" means a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

(4) "Case series" means an evaluation of a series of patients with a particular outcome, without the use

of a control group.

(5) "Cohort study" means a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention.

(6) "Disclose" means to release, transfer, or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

(7) "Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

(8) "Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

(9) "Health information" means information or data, whether oral or recorded in any form or medium, including personal facts or information about events or relationships that relate to:

(a) the past, present, or future physical, mental, or behavioral health or condition of a covered person or a member of the covered person's family;

(b) the provision of health care services to a covered person; or

(c) payment for the provision of health care services to a covered person.

(10) "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

(11) "Medical or scientific evidence" means evidence found in 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 and Excerpta Medica, published by the Reed Elsevier group;

(c) medical journals recognized by the secretary of health and human services under 42 U.S.C. 1861(t)(2) of the federal Social Security Act;

(d) the following standard reference compendia:

(i) the American Hospital Formulary Service drug information;

(ii) Drug Facts and Comparisons;

(iii) the American Dental Association Guide to Dental Therapeutics; and

(iv) the United States Pharmacopeia;

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

(i) the federal agency for healthcare research and quality;

(ii) the national institutes of health;

(iii) the national cancer institute;

(iv) the national academy of sciences;

(v) the centers for medicare and medicaid services;

(vi) the food and drug administration; and

(vii) any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services; or

(f) any other medical or scientific evidence that is comparable to the sources listed in subsections (11)(d) or (11)(e).

(12) "NAIC" means the national association of insurance commissioners.

(13) "Protected health information" means health information:

(a) that identifies an individual who is the subject of the information; or

(b) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(14) "Randomized clinical trial" means a controlled, prospective study of patients who have been assigned at random to an experimental group or a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention. The term includes a study of the groups for variables and anticipated outcomes over time.

NEW SECTION. **Section 26. Notice of right to external review.** (1) A health insurance issuer shall:

(a) notify the covered person in writing of the covered person's right to request an external review pursuant to [section 29, 30, or 31]; and

(b) include the appropriate statements and information described in subsection (2) at the same time the health insurance issuer sends written notice of:

(i) an adverse determination upon completion of the health insurance issuer's utilization review process described in [sections 7 through 15]; and

(ii) a final adverse determination.

(2) The health insurance issuer shall include in the written notice required under subsection (1) the following, or substantially equivalent, language:

"We have denied your request for the provision of or payment for a health care service or course of treatment. You have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or level of effectiveness of the health care service or treatment you requested. You may exercise this right by submitting a request for external review to the office of the insurance commissioner [insert address and telephone number of the office of the insurance commissioner]."

(3) The commissioner may prescribe the form and content of the notice required under this section.

(4) The health insurance issuer shall include in the notice required under subsection (1) a statement that:

(a) for a notice related to an adverse determination:

(i) the covered person or the covered person's authorized representative may file a grievance under the health insurance issuer's internal grievance process provided for in [section 22];

(ii) if the health insurance issuer has not issued a written decision to the covered person or the covered person's authorized representative within 30 days of the date the covered person or the covered person's authorized representative files the grievance with the health insurance issuer and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review pursuant to [section 27]. Under those conditions, the covered person or the covered person's representatives is considered to have exhausted the health insurance issuer's internal grievance process for the purposes of [section 21].

(iii) the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to [section 30 or 31], as applicable, under the following circumstances:

(A) a review under [section 30] may be requested if the covered person has a medical condition with regard to which the timeframe for completion of an expedited review of an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(B) a review under [section 31] may be requested if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated. The physician's certification must be at the same time the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination. However, the independent review organization assigned to conduct the expedited external review is responsible for determining whether the covered person is required to complete the expedited review of the grievance before the expedited external review can begin.

(b) for a notice related to a final adverse determination, the covered person or the covered person's authorized representative may file a request for:

(i) an expedited external review under [section 30] if the covered person has a medical condition for which the timeframe for completion of a standard external review under [section 29] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function;

(ii) an expedited external review under [section 30] if the covered person has received emergency services and has not been discharged from a facility and the request concerns an admission, the availability of care, a continued stay, or a health care service for which the covered person received emergency services;

(iii) a standard external review under [section 29] if the denial of coverage was based on a determination that the recommended or requested health care service or treatment is experimental or investigational; or

(iv) an expedited external review under [section 30] if a covered person to which subsection (4)(b)(iii) applies attaches a written certification from the covered person's treating health care provider that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(5) In addition to the information to be provided in subsections (1) and (2), the health insurance issuer shall include a description of both the standard and the expedited external review procedures as required by the disclosure requirements under [section 38], highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

(6) Among the forms provided under this section, the health insurance issuer shall include an

authorization form or other document approved by the commissioner that complies with the requirements of 45 CFR 164.508 and 33-19-206, by which the covered person, for purposes of conducting an external review under [sections 24 through 38], authorizes the health insurance issuer and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person for the purposes of the external review.

NEW SECTION. **Section 27. Request for external review.** (1) Except for a request for an expedited external review provided for in [section 30], all requests for an external review must be made in writing to the commissioner.

(2) The commissioner may prescribe the form and content of external review requests submitted under this section.

(3) A covered person or the covered person's authorized representative may make a request for an external review of an adverse determination or final adverse determination.

NEW SECTION. **Section 28. Exhaustion of internal grievance process.** (1) Except as provided in subsections (2), (4), and (5), a request for an external review pursuant to [section 29, 30, or 31] may not be made until the covered person has exhausted the health insurance issuer's internal grievance process provided for in [sections 16 through 23].

(2) For the purposes of this section, a covered person is considered to have exhausted the health insurance issuer's internal grievance process if the covered person or the covered person's authorized representative:

(a) has filed a grievance involving an adverse determination pursuant to [section 22]; and

(b) has not received a written decision on the grievance from the health insurance issuer within 30 days following the date the covered person or the covered person's authorized representative filed the grievance with the health insurance issuer except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay.

(3) Except as provided in subsection (2), a covered person or the covered person's authorized representative may not request an external review of an adverse determination involving a retrospective review determination made pursuant to [sections 16 through 23] until the covered person has exhausted the health insurance issuer's internal grievance process.

(4) (a) At the same time a covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination under [section 22], the covered person or the covered person's authorized representative may file a request for an expedited external review of the adverse determination:

(i) under [section 30] if the covered person has a medical condition for which the timeframe for completion of an expedited review of the grievance involving an adverse determination provided for in [section 22] would seriously jeopardize the life or the health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(ii) under [section 31] if the adverse determination involves a denial of coverage based on a determination that:

(A) the recommended or requested health care service or treatment is experimental or investigational; and

(B) the covered person's treating health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.

(b) Upon receipt of a request for an expedited external review under subsection (4)(a), the independent review organization conducting the external review as provided under [section 30 or 31] shall determine whether the covered person must be required to complete the expedited review process for grievances provided for in [section 23] before an expedited external review can be conducted.

(c) Upon a determination made pursuant to subsection (4)(b) that the covered person must first be required to complete the expedited grievance review process provided for in [section 23], the independent review organization shall immediately notify the covered person and, if applicable, the covered person's authorized representative of this determination. The notification also must state that the independent review organization will not proceed with the expedited external review under [section 30] until:

(i) the expedited grievance review process under [section 23] is completed; and

(ii) the covered person's grievance at the completion of the expedited grievance review process remains unresolved.

(5) A request for an external review of an adverse determination may be made before the covered person has exhausted the health insurance issuer's internal grievance procedures as provided in [section 21] whenever the health insurance issuer agrees to waive the exhaustion requirement.

(6) If the requirement to exhaust the health insurance issuer's internal grievance procedures is waived under subsection (5), the covered person or the covered person's authorized representative may file a request in writing for a standard external review under [section 29 or 30], as applicable.

NEW SECTION. **Section 29. Standard external review.** (1) Within 6 months of the date of receipt of a notice of an adverse determination or final adverse determination pursuant to [section 26], a covered person or the covered person's authorized representative may file a request for an external review with the commissioner.

(2) Within 1 business day after the date of receipt of a request for external review, the commissioner shall send a copy of the request to the health insurance issuer.

(3) Within 5 business days of the date of receipt of the copy of the external review request from the commissioner, the health insurance issuer shall complete a preliminary review of the request to determine whether:

(a) the individual is or was a covered person in the health plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health plan at the time the health care service was provided;

(b) the health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health plan but is not covered because of a determination by the health insurance issuer that the health care service does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or level of effectiveness;

(c) the covered person has exhausted the health insurance issuer's internal grievance process as set forth in [sections 16 through 23] or the covered person is exempt under [section 21(2)]; and

(d) the covered person has provided all the information and forms required to process an external review.

(4) Within 1 business day after completion of the preliminary review, the health insurance issuer shall notify the commissioner and the covered person and, if applicable, the covered person's authorized representative in writing as to whether:

(a) the request is complete; and

(b) the request is eligible for external review.

(5) (a) If the request is not complete, the health insurance issuer shall inform the commissioner, the

covered person, and, if applicable, the covered person's authorized representative in writing and include in the notice the information or materials that are needed to make the request complete.

(b) If the request is not eligible for external review, the health insurance issuer shall inform the covered person, the covered person's authorized representative, if applicable, and the commissioner in writing and include in the notice the reasons for its ineligibility.

(6) (a) The commissioner may specify the form for the health insurance issuer's notice of initial determination under this section and any supporting information to be included in the notice.

(b) The notice of initial determination must include a statement informing the covered person and, if applicable, the covered person's authorized representative of the right to appeal to the commissioner a health insurance issuer's initial determination that the external review request is ineligible for review.

(7) (a) If the commissioner receives a request under [section 27(3)], the commissioner may require a referral for external review, notwithstanding a health insurance issuer's initial determination that the request is ineligible.

(b) A determination by the commissioner under subsection (7)(a) must be based on the terms of the covered person's health plan and all applicable provisions of [sections 7 through 38].

(8) Whenever the commissioner receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection (4), the commissioner shall within 1 business day after the date of receipt of the notice:

(a) assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to [section 33] to conduct the external review;

(b) notify the health insurance issuer of the name of the independent review organization assigned under subsection (8)(a); and

(c) notify in writing the covered person and, if applicable, the covered person's authorized representative that the commissioner considered the request eligible for external review and initiated an external review.

(9) The assigned independent review organization, in reaching its decision, is not bound by any decisions or conclusions reached during the health insurance issuer's utilization review process set forth in [sections 7 through 15] or the health insurance issuer's internal grievance process set forth in [sections 16 through 23].

(10) The commissioner shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's

authorized representative may submit in writing to the assigned independent review organization within 5 business days following the date of receipt of the notice provided pursuant to subsection (8) any additional information for the independent review organization's consideration when conducting the external review. The independent review organization shall accept and consider information submitted within the 5 business days of the date of receipt of the notice and may accept and consider additional information submitted after the 5 business days.

(11) Within 5 business days after the date of receipt of the notice provided pursuant to subsection (8), the health insurance issuer or its designated utilization review organization shall provide to the assigned independent review organization the documents and any information used in making the adverse determination or final adverse determination.

(12) Except as provided in [section 33], failure by the health insurance issuer or its designated utilization review organization to provide the documents and information within the time specified in subsection (11) may not delay the conduct of the external review.

(13) (a) If the health insurance issuer or its utilization review organization fails to provide the documents and information within the time specified in subsection (11), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Within 1 business day after making a decision under subsection (13)(a), the independent review organization shall notify the covered person and, if applicable, the covered person's authorized representative as well as the health insurance issuer and the commissioner.

(14) If the provisions of subsection (13) do not apply, the assigned independent review organization shall review all of the information and documents received pursuant to subsection (11) and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to subsection (10).

(15) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subsection (10), the assigned independent review organization shall within 1 business day forward the information to the health insurance issuer.

(16) Upon receipt of the information, if any, forwarded as provided in subsection (15), the health insurance issuer may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(17) Reconsideration by the health insurance issuer of its adverse determination or final adverse determination pursuant to subsection (16) may not delay or terminate the external review.

(18) The external review may be terminated only if the health insurance issuer decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

(19) (a) Within 1 business day after making a decision to reverse its adverse determination or final adverse determination, as provided in subsection (18), the health insurance issuer shall notify the following in writing of its decision:

(i) the covered person;

(ii) if applicable, the covered person's authorized representative;

(iii) the assigned independent review organization; and

(iv) the commissioner.

(b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health insurance issuer sent pursuant to subsection (19)(a).

(20) In addition to the documents and information provided pursuant to subsection (11), the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(a) the covered person's medical records;

(b) the attending health care professional's recommendation;

(c) consulting reports from appropriate health care professionals and other documents submitted by the health insurance issuer, the covered person, the covered person's authorized representative, or the covered person's treating health care provider;

(d) the terms of coverage under the covered person's health plan with the health insurance issuer to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health plan with the health insurance issuer;

(e) the most appropriate practice guidelines. These must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, professional boards, and professional associations.

(f) any applicable clinical review criteria developed and used by the health insurance issuer or its

designated utilization review organization; and

(g) the opinion of the independent review organization's clinical reviewer after considering the provisions of subsections (20)(a) through (20)(f) to the extent the information or documents are available and the clinical reviewer considers the information appropriate.

(21) Within 45 days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:

(a) the covered person;

(b) if applicable, the covered person's authorized representative;

(c) the health insurance issuer; and

(d) the commissioner.

(22) The independent review organization shall include in the notice sent pursuant to subsection (21):

(a) a general description of the reason for the request for the external review;

(b) the date the independent review organization received the assignment from the commissioner to conduct the external review;

(c) the time period over which the external review was conducted;

(d) the date of its decision;

(e) the principal reasons for its decision, including any applicable evidence-based standards that formed a basis for its decision;

(f) the rationale for its decision; and

(g) references to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

(23) If a notice of a decision under subsection (21) reverses the adverse determination or final adverse determination, the health insurance issuer shall immediately upon receipt of the notice approve the coverage that was the subject of the adverse determination or final adverse determination.

(24) The commissioner shall assign an approved independent review organization in accordance with this section on a random basis from among those approved independent review organizations that are qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination. The commissioner shall also take into account other circumstances, including conflict of interest concerns pursuant to [section 34(4)].

NEW SECTION. **Section 30. Expedited external review.** (1) Except as provided in subsection (12), a covered person or the covered person's authorized representative may request an expedited external review with the commissioner at the time the covered person receives:

(a) an adverse determination if:

(i) the adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination under [section 23] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(ii) the covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as provided in [section 23]; or

(b) a final adverse determination:

(i) if the covered person has a medical condition for which the timeframe for completion of a standard external review pursuant to [section 29] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(ii) if the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility.

(2) Upon receipt of a request for an expedited external review, the commissioner immediately shall send a copy of the request to the health insurance issuer.

(3) Immediately upon receipt of the request pursuant to subsection (2), the health insurance issuer shall determine whether the request meets the review requirements under [section 29(3)]. The health insurance issuer shall immediately notify the commissioner and the covered person and, if applicable, the covered person's authorized representative of its eligibility determination.

(4) (a) The commissioner may specify the form for the health insurance issuer's notice of initial determination under this subsection and any supporting information to be included in the notice.

(b) The notice of initial determination must include a statement informing the covered person and, if applicable, the covered person's authorized representative of the right to appeal to the commissioner a health insurance issuer's initial determination that an external review request is ineligible.

(5) (a) The commissioner may determine that a request is eligible for external review under [section 29(7)]

and require a referral for external review, notwithstanding a health insurance issuer's initial determination that the request is ineligible.

(b) A determination by the commissioner under subsection (5)(a) must be based on the terms of the covered person's health plan and all applicable provisions of [sections 7 through 38].

(6) Upon receiving a notice that a request meets review requirements, the commissioner shall immediately assign an independent review organization to conduct the expedited external review. The assignment must be from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to [section 33]. The commissioner shall immediately notify the health insurance issuer of the name of the assigned independent review organization.

(7) In reaching a decision as provided in subsection (10), the assigned independent review organization is not bound by any decisions or conclusions reached during the health insurance issuer's utilization review process, as provided in [sections 7 through 15], or the health insurance issuer's internal grievance process provided in [sections 16 through 23].

(8) Upon receiving the commissioner's notice containing the name of the independent review organization assigned to conduct the expedited external review, the health insurance issuer or its designated utilization review organization shall provide or transmit all necessary documents and information used in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(9) In addition to the documents and information provided or transmitted pursuant to subsection (8), the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(a) the covered person's pertinent medical records;

(b) the attending health care professional's recommendation;

(c) consulting reports from appropriate health care professionals and other documents submitted by the health insurance issuer, covered person, the covered person's authorized representative, or the covered person's treating health care provider;

(d) the terms of coverage under the covered person's health plan to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health plan;

(e) the most appropriate practice guidelines, which must include evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical

societies, professional boards, and professional associations;

(f) any applicable clinical review criteria developed and used by the health insurance issuer or its designated utilization review organization in making adverse determinations; and

(g) the opinion of the independent review organization's clinical reviewer or reviewers after considering subsections (9)(a) through (9)(f) to the extent the information and documents are available and the clinical reviewer considers the information appropriate.

(10) (a) As expeditiously as the covered person's medical condition or circumstances require but no more than 72 hours after receiving the request for an expedited external review that meets the review requirements set forth in [section 29(3)], the assigned independent review organization shall:

(i) decide whether to uphold or reverse the adverse determination or final adverse determination; and

(ii) notify the covered person, the covered person's authorized representative if applicable, the health insurance issuer, and the commissioner of the decision.

(b) If the notice required under subsection (10)(a) was not in writing, the assigned independent review organization shall within 48 hours after the date of providing the notice:

(i) provide written confirmation of the decision to the covered person and, if applicable, the covered person's authorized representative as well as to the health insurance issuer and the commissioner; and

(ii) include the information required in [section 29(22)].

(11) Upon receipt of the notice regarding a decision reversing the adverse determination or final adverse determination, the health insurance issuer shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

(12) An expedited external review may not be provided for retrospective adverse or final adverse determinations.

(13) The commissioner shall assign an approved independent review organization to conduct an external review in accordance with this section on a random basis from among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination. The commissioner shall also take into account other circumstances, including conflict of interest concerns pursuant to [section 34(4)].

NEW SECTION. **Section 31. External review of adverse determinations for experimental or investigational treatment -- expedited external review.** (1) Within 6 months of the date when a covered

person or the covered person's authorized representative receives notice pursuant to [section 26] of an adverse determination or final adverse determination that involves a denial of coverage because a health insurance issuer determined that the health care service or treatment recommended or requested is experimental or investigational, the covered person or the covered person's authorized representative may file a request for external review with the commissioner.

(2) (a) A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to subsection (1) if the covered person's treating health care provider certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(b) Upon receipt of a request for an expedited external review, the commissioner shall immediately notify the health insurance issuer.

(c) (i) Upon notice of the request for expedited external review, the health insurance issuer shall immediately determine whether the request meets the review requirements of subsection (4).

(ii) The health insurance issuer shall immediately notify the commissioner and the covered person and, if applicable, the covered person's authorized representative of its eligibility determination.

(iii) The commissioner may specify the form for the health insurance issuer's notice of initial determination under subsection (2)(c)(ii) and any supporting information to be included in the notice.

(iv) The notice of initial determination under subsection (2)(c)(ii) must include a statement informing the covered person and, if applicable, the covered person's authorized representative of the right to appeal to the commissioner a health insurance issuer's initial determination that the external review request is ineligible for review.

(d) (i) The commissioner may determine that a request is eligible for external review under [section 27(3)] or subsection (4) of this section and may require referral for external review, notwithstanding a health insurance issuer's initial determination that the request is ineligible.

(ii) The determination by the commissioner under subsection (2)(d)(i) must be based on the terms of the covered person's health plan and all applicable provisions of [sections 24 through 38].

(e) Upon receipt of a notice that the expedited external review request meets the review requirements of subsection (4), the commissioner shall immediately:

(i) assign an independent review organization from the list of approved independent review organizations

compiled and maintained by the commissioner pursuant to [section 33] to review the expedited request; and

(ii) notify the health insurance issuer of the name of the assigned independent review organization.

(f) After receiving the notice of the assigned independent review organization pursuant to subsection (2)(e),the health insurance issuer or its designated utilization review organization shall provide or transmit to the assigned independent review organization electronically, by telephone, by facsimile, or by any other available expeditious method all necessary documents and information used to make the adverse determination or final adverse determination.

(3) Except for a request for an expedited external review made pursuant to subsection (2)(a), within 1 business day after the date that the commissioner receives a request for an external review, the commissioner shall notify the health insurance issuer of the request.

(4) Within 5 business days following the date that the health insurance issuer receives the notice sent under subsection (3), the health insurance issuer shall conduct and complete a preliminary review of the request to determine whether:

(a) the individual is or was a covered person in the health plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health plan at the time the health care service or treatment was provided;

(b) the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:

(i) is a covered benefit under the covered person's health plan except for the health insurance issuer's determination that the service or treatment is experimental or investigational for a particular medical condition; and

(ii) is not explicitly listed as an excluded benefit under the covered person's health plan;

(c) the covered person's treating health care provider has certified that one of the following situations is applicable:

(i) standard health care services or treatments have not been effective in improving the condition of the covered person;

(ii) standard health care services or treatments are not medically appropriate for the covered person; or

(iii) there is no available standard health care service or treatment covered by the health insurance issuer that is more beneficial than the recommended or requested health care service or treatment described in subsection (4)(d);

(d) (i) the covered person's treating health care provider has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments; or

(ii) a physician who is licensed, board-certified, or eligible to take the examination to become board-certified and is qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person who is subject to the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

(e) the covered person has exhausted the health insurance issuer's internal grievance process provided in [sections 16 through 23] or the covered person is exempt under [section 21(2)]; and

(f) the covered person has provided all the information and forms required by the commissioner that are necessary to process an external review.

(5) Within 1 business day after completion of the preliminary review, the health insurance issuer shall notify the commissioner and the covered person and, if applicable, the covered person's authorized representative in writing whether:

(a) the request is complete; and

(b) the request is eligible for external review.

(6) (a) If the request is not complete, the health insurance issuer shall inform the covered person, the covered person's authorized representative, if applicable, and the commissioner in writing and include in the notice the information or materials that are needed to make the request complete.

(b) If the request is not eligible for external review, the health insurance issuer shall inform the covered person, the covered person's authorized representative, if applicable, and the commissioner in writing and include in the notice the reasons for its ineligibility.

(7) (a) The commissioner may specify the form for the health insurance issuer's notice of initial determination under subsection (6) and any supporting information to be included in the notice.

(b) The notice of initial determination provided under subsection (6) must include a statement regarding the right to appeal to the commissioner a health insurance issuer's initial determination that the external review request is ineligible for review.

(8) Whenever a request for external review is determined eligible for external review, the health

insurance issuer shall notify the commissioner, the covered person, and the covered person's authorized representative, if applicable.

(9) Within 1 business day after the receipt of the notice from the health insurance issuer that the external review request is eligible for external review pursuant to subsection (2)(d) or (8), the commissioner shall:

(a) assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to [section 33] to conduct the external review and notify the health insurance issuer of the name of the assigned independent review organization; and

(b) notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review.

(10) The commissioner shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within 5 business days following the date of receipt of the notice provided pursuant to subsection (8) additional information for the independent review organization to consider in conducting the external review. The independent review organization shall accept and consider information submitted within the 5 business days of the date of receipt of the notice and may accept and consider additional information submitted after the 5 business days.

(11) Within 1 business day after the receipt of the notice of assignment to conduct the external review pursuant to subsection (9), the assigned independent review organization shall:

(a) select one or more clinical reviewers, as it determines to be appropriate, pursuant to subsection (12), to conduct the external review; and

(b) make a decision, based on the opinion of the clinical reviewers, to uphold or reverse the adverse determination or final adverse determination.

(12) (a) In selecting clinical reviewers, the assigned independent review organization shall select physicians or other health care providers who meet the minimum qualifications described in [section 34] and who, through clinical experience in the past 3 years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(b) The choice of the physicians or other health care providers to conduct the external review may not be made by the covered person, the covered person's authorized representative, if applicable, or the health insurance issuer.

(13) (a) In accordance with subsection (20), each clinical reviewer shall provide a written opinion to the

assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

(b) In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health insurance issuer's utilization review process, provided for in [sections 7 through 15], or in the health insurance issuer's internal grievance process provided for in [sections 16 through 23].

(14) (a) Within 5 business days after the date of receipt of the notice provided pursuant to subsection (9), the health insurance issuer or its designated utilization review organization shall provide to the assigned independent review organization, any documents and information considered in making the adverse determination or the final adverse determination.

(b) Except as provided in subsection (15), failure by the health insurance issuer or its designated utilization review organization to provide the documents and information within the time specified in subsection (14)(a) may not delay the conduct of the external review.

(15) (a) If the health insurance issuer or its designated utilization review organization fails to provide the documents and information within the time specified in subsection (14)(a), the assigned independent review organization may terminate the external review and decide to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the determination under subsection (15)(a), the independent review organization shall notify the covered person, the covered person's authorized representative, if applicable, the health insurance issuer, and the commissioner.

(16) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subsection (10) the assigned independent review organization shall, within 1 business day after the receipt of the information, forward the information to the health insurance issuer.

(17) (a) Upon receipt of the information required to be forwarded pursuant to subsection (16), the health insurance issuer may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(b) Reconsideration by the health insurance issuer of its adverse determination or final adverse determination pursuant to subsection (17)(a) may not delay or terminate the external review.

(18) (a) The external review may be terminated only if the health insurance issuer decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of

the adverse determination or final adverse determination.

(b) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in subsection (18)(a), the health insurance issuer shall notify the covered person, the covered person's authorized representative if applicable, the assigned independent review organization, and the commissioner in writing of its decision.

(c) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health insurance issuer pursuant to subsection (18)(b).

(19) Each clinical reviewer selected pursuant to subsection (12) shall review all of the information and documents received pursuant to subsection (14) and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to subsection (10).

(20) (a) Except as provided in subsection (20)(c), within 20 days after being selected in accordance with subsection (12) to conduct the external review, each clinical reviewer shall provide an opinion to the assigned independent review organization pursuant to subsection (21) on whether the recommended or requested health care service or treatment should be covered.

(b) Except for an opinion provided pursuant to subsection (20)(c), each clinical reviewer's opinion must be in writing and include the following information:

(i) a description of the covered person's medical condition;

(ii) a description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(iii) a description and analysis of any medical or scientific evidence considered in reaching the opinion;

(iv) a description and analysis of any evidence-based standard; and

(v) information on whether the clinical reviewer's rationale for the opinion is based on subsection (21)(a) or (21)(b).

(c) (i) For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances require, but no more than 5 calendar days after being selected in accordance with subsection (12).

(ii) If the opinion provided pursuant to subsection (20)(c)(i) was not in writing, the clinical reviewer shall

provide to the assigned independent review organization written confirmation of the opinion within 48 hours following the date the opinion was delivered and include the information required under subsection (20)(b).

(21) In addition to the documents and information provided under this section, each clinical reviewer selected pursuant to subsection (12), shall consider the following information in reaching an opinion as required in subsection (20) to the extent that the information is available and the reviewer considers the information to be appropriate:

(a) the covered person's pertinent medical records;

(b) the attending physician or health care professional's recommendation;

(c) consulting reports from appropriate health care professionals and other documents submitted by the health insurance issuer, the covered person, the covered person's authorized representative, or the covered person's treating physician or health care provider;

(d) the terms of coverage under the covered person's health plan with the health insurance issuer. The terms of coverage must be analyzed to ensure that, but for the health insurance issuer's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the clinical reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health insurance issuer; and

(e) whether the recommended or requested health care service or treatment has been approved by the food and drug administration, if applicable, for the condition or whether medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

(22) (a) Except as provided in subsection (22)(b), within 20 days after the date of receiving the opinion of each clinical reviewer pursuant to subsection (20), the assigned independent review organization shall make a decision and provide written notice of the decision to the covered person, the covered person's authorized representative, if applicable, the health insurance issuer, and the commissioner.

(b) (i) For an expedited external review, within 48 hours after the date of receiving the opinion of each clinical reviewer pursuant to subsection (20), the assigned independent review organization, in accordance with subsection (22)(c), shall make a decision and provide notice of the decision orally or in writing to the persons

listed in subsection (22)(a).

(ii) If the notice provided under subsection (22)(b)(i) was not in writing, within 48 hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the persons listed in subsection (22)(a) and include the information set forth in subsection (22)(d).

(c) (i) If a majority of the clinical reviewers respond that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health insurance issuer's adverse determination or final adverse determination.

(ii) If a majority of the clinical reviewers respond that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health insurance issuer's adverse determination or final adverse determination.

(iii) If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical reviewer to help the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to subsections (22)(c)(i) or (22)(c)(ii).

(iv) The additional clinical reviewer selected under (22)(c)(iii) shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to subsection (20).

(v) The selection of the additional clinical reviewer under subsection (22)(c)(iii) may not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers.

(d) The independent review organization shall include in the notice provided pursuant to subsection (22)(b):

(i) a general description of the reason for the request for external review;

(ii) the written opinion of each clinical reviewer, including the opinion of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

(iii) the date on which the independent review organization was assigned by the commissioner to conduct the external review;

(iv) the time period during which the external review was conducted;

(v) the date of the independent review organization's decision; and

(vi) the principal rationale for its decision.

(e) Upon receipt of a notice of a decision pursuant to subsection (22)(c)(i) reversing the adverse determination or final adverse determination, the health insurance issuer shall immediately approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

(23) The commissioner shall assign on a random basis an approved independent review organization to conduct an external review in accordance with this section from among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to [section 34(4)].

NEW SECTION. **Section 32. Binding nature of external review decisions.** (1) An external review decision is binding on:

(a) the health insurance issuer except to the extent the health insurance issuer has other remedies available under applicable state law; and

(b) the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

(2) A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to [sections 24 through 38].

NEW SECTION. **Section 33. Approval of independent review organizations.** (1) The commissioner shall approve independent review organizations that are eligible to conduct external reviews under [sections 24 through 38].

(2) To be eligible for approval by the commissioner to conduct external reviews under [sections 24 through 38], an independent review organization:

(a) must, except as provided in subsection (5)(b), be accredited by a nationally recognized private accrediting entity as provided in subsection (5)(a) and meet the qualifications provided in [section 34]; and

(b) shall submit an application for approval in accordance with subsection (4).

(3) The commissioner shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

(4) Any independent review organization seeking to be approved to conduct external reviews under [sections 24 through 38] shall submit the application form and include with the form all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under [section 34] and subsection (5) of this section.

(5) (a) Subject to subsection (5)(b), an independent review organization is eligible for approval under this section only if it is accredited by a nationally recognized private accrediting entity approved by the commissioner as having independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under [section 34].

(b) The commissioner may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

(6) The commissioner's approval of an independent review organization is effective for 2 years unless the commissioner determines before the expiration date that the independent review organization is not satisfying the minimum qualifications established under [section 34].

(7) If the commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under [section 34], the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations maintained by the commissioner pursuant to subsection (8).

(8) The commissioner shall maintain and periodically update a list of approved independent review organizations.

NEW SECTION. **Section 34. Minimum qualifications for independent review organizations.** (1) To be approved to conduct external reviews as provided in [section 33], an independent review organization shall establish and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in [sections 29 and 30]. The written policies and procedures must include, at a minimum:

(a) a quality assurance mechanism that ensures:

(i) that external reviews are conducted within the specified timeframes and that required notices are provided in a timely manner;

(ii) that the independent review organization is unbiased;

(iii) the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and the suitable matching of reviewers to specific cases;

(iv) that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet the objective of qualified, impartial reviews;

(v) the confidentiality of medical and treatment records and clinical review criteria; and

(vi) that any person employed by or under contract with the independent review organization adheres to the requirements of [sections 24 through 38];

(b) a toll-free telephone service to receive information related to external reviews on a 24-hour-a-day, 7-day-a-week basis. The telephone service must be capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.

(c) an agreement to maintain and provide to the commissioner the information required under [section 36].

(2) All clinical reviewers assigned by an independent review organization to conduct external reviews must:

(a) be physicians or other appropriate health care providers; and

(b) meet the following minimum qualifications:

(i) be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

(ii) 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 covered person;

(iii) hold a nonrestricted professional license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in one or more areas appropriate to the subject of the external review; and

(iv) have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, either taken or pending by any hospital, governmental agency, governmental unit, or any regulatory body if the disciplinary actions or sanctions raise a substantial question as to the clinical reviewer's physical, mental, or professional competence or moral character.

(3) In addition to the requirements in subsection (1), an independent review organization may not own or control, be a subsidiary of, or in any way be owned or controlled by or exercise control over a health plan, a health insurance issuer, a national, state, or local trade association of health plans, or a national, state, or local

trade association of health care providers.

(4) (a) In addition to the requirements in subsections (1) through (3), to be approved under [section 33] to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(i) the health insurance issuer that is the subject of the external review;

(ii) the covered person whose treatment is the subject of the external review or the covered person's authorized representative;

(iii) any officer, director, or management employee of the health insurance issuer that is the subject of the external review;

(iv) the health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(v) the facility at which the recommended health care service or treatment would be provided; or

(vi) the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(b) In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial, or financial conflict of interest, the commissioner shall take into consideration:

(i) situations in which the independent review organization to be assigned to conduct an external review of a specified case or a clinical reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in subsection (4)(a) if the characteristics of that relationship or connection do not pose a material professional, familial, or financial conflict of interest that otherwise would result in the disapproval of the independent review organization or the clinical reviewer from conducting the external review; and

(ii) whether other medical expertise is available within a reasonable timeframe.

(5) (a) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards determined by the commissioner to be equivalent to or exceed the minimum qualifications of this section is presumed to be in compliance with this section and eligible for approval under [section 33].

(b) The commissioner shall initially and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are and continue to be equivalent to or exceed the minimum qualifications established under this section. The commissioner may accept a review conducted by the NAIC for the determination under this subsection (5)(b).

(c) Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the NAIC to enable the commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The commissioner may exclude any private accrediting entity that is not reviewed by the NAIC.

NEW SECTION. **Section 35. Liability limits for independent review organization.** (1) Except as provided in subsection (2), an independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent, or contractor of an independent review organization is not liable to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to [sections 24 through 38].

(2) The liability exemption under subsection (1) does not apply if the opinion was rendered or if the act or omission was performed in bad faith or involved gross negligence.

NEW SECTION. **Section 36. External review reporting requirements.** (1) An independent review organization assigned pursuant to [section 29, 30, or 31] to conduct an external review shall maintain written records in the aggregate by state and by health insurance issuer on all requests for external reviews for which the independent review organization conducted an external review during a calendar year and, upon request, shall submit a report to the commissioner as required under subsection (2).

(2) Each independent review organization required to maintain written records as provided in subsection (1) shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(3) The report must include, aggregated by state and by health insurance issuer:

(a) the total number of requests for external review;

(b) the number of requests for external review resolved and, of those resolved, the number resolved

upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(c) the average length of time for resolution;

(d) a summary of the types of coverages or cases for which an external review was sought, provided in the format required by the commissioner;

(e) the number of external reviews that were terminated pursuant to [section 29(18)] as the result of a reconsideration by the health insurance issuer of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

(f) any other information the commissioner may request or require.

(4) The independent review organization shall retain the written records required pursuant to subsection (1) for at least 3 years.

(5) Each health insurance issuer shall maintain in the aggregate by state and for each type of health plan offered by the health insurance issuer written records on all requests for external review for which the health insurance issuer received notice from the commissioner pursuant to [sections 7 through 38].

(6) Each health insurance issuer required to maintain written records on all requests for external review pursuant to subsection (5) shall submit to the commissioner a report in the format specified by the commissioner.

(7) The report must include in the aggregate by state and by type of health plan:

(a) the total number of requests for external review;

(b) the number of requests determined eligible for a full external review based on the total number of requests for external review reported under subsection (7)(a); and

(c) any other information the commissioner may request or require.

(8) The health insurance issuer shall retain the written records required pursuant to subsection (5) for at least 3 years.

NEW SECTION. **Section 37. Funding of external review.** The health insurance issuer against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

NEW SECTION. **Section 38. Disclosure requirements.** (1) Each health insurance issuer shall include

a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons.

(2) The disclosure required under subsection (1) must:

(a) be in a format prescribed by the commissioner;

(b) include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the commissioner. The statement may explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or level of effectiveness. The statement must include the telephone number and address of the commissioner.

(3) In addition to the requirements under subsection (2), the statement must inform the covered person that, when filing a request for an external review, the covered person is required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

NEW SECTION. **Section 39. Repealer.** The following sections of the Montana Code Annotated are repealed:

33-32-201. Conduct of utilization review.
33-32-203. Appeal and assignment of claim.
33-37-101. Definitions.
33-37-102. Independent review of adverse determinations.
33-37-103. Peer review.
33-37-104. Contract provisions -- contract termination.
33-37-105. Rulemaking authority.
33-37-106. Application to certain entities.

NEW SECTION. **Section 40. Codification instruction.** [Sections 7 through 38] are intended to be codified as an integral part of Title 33, chapter 32, and the provisions of Title 33, chapter 32, apply to [sections 7 through 38].

NEW SECTION. **Section 41. Severability.** If a part of [this act] is invalid, all valid parts that are

severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 42. Effective date.** [This act] is effective July 1, 2011.

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