ARIZONA HOUSE OF REPRESENTATIVES

Fifty-sixth Legislature
Second Regular Session

HB 2599: health care appeals
Sponsor: Representative Livingston, LD 28
Committee on Commerce

Overview

Revises statute relating to health care appeals.

History

Title 20, Chapter 15, A.R.S. prescribes and governs the health care appeal process for members whose covered service or claim for a service has been denied by a health care insurer. Each utilization review agent and each health care insurer whose utilization review system includes the power to affect the direct or indirect denial of requested medical or health care services or claims for medical or health care services shall adopt written utilization review standards and criteria and processes for the review, reconsideration and appeal of denials.

Provisions

1. Clarifies a member who *receives an adverse determination*, rather than is denied a covered service or whose claim for a service is denied, may pursue the applicable review process. (Sec. 4)
2. Modifies the levels of review a health care insurer must provide relating to health care appeals. (Sec. 4)
3. Removes language relating to providing an additional level of review. (Sec. 4)
4. Allows a health care insurer, for group plans, to offer a voluntary internal appeal as an additional internal level of review. (Sec. 4)
5. Outlines requirements for a health care insurer who offers a voluntary internal appeal for group plans relating to denial of a claim for service. (Sec. 4)
6. Provides requirements for a health care insurer, for individual plans and group plans in which a voluntary internal appeal is not offered relating to denial of a claim for service. (Sec. 4)
7. Instructs a health care insurer to provide a required written determination and include the basis, criteria used, clinical reasons and rationale for the determination. (Sec. 4)
8. Specifies a member has exhausted the insurer's internal levels of review provided the insurer fails to comply with statutory requirements relating to health care appeals process, with exception. (Sec. 4)
9. Permits a health care insurer to waive the internal appeal process. (Sec. 4)

☐ Prop 105 (45 votes) ☐ Prop 108 (40 votes) ☐ Emergency (40 votes) ☐ Fiscal Note

10. Clarifies the information that must be included in a health care insurers information packet that is provided to a member. (Sec. 4)

11. Adds that if a member's complaint is experimental or investigational under the coverage document, an internal appeal process must be performed. (Sec. 4)

12. Instructs the health care insurer, prior to making a final adverse determination that relies on new or additional evidence, to provide the new or additional information to the member free of charge sufficiently in advance of the final adverse determination to allow the member a reasonable opportunity to respond. (Sec. 4)

13. Specifies that any member who receives an adverse determination, except for a denial of a claim for service or a rescission of coverage, may pursue an expedited medical review of that denial if the member's treating provider certifies in writing that the time period for the initial appeal process and the voluntary internal appeal process are likely to cause a significant negative change in the member's medical condition. (Sec. 5)

14. Adds that if a member's complaint is experimental or investigational under the coverage document and not whether the service is covered:
    a) the agent, prior to making a determination, must consult with a licensed physician or other licensed health care professional; and
    b) any provider, physician or other specified health care professional must review the expedited appeal and render a determination based on the utilization review plan. (Sec. 5)

15. Specifies a member has up to two years to request an initial appeal, rather than an informal reconsideration, after a service has been denied. (Sec. 6)

16. Removes language relating to a health care insurer providing its members an informal reconsideration. (Sec. 6)

17. Instructs a utilization review agent to select a provider to review the appeal and render a determination based on the utilization review plan if a member's appeal is an issue of medical necessity or appropriateness. (Sec. 6)

18. Requires a utilization review agent to send their determination within the statutory time frames relating to claim denial, rather than 30 days after receipt of the request for reconsideration. (Sec. 6)

19. Clarifies the information that must be included in the utilization review agent's written statement of the agent's decision regarding denial of a covered service. (Sec. 6)

20. Specifies a member may appeal an adverse determination to the voluntary appeal level if a health care insurer offers a voluntary appeal level as part of its internal review levels. (Sec. 7)

21. Removes language relating to a member filing a written appeal regarding a denial of a claim within two years after receipt of the notice of the denial. (Sec. 7)

22. Stipulates a provider, physician or other specified health professional must review an appeal if the appeal is an issue of appropriateness, including health care setting, level of care of effectiveness of a covered benefit or is experimental or investigation. (Sec. 7)

23. Instructs a utilization review agent to send the member their determination and the basis, reasons and rationale for the determination within the statutory time frames

relating to claim denial, instead of up to the 30-day and 60-day time frame as outlined. (Sec. 7)

24. Clarifies a member may initiate an external independent review if the utilization review agent denies a request for a covered service or claim at all applicable internal levels of review or if the member has exhausted the health care insurer's internal levels of review. (Sec. 8)

25. Requires the written acknowledgment relating to an external independent review to include notice to the member that the member has five business days after receiving the notice to submit additional written evidence to DHS for consideration by the assigned independent review organization. (Sec. 8)

26. Instructs DHS, within one business day after receiving additional written evidence submitted by the member, to provide a copy of the evidence to the health care insurer and the independent review organization.

27. Requires the independent review organization to consider the evidence in making its determination and allows the organization to consider evidence submitted after five business days. (Sec. 8)

28. Instructs the independent review organization, within 21 days after receiving a case for review from DHS, to evaluate and analyze the case. (Sec. 8)

29. Requires the independent review organization, for claims or requests for services denied as experimental or investigational, to render a determination that is consistent with the review plan and send a copy of the determination to DHS in accordance with specified requirements. (Sec. 8)

30. Instructs DHS to send a notice of the determination to specified individuals within five business days after receiving a notice of determination from the independent review organization. (Sec. 8)

31. Asserts the determination is a final administrative decision and is subject to judicial review. (Sec. 8)

32. Requires the health care insurer to provide any service or pay any claim determined to be covered and medically necessary by the independent review organization for a case under review without delay regardless of whether judicial review is sought. (Sec. 8)

33. Outlines the circumstances for which a member may initiate an expedited external independent review and extends the time frame for submitting a written requesting for an independent review from five business days to four months. (Sec. 8)

34. Adds that, for a matter involving an experimental or investigational determination, a member may make an oral request provided the member's treating physician certifies in writing that the recommended service or treatment would be less effective if not promptly initiated. (Sec. 8)

35. Requires the independent review organization, for cases involving an issue of appropriateness, including health care setting, level of care or effectiveness of a covered benefit or is experimental or investigational, to evaluate and analyze the case. (Sec. 8)

36. Directs a health care insurer and an independent review organization to maintain all records relating to internal and external appeals and exception requests for at least three years after the completion of the appeals process or exception request process. (Sec. 9)

37. Changes references of informal reconsideration to initial appeal. (Sec. 4, 6, 7)

38. Includes a definition for *final adverse determination, internal level of review,* and *rescission.* (Sec. 1)

39. Changes the defined term of *adverse decision* to *adverse determination* and revises the definition. (Sec. 1)

40. Replaces the term *adverse decision* with *adverse determination* as appropriate. (Sec. 3)

41. Contains a delayed effective date of January 1, 2025. (Sec. 10)

42. Makes technical changes. (Sec. 1-8)