ARIZONA HOUSE OF REPRESENTATIVES

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HB 2599: health care appeals
Sponsor: Representative Livingston, LD 28
Caucus & COW

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

Levels of Review

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. Removes references of a formal appeal process as a level of review. (Sec. 4)
3. Deletes language relating to a health care insurer offering certain additional levels 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 after a determination of an initial appeal. (Sec. 4)
5. Outlines requirements for a health care insurer, who offers a voluntary internal appeal for group plans, relating to the time frame for providing a written determination. (Sec. 4)
6. Outlines requirements for a health care insurer, for individual plans and group plans for which a voluntary internal appeal is not offered, relating to the time frame for providing a written determination. (Sec. 4)
7. Instructs a health care insurer to provide a written determination and include the basis, criteria used, clinical reasons and rationale for the determination. (Sec. 4)
8. Specifies a member has exhausted the health care insurer's internal levels of review if the insurer fails to comply with statutory requirements relating to health care appeals, with outlined exceptions. (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)

Expedited Medical Review

13. Clarifies 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. Clarifies that the utilization review agent's determination notice must include *the basis*, criteria used, clinical reasons *and rationale* for the determination. (Sec. 5)

15. Applies certain requirements relating to complaints that are an issue of medical necessity to complaints that are experimental or investigational. (Sec. 5)

Initial Appeal

16. Changes references of an informal reconsideration to initial appeal. (Sec. 6, 7)

17. Adds that a member whose claim for a service that has already been provided is denied may request an initial appeal of that denial. (Sec. 6)

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

19. Instructs a utilization review agent to select a provider to review an appeal that is an issue of medical necessity or appropriateness, including health care setting, level of care or effectiveness of a covered benefit or is experimental or investigational under the coverage document and render a determination based on the utilization review plan. (Sec. 6)

20. Defines *provider*. (Sec. 6)

21. Requires a utilization review agent to send a notice of their determination, and the *basis*, criteria used, clinical reasons and *rationale*, within the statutory time frames relating to claim denial, rather than 30 days after receipt of the request for reconsideration. (Sec. 6)

22. Requires the determination to include a notice of the option to proceed to the voluntary internal appeal process, as applicable, or to an external independent review if the member has only one internal level of review. (Sec. 6)

Voluntary Internal Appeal

23. 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)

24. Changes references of formal appeal to voluntary internal appeal. (Sec. 7)

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

26. Instructs a utilization review agent to send the member and the treating provider a notice of their determination and the basis, criteria used, clinical 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)

External Independent Review

27. 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)

28. 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 Department of Insurance and Financial Institutions (DIFI) for consideration by the assigned independent review organization. (Sec. 8)

29. Instructs DIFI, 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. (Sec. 8)

30. 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)

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

32. 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 DIFI in accordance with specified requirements. (Sec. 8)

33. Instructs DIFI 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)

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

35. 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)

36. Lowers the number of additional days DIFI may extend the time frame for the independent review organization to evaluate and analyze specified cases, from 30 days to 10 days. (Sec. 8)

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

38. 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)

39. 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 within 72 hours from the date of receiving a case for expedited external independent review from DIFI. (Sec. 8)

Miscellaneous

40. 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)

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

42. Replaces the term *adverse decision* with *adverse determination* as appropriate. (Sec. 3, 4)

43. Includes a definition for *final adverse determination, internal level of review* and *rescission*. (Sec. 1, 2)

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

45. Adds that *denial* includes a denial, reduction or termination of a service or a rescission of coverage. (Sec. 1)

46. Makes technical and conforming changes. (Sec. 1, 4, 5, 6, 7, 8)

Amendments

Committee on Commerce

1. Changes the defined term of *final adverse determination* to *final internal adverse determination* and modifies the definition.

2. Includes a definition for *grandfathered individual plan* and *health care setting*.

3. Adds that no minimum dollar amount may be imposed on any claim that is the subject of an adverse determination for a member.

4. Allows a health care insurer to offer a voluntary internal appeal for grandfathered individual plans.

5. Adds that if a member's complaint involves an issue of appropriateness, including health care setting, level of care or effectiveness of a covered benefit the initial appeal process must be performed and the expedited review or voluntary internal appeal must be decided by a health care professional.

6. Changes the deadline for a utilization review agent to make a determination regarding expeditated medical review from 1 business day to 72 hours.

7. Adds that if the members complaint involves an issue of appropriateness, including health care setting, level of care or effectiveness of a covered benefit must consult with a health care professional.
8. Clarifies the types of complaints in which a utilization review agent must select a provider to review the appeal and render the determination based on the review plan adopted by the agent.
9. Includes a definition for *provider*.
10. Removes the requirement for a utilization review agent to send a written acknowledgment to the member and treating provider after receiving the request for initial appeal or voluntary internal appeal.
11. Specifies the independent review organization's determination must be consistent with the utilization review plan.
12. Makes further clarifying changes.