ARIZONA STATE SENATE

Fifty-Sixth Legislature, Second Regular Session

FACT SHEET FOR H.B. 2599

health care appeals

Purpose

Effective January 1, 2025, modifies procedures and health care insurer (insurer) and utilization review agent requirements relating to health care appeals.

Background

Statute prescribes and governs the health care appeal process for members whose covered service or claim for a service has been denied by an insurer. Each utilization review agent and 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 must adopt written utilization review standards, criteria and processes for the review, reconsideration and appeal of denials.

Statute requires the Director of the Department of Insurance and Financial Institutions (DIFI) to require any member who files a complaint with DIFI relating to an adverse decision to pursue the review process prescribed by law. There are two types of health care appeals, an expedited appeal for urgent matters and a standard appeal. Each type of appeal has three levels of review. The appeals operate in a similar fashion, except that expedited appeals are expedited because of a member's condition (A.R.S. Title 20, Chapter 15, Article 2; DIFI).

There is no anticipated fiscal impact to the state General Fund associated with this legislation.

Provisions

Insurer Levels of Review

1. Prohibits a minimum dollar amount from being imposed on any claim that is the subject of an adverse determination for a member to pursue the applicable review process and specifies that a member who receives an adverse determination may pursue the applicable review process.

2. Replaces the formal appeals process with the voluntary internal appeal level of review.

3. Removes the authorization for an insurer to offer additional levels of review as long as the additional levels of review do not increase the statutory time period limitations.

4. Requires the initial appeal process to be performed by a licensed health care professional when the member's complaint involves an issue of medical appropriateness, including health care setting, level of care or effectiveness of a covered benefit or is experimental or investigational under the coverage document.

5. Requires an insurer to provide a written determination by the applicable deadline and include the basis, criteria used, clinical reasons and rationale for the determination.

6. Requires an insurer, before the insurer makes a final internal adverse determination that relies on new or additional evidence generated by the insurer, to provide the new or additional information to the member free of charge sufficiently in advance of the determination to allow the member a reasonable opportunity to respond within the applicable time frames for the insurer to provide the member with a written determination.

7. Requires an insurer, for individual and group plans for which the insurer does not elect to offer a voluntary internal appeal, to:
   a) send the member a written determination within 30 days after the insurer receives the appeal request, except for a claim denial for service that has already been provided; and
   b) for a claim denial for service that has already been provided, send the member a written determination within 60 days after the insurer receives the appeal request.

8. Requires a member to be considered to have exhausted an insurer's internal levels of review if the insurer fails to comply with health care appeals laws, except to the extent that the member requested or agreed to the delay, and allows the member to simultaneously initiate an expedited external independent review.

Expedited Medical Review Requirements

9. Specifies that any member who receives an adverse determination, except for a claim denial for service or a rescission of coverage, may pursue an expedited medical review if the provider certifies and provides documentation that the appeal time frames are likely to cause a significant negative change in the member's medical condition.

10. Increases, from one business day to 72 hours, the time period within which a utilization review agent must make a determination after receiving certification and supporting documentation from the provider.

11. Requires a utilization review agent, if the member's complaint involves an issue of medical appropriateness, including health care setting, level of care or effectiveness of a covered benefit or is experimental or investigational under the coverage document, to consult with specified health care professionals before making a determination.

12. Requires the utilization review agent, if a member choose to proceed with an expedited medical review and the member's complaint involves 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, to select a health care provider to review the appeal and render the determination based on the utilization review plan adopted by the agent.

Initial Appeals

13. Replaces the term *informal reconsideration* with the term *initial appeal* and applies the requirements relating to informal reconsiderations to initial appeals.

14. Specifies that any member who receives an adverse determination, rather than any member who is denied a service, to request an initial appeal of the denial.

15. Requires a utilization review agent, if the member's appeal involves 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, to select a provider to review the appeal and render a determination based on the utilization review plan.

16. Requires a utilization review agent to send, within the applicable timeframe, the member and the member's treating provider notice of the determination and the basis, criteria used, clinical reasons and rationale.

17. Requires a determination to include a notice of the option to proceed to the voluntary internal appeal process or the external independent review, whichever is applicable.

Voluntary Internal Appeal

18. Allows an insurer, for group plans and grandfathered individual plans, to elect to offer a voluntary internal appeal as an additional internal level of review after a determination of an initial appeal.

19. Requires an insurer that elects to offer a voluntary internal appeal for the insurer's group plans:
    a) send the member a written determination within 15 days after the insurer receives the initial appeal request and within 15 days after the insurer receives the voluntary internal appeal request, except for a claim denial for service that has already been provided; and
    b) for a claim denial for service that has already been provided, send the member a written determination within 30 days after the insurer receives the initial appeal request and within 30 days after the insurer receives the voluntary internal appeal request.

20. Requires the voluntary internal appeal to be decided by a physician, provider or other health care professional when the member's complaint involves an issue of medical appropriateness, including health care setting, level of care or effectiveness of a covered benefit or is experimental or investigational under the coverage document.

21. Specifies that a member may appeal an adverse determination to the voluntary appeal level if an insurer elects to include, as part of its internal review levels, a voluntary internal appeal level.

22. Replaces the term *formal appeal* with the term *voluntary internal appeal* and applies the requirements relating to informal reconsiderations to initial appeals.

External Independent Review

23. Stipulates that, if a member's request for a covered service or claim for a covered service is denied at all applicable levels of review or exhausted, the member may initiate an external independent review within four months after receiving notice of the adverse determination.

24. Requires an insurer and an independent review organization to maintain all records related to internal and external appeals and exception requests for at least three years after the completion of the appeals process or exception request process.

25. Requires a utilization review agent's acknowledgment of a request for 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 DIFI for consideration by the assigned independent review organization.

26. Requires the Director of DIFI, within one business day after receiving additional written evidence, to provide a copy of the evidence to the insurer and independent review organization.

27. Require an independent review organization to consider the evidence in making its determination and allows the independent review organization, in its discretion, to consider evidence submitted after five business days.

28. Requires an independent review organization's determination to be consistent with the following:
    a) the independent review organization reviewer must consider the following in rendering a determination, as appropriate and available under the circumstances: and
        i. the member's pertinent medical records;
        ii. the treating provider's recommendation;
        iii. any consulting report from a health care professional;
        iv. any document submitted by an insurer or member;
        v. for claims or requests for services denied for reasons other than as experimental or investigational, the independent review organization must also consider: and
            1. the most appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
            2. any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization; and
            3. the opinion of the independent review organization’s clinical reviewer or reviewers after considering specified information to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate;
        vi. for claims or requests for services denied as experimental or investigational, the independent review organization must also consider the terms of coverage under the member's policy with the insurer to ensure that except for an insurer's determination for an experimental or investigational service, the reviewer's opinion is not contrary to the terms of coverage and any of the following:
            1. whether the service has been approved by the U.S. Food and Drug Administration for the condition; or
            2. whether the medical or scientific evidence or evidence-based standards demonstrate that the expected benefit of the service is more likely than not to be beneficial to the member than any available standard service and that any adverse risk is not substantially increased over adverse risks of available standard services;
    b) the independent review organization reviewer's written determination must include:
        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 expected benefit of the service is more likely than not to be beneficial to the member than any available standard service and that any adverse risk is not substantially increased over adverse risks of available standard services;
iii. a description and analysis of any medical or scientific evidence considered in reaching the determination;
iv. a description and analysis of any evidence-based standard; and
v. information on whether the reviewer's rationale for the determination is based on specified information.

29. Reduces, from 30 days to 10 days, the extension period for external independent review determinations that an independent review organization, member or utilization review agent may request from the Director of DIFI.

30. Allows a member to request to initiate an expedited external independent review, in specified circumstances, within four months, rather than five business days, after the member receives notice of the adverse determination.

31. Allows a member, for an adverse determination involving an experimental or investigational service, to make an oral request if the member's treating physician certifies in writing that the recommended service or treatment would be significantly less effective if not promptly initiated.

Miscellaneous

32. Requires an insurer's policy information packet to be prominently displayed on its website.

33. Replaces the definition of *adverse decision* with *adverse determination* and modifies the definition.

34. Modifies the definition of *indirect denial* to include the timelines prescribed for prior authorizations.

35. Modifies the definition of *denial* to include a denial, reduction or termination of service or a rescission.

36. Defines terms.

37. Makes technical and conforming changes.

38. Becomes effective on January 1, 2025.

House Action

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