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HB 2599: health care appeals
Sponsor: Representative Livingston, LD 28
Transmitted to the Governor

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. Adds that no minimum dollar amount may be imposed on any claim that is the subject of an adverse determination for a member to pursue the applicable review process. (Sec. 3)
2. 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. 3)
3. Removes references of a formal appeal process as a level of review. (Sec. 3, 6)
4. Deletes language relating to a health care insurer offering certain additional levels of review. (Sec. 3)
5. Allows a health care insurer, for group plans and grandfathered individual plans, to offer a voluntary internal appeal as an additional internal level of review after a determination of an initial appeal. (Sec. 3)
6. 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. 3)
7. 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. 3)
8. Instructs a health care insurer to provide a written determination and include the basis, criteria used, clinical reasons and rationale for the determination. (Sec. 3)

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

9. 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. 3)

10. Permits a health care insurer to waive the internal appeal process. (Sec. 3)

11. Clarifies the information that must be included in a health care insurers information packet that is provided to a member. (Sec. 3)

12. Adds that if a member's complaint involves an issue of appropriateness, including health care setting, level of care of effectiveness of a covered benefit, or is experimental or investigational under the coverage document:
    a) an initial appeal process must be performed; and
    b) the expedited review or voluntary internal appeal must be decided by a physician, provider or other health care professional. (Sec. 3)

13. Instructs the health care insurer, prior to making a final internal 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. 3)

Expedited Medical Review

14. 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. 4)

15. Increases the amount of time a utilization review agent has to send the member and the treating provider a determination notice from one business day to 72 hours. (Sec. 4)

16. Clarifies that the utilization review agent's determination notice must include *the basis*, criteria used, clinical reasons *and rationale* for the determination. (Sec. 4)

17. Adds that if the member's complaint involves an issue of appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational under the coverage document, the agent must consult with a qualified physician or health care professional. (Sec. 4)

18. Clarifies that if a member chooses to proceed with an expedited appeal and the member's compliant involves an issue of appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational under the coverage document, the agent must select a provider to review the appeal and render the determination. (Sec. 4)

19. Includes a definition of *provider.* (Sec. 4)

Initial Appeal

20. Specifies a member who receives an adverse determination, rather than being denied a service, may request an initial appeal of that denial. (Sec. 5)

21. Instructs a utilization review agent to select a provider to review the appeal that 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 and render a determination based on the utilization review plan. (Sec. 5)

22. Includes a definition of *provider*. (Sec. 5)

23. 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. 5)

24. Requires the determination to include a notice of the option to proceed to the voluntary internal appeal process or to an external independent review if the member has only one internal level of review. (Sec. 5)

25. Removes language relating to an informal reconsideration. (Sec. 5)

26. Changes references of an informal reconsideration to initial appeal. (Sec. 3, 4, 5, 6)

Voluntary Internal Appeal

27. Specifies a member may appeal an adverse determination to the voluntary appeal level if a health care insurer elects to include as part of its internal review levels a voluntary internal appeal level. (Sec. 6)

28. Restates that a utilization review agent must select a provider to review a member's appeal that involves an issue of medical necessity or appropriateness, including health care setting, level of care of 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)

29. Includes a definition of *provider*. (Sec. 6)

30. 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. 6)

31. Changes references of formal appeal to voluntary internal appeal. (Sec. 6)

External Independent Review

32. 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. 7)

33. 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. 7)

34. 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. 7)

35. 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. 7)

36. Expands the types of cases for which the independent review organization must evaluate, analyze and submit a determination to DIFI. (Sec. 7)

37. Requires the independent review organization's determination to be consistent with the utilization review plan and in accordance with outlined criteria. (Sec. 7)

38. Restates that DIFI must send a notice of the determination to specified individuals within five business days after receiving a notice of determination from the independent review organization and that the determination is a final administrative decision and is subject to judicial review. (Sec. 7)

39. 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. 7)

40. Clarifies the conditions in which a member may initiate an expedited external independent review. (Sec. 7)

41. Increase the amount of time, from within five business days to within four months after receiving the utilization review agent's adverse determination, a member must send a written request for an expedited external independent review and provides a condition for allowing the member to make an oral request. (Sec. 7)

Miscellaneous

42. 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. 8)

43. Contains a delayed effective date of January 1, 2025. (Sec. 9)

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

45. Includes a definition for *final internal adverse determination, grandfathered individual plan, health care setting, internal level of review* and *rescission.* (Sec. 1)

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

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

48. Makes technical and conforming changes. (Sec. 1-7)