Regular Session, 2012

HOUSE BILL NO. 978

BY REPRESENTATIVE HUVAL

INSURANCE/HEALTH: Provides relative to internal and external appeals

AN ACT

To amend and reenact R.S. 22:821(B)(28), to enact Chapter 18 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:2391 through 2453, and to repeal Subpart F of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1121 through 1144, relative to internal and external appeals, including a process for utilization review; to provide for licensing fees; to provide for penalties; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:821(B)(28) is hereby amended and reenacted and Chapter 18 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:2391 through 2453, is hereby enacted to read as follows:

§821. Fees

* * *

B. The following fees and licenses shall be collected in advance by the commissioner of insurance:

* * *

(28) ~~Medical Necessity Review Organizations other than a health insurance issuer~~ Utilization Review Organization or Independent Review Organization

(a) Licensing fee..... $ 1,500.00

(b) Annual report filing fee .....$ 500.00

* * *

CHAPTER 18. UTILIZATION REVIEW ORGANIZATIONS, GRIEVANCE PROCEDURES, AND EXTERNAL REVIEW ACT

PART I. TITLE, DEFINITIONS, AND LICENSURE

§2391. Purpose; short title

A. The purpose of this Chapter is the following:

(1) To 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.

(2) To provide standards for the establishment and maintenance of procedures by health insurance issuers to assure that covered persons have the opportunity for the appropriate resolution of grievances, as defined in this Chapter.

(3) To provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in this Chapter.

B. This Chapter shall be known and may be cited as the "Utilization Review Organizations, Grievance Procedures, and External Review Act".

§2392. Definitions

As used in this Chapter:

(1) "Adverse determination" means any of the following:

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

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

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit under a health benefit plan.

(d) A rescission of coverage determination.

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

(3) "Authorized representative" means any of the following:

(a) A person to whom a covered person has given express written consent to represent the covered person for purposes of this Chapter. It may also include the covered person's treating provider if the covered person appoints the provider as his authorized representative and the provider waives in writing any right to payment from the covered person other than any applicable copayment or other coinsurance amount. In the event that the service is determined not to be medically necessary, and the covered person or his authorized representatives, except for the covered person's treating health care professional, thereafter requests the services, nothing shall prohibit the provider from charging usual and customary charges for all nonmedically necessary services provided.

(b) A person authorized by law to provide substituted consent for a covered person.

(c) A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent.

(d) A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional.

(e) In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

(4) "Best evidence" means evidence based on any of the following:

(a) Randomized clinical trials.

(b) If randomized clinical trials are not available, cohort studies, or case-control studies.

(c) If Subparagraphs (a) and (b) of this Paragraph are not available, case-series.

(d) If Subparagraphs (a), (b), and (c) of this Paragraph are not available, expert opinion.

(5) "Business day" means a day of normal business operation other than federally recognized holidays. Any day not specified as a business day shall be a twenty-four-hour period, including weekends and holidays.

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

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

(8) "Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

(9) "Certification" or "certify" means a determination by a health insurance issuer or its designee utilization review organization that a request for a benefit under the health insurance issuer's health benefit plan 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 effectiveness.

(10) "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar

specialty as typically manages the medical condition, procedure, or treatment under review.

(11) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the health insurance issuer to determine the medical necessity and appropriateness of health care services including those used in the determination of an item or health care service as experimental.

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

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

(14) "Commissioner" means the commissioner of insurance.

(15) "Concurrent review" means 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.

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

(17) "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

(18) "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 following discharge from a facility.

(19) "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.

(20) "Emergency medical condition" means a medical condition manifesting itself by symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in

serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(21) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

(22) "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.

(23) "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.

(24) "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, rehabilitation and other therapeutic health settings, and inpatient hospice facilities.

(25) "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health insurance issuer, or its designee utilization review organization, at the completion of the health insurance issuer's internal grievance process procedures as set forth in Part III of this Chapter, R.S. 22:2421 et seq.

(26) "Grievance" means a written complaint or oral complaint that has gone through the grievance process as set forth in Part III of this Chapter, R.S. 22:2421 et seq., if the complaint involves an urgent care request submitted by or on behalf of a covered person regarding any of the following:

(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.

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

(27) "Health benefit plan" means group and individual health insurance coverage, coverage provided under a group health plan, or coverage provided by a nonfederal governmental plan, as those terms are defined in R.S. 22:1061. "Health benefit plan" shall not include a plan providing coverage for excepted benefits as defined in R.S. 22:1061(3) and short-term policies that have a term less than twelve months.

(28) "Health care professional" means a physician or other health care practitioner licensed, accredited, registered, or certified to perform specified health care services consistent with state law.

(29) "Health care provider" or "provider" means a health care professional or a facility.

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

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

(32) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relate to any of the following:

(a) The past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family.

(b) The provision of health care services to an individual.

(c) Payment for the provision of health care services to an individual.

(33) "Health insurance issuer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service

corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

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

(35)(a) "Managed care plan" means a health benefit 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 the health insurance issuer.

(b) "Managed care plan" includes:

(i) A closed plan, as defined in Paragraph (12) of this Section.

(ii) An open plan, as defined in Paragraph (39) of this Section.

(36) "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 (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE).

(c) Medical journals recognized by the Secretary of Health and Human Services under Section 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 Accepted Dental Therapeutics.

(iv) The United States Pharmacopeia-Drug Information.

(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 & Medicaid Services.

(vi) The federal Food and Drug Administration.

(vii) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services.

(f) Any other medical or scientific evidence that is comparable to the sources listed in Subparagraphs (a) through (e) of this Paragraph.

(37) "NAIC" means the National Association of Insurance Commissioners.

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

(39) "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.

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

(41) "Person" or "entity" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

(42) "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 its provision.

(43) "Protected health information" means either of the following:

(a) Health information that identifies an individual who is the subject of the information.

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

(44) "Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

(45) "Rescission" means the following:

(a) A cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.

(b) "Rescission" does not include a cancellation or discontinuance of coverage under a health benefit plan if either.

(i) The cancellation or discontinuance of coverage has only a prospective effect.

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

(46) "Retrospective review" means a utilization review conducted after services have been provided to a patient, but 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.

(47) "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 medical necessity and appropriateness of the initial proposed health care service.

(48) "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to a pregnant woman, the woman delivered, including the placenta.

(49) "Urgent care request" means:

(a) A request for a health care service or course of treatment with respect to which the time periods for making non-urgent care request determination either:

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

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

(b)(i) Except as provided in Item (ii) of this Subparagraph, 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 layperson who possesses an average knowledge of health and medicine.

(ii) Any request that a physician with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of Subparagraph (a) of this Paragraph shall be treated as an urgent care request.

(50) "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, providers, or facilities. Techniques

may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

(51) "Utilization review organization" means an entity that conducts utilization review.

§2393. Licensure as a utilization or independent review organization

A. No health insurance issuer or entity acting on behalf of or agent of a health insurance issuer shall act as a utilization or independent review organization unless authorized as such by the commissioner as provided in this Chapter.

B. Any other entity may apply for and be issued a license pursuant to this Chapter to act as a utilization or independent review organization on behalf of a health benefit plan.

C. An entity licensed as a utilization or an independent review organization shall notify the commissioner of any material change in fact or circumstance affecting its qualification for a license in this state within sixty days of the effective date of the change. The notice shall include any documentation as the commissioner may require. Changes in fact or circumstances shall include the following items:

(1) Changes in control as defined in R.S. 22:692(3).

(2) Amendments to the articles of incorporation.

(3) Changes in officers and directors.

(4) Merger or consolidation of the utilization or independent review organization with any other person or entity.

(5) Use of a tradename in this state.

§2394. Procedure for application to act as a utilization or independent review organization

A. Any applicant for licensure other than a health insurance issuer shall submit an application to the commissioner and pay the initial licensing fee specified in R.S. 22:821(B)(28). The application shall be on a form and accompanied by any supporting documentation required by the commissioner and shall be signed and

verified by the applicant. The information required by the application shall include but need not be limited to the following:

(1) The name of the entity operating as a utilization or independent review organization and any trade or business names used by that entity in connection with making utilization review or external review determinations.

(2) The names and addresses of every officer and director of the entity operating as an utilization or independent review organization, as well as the name and address of the corporate officer designated by the utilization or independent review organization as the corporate representative to oversee the utilization review or external appellate review for the entity.

(3) The name and address of every person owning, directly or indirectly, five percent or more of the entity operating as a utilization or independent review organization.

(4) The principal place of business of the utilization or independent review organization.

(5) A general description of the operation of the utilization or independent review organization which includes a statement that the utilization or independent review organization does not engage in the practice of medicine or act to impinge or encumber the independent medical judgment of treating physicians or health care providers.

(6) A copy of the utilization or independent review organization's procedures manual which meets the requirements of this Chapter for making utilization review or external review determinations.

(7) A sample copy of any contract, absent fees charged, with a health insurance issuer, nonfederal government health benefit plan, or other group health plan for making utilization review determinations.

(8) The names, addresses, and qualifications of individuals being designated to make adverse making utilization review or external review determinations pursuant to this Chapter.

B. A health insurance issuer holding a valid certificate of authority to operate in this state may be authorized to act as a utilization or independent review organization under the requirements of this Chapter following submission to the commissioner of appropriate documentation for review and approval that shall include but need not be limited to the following:

(1) A general description of the operation of the utilization or independent review organization which includes a statement that the utilization or independent review organization does not engage in the practice of medicine or act to impinge upon or encumber the independent medical judgment of treating physicians or health care providers.

(2) A copy of the utilization or independent review organization's program description or procedures manual which meets the requirements of this Chapter for making medical necessity determinations and resolving disputes on an internal and external basis.

(3) A sample copy of any contract, absent fees charged, with another health insurance issuer for making utilization review determinations.

PART II. UTILIZATION REVIEW AND BENEFIT DETERMINATION ACT

§2401. Short title

This Part shall be known and may be cited as the "Utilization Review and Benefit Determination Act".

§2402. Purpose and intent

The purpose of this Part is to 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.

§2403. Applicability and scope

This Part shall apply to a health insurance issuer offering a health benefit plan that provides or performs utilization review services. The requirements of this Part also shall apply to any designee of the health insurance issuer or utilization review organization that performs utilization review functions on the insurance issuer's

behalf. This Part also shall apply to a health insurance issuer or its designee utilization review organization that provides or performs prospective review or retrospective review benefit determinations.

§2404. Licensure and corporate oversight of utilization review program

A. Licensure.

(1) No health insurance issuer shall act as a utilization review organization for the purpose of conducting utilization review unless authorized as a utilization review organization by the commissioner as provided in this Part.

(2) No entity acting on behalf of or as the agent of a health insurance issuer may act as a utilization review organization for the purpose of conducting utilization review unless licensed as a utilization review organization by the commissioner as provided in this Part.

(3) Any other entity may apply for and be issued a license pursuant to this Part to act as a utilization review organization for the purposes of conducting utilization review.

(4) An entity licensed as a utilization review organization shall notify the commissioner of any material change in fact or circumstance affecting its qualification for a license in this state within sixty days of the effective date of the change. The notice shall include any documentation as the commissioner may require. Material changes in fact or circumstances shall include the following items:

(a) Changes in control as defined in R.S. 22:692(3).

(b) Amendments to the articles of incorporation.

(c) Changes in officers and directors.

(d) Merger or consolidation of the utilization review organization with any other person or entity.

(e) Use of a tradename in this state.

B. A health insurance issuer shall be responsible for monitoring all utilization review activities carried out by, or on behalf of, the health insurance issuer and for ensuring that all requirements of this Part and applicable regulations are met.

The health insurance issuer also shall ensure that appropriate personnel have operational responsibility for the conduct of the health insurance issuer's utilization review program.

§2405. Contracting

Whenever a health insurance issuer contracts to have a utilization review organization or other entity perform the utilization review functions required by this Part or applicable regulations, the commissioner shall hold the health insurance issuer responsible for monitoring the activities of the utilization review organization or entity with which the health insurance issuer contracts and for ensuring that the requirements of this Part and applicable regulations are met.

§2406. Scope and content

A.(1) A health insurance issuer that requires a request for benefits under the covered person's health benefit plan to be subjected to utilization review shall implement a written utilization review program that describes all review activities and procedures, both delegated and non-delegated for all of the following:

(a) The filing of benefit requests.

(b) The notification of utilization review and benefit determinations.

(c) The review of adverse determinations in accordance with insert reference to state law equivalent to Part III of this Chapter, R.S. 22:2421 et seq.

(2) The program document shall describe all of 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 assuring confidentiality of clinical and proprietary information.

(f) The organizational structure, for example, utilization review committee, quality assurance committee, or other committee, that periodically assesses utilization review activities and reports to the health insurance issuer's governing body.

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

B.(1) A health insurance issuer shall file an annual summary report of its utilization review program activities with the commissioner or other appropriate state regulatory agency in the format specified.

(2)(a) In addition to the summary report required to be filed pursuant to Paragraph (1) of this Subsection, a health insurance issuer shall maintain records for a minimum of six years of all benefit requests and claims and notices associated with utilization review and benefit determinations made in accordance with R.S. 22:2408 and 2409.

(b) The health insurance issuer shall make the records available for examination by covered persons and the commissioner and appropriate federal oversight agencies upon request.

§2407. Operational requirements

A. A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health insurance issuer may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors. A health insurance issuer shall make available its clinical review criteria upon request to authorized government agencies, including the Department of Insurance, which shall be authorized to request affirmation of such criteria from other appropriate state regulatory agencies.

B. A utilization review organization shall have a medical director who shall be a duly licensed physician. The medical director shall administer the program and

oversee all review decisions. A clinical peer shall evaluate the clinical appropriateness of adverse determinations.

C.(1) A health insurance issuer shall issue utilization review and benefit determinations in a timely manner pursuant to the requirements of R.S. 22:2408 and 2409.

(2)(a) Whenever a health insurance issuer fails to strictly adhere to the requirements of R.S. 22:2408 and 2409 with respect to making utilization review and benefit determinations of a benefit request or claim, the covered person shall be deemed to have exhausted the provisions of this Part and may take action under Subparagraph (b) of this Paragraph regardless of whether the health insurance issuer asserts that it substantially complied with the requirements of R.S. 22:2408 and 2409, as applicable, or that any error it committed was de minimus.

(b)(i) A covered person may file a request for external review in accordance with the procedures outlined in Part IV of this Chapter, R.S. 22:2431 et seq.

(ii) In addition to Item (i) of this Subparagraph, 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. A covered person or his representatives, heirs, assigns, or health care providers shall have a cause of action for benefits or damages against an utilization review organization, health insurance issuer, or health benefit plan for any action involving or resulting from a decision made pursuant to this Part if the determination or opinion was rendered in bad faith or involved negligence, gross negligence, or intentional misrepresentation of factual information about the covered person's medical condition.

D. A health insurance issuer shall have a process to ensure that utilization reviewers apply clinical review criteria in conducting utilization review consistently.

E. A health insurance issuer shall routinely, but at least annually, assess the effectiveness and efficiency of its utilization review program and report any deficiencies or changes to the commissioner.

F. A health insurance issuer's data systems shall 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.

G. If a health insurance issuer delegates any utilization review activities to a utilization review organization, the health insurance issuer shall maintain oversight, which shall include the following:

(1) A written description of the utilization review organization's activities and responsibilities, including reporting requirements.

(2) Evidence of formal approval of the utilization review organization program by the health insurance issuer.

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

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

I. A health insurance issuer shall provide covered persons and participating providers with access to its review staff by a toll-free number or collect call telephone line for any period of time that an authorization, certification, or approval of coverage is required.

J. When conducting utilization review, the health insurance issuer shall collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination.

K.(1) In conducting utilization review, the health insurance issuer shall ensure that the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the utilization review or benefit determination.

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

§2408. Procedures for standard utilization review and benefit determinations

A. A health insurance issuer shall maintain written procedures pursuant to this Section for making standard utilization review and benefit determinations on requests submitted to the health insurance issuer by covered persons or their authorized representatives for benefits and for notifying covered persons and their authorized representatives of its determinations with respect to these requests within the specified time frames required under this Section.

B.(1)(a)(i) Subject to Subparagraph (b) of this Paragraph, 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 in no event later than fifteen days after the date the health insurance issuer receives the request.

(ii) Whenever the determination is an adverse determination, the health insurance issuer shall make the notification of the adverse determination in accordance with Subsection F of this Section.

(b) 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 Subparagraph (a) of this Paragraph may be extended one time by the health insurance issuer for up to fifteen days, provided the health insurance issuer does both of the following:

(i) Determines that an extension is necessary due to matters beyond the health insurance issuer's control.

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

(c) If the extension under Subparagraph (b) of this Paragraph is necessary due to 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 shall do both of the following:

(i) Specifically describe the required information necessary to complete the request.

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

(2)(a) Whenever the health insurance issuer receives a prospective review request from a covered person or the covered person's authorized representative 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 information on the proper procedures to be followed for filing a request.

(b)(i) The notice required under Subparagraph (a) of this Paragraph shall be provided, as soon as possible, but in no event later than five days following the date of the failure.

(ii) 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.

(c) The provisions of this Subparagraph shall apply only in the case of a failure that includes both of the following:

(i) A communication by a covered person or the covered person's authorized representative that is received by a person or organizational unit of the health insurance issuer responsible for handling benefit matters.

(ii) A communication that refers 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.

C.(1) 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 number of treatments, both of the following shall apply:

(a) Any reduction or termination by the health insurance issuer during the course of treatment before the end of the period or number of treatments, shall constitute an adverse determination.

(b) The health insurance issuer shall notify the covered person of the adverse determination in accordance with Subsection F of this Section 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 file a grievance to request a review of the adverse determination pursuant to Part III of this Chapter, R.S. 22:2421 et seq. and obtain a determination with respect to that review of the adverse determination before the benefit is reduced or terminated.

(2) The health care service or treatment that is the subject of the adverse determination shall be continued without liability to the covered person with respect to the internal review request made pursuant to Part III of this Chapter, R.S. 22:2421 et seq. The covered person shall not be liable for the cost of any services delivered until the adverse determination is received by the covered person or a covered person's authorized representative other than a health care provider.

D.(1)(a) For retrospective review determinations, a health insurance issuer shall make the determination within a reasonable period of time, but in no event later than thirty days after the date of receiving the benefit request. The utilization review organization shall not subsequently retract an authorization after services have been provided or reduce payment for an item or service furnished in reliance upon prior approval, unless the approval was based upon a material omission or

misrepresentation about the covered person's health condition made by the provider or unless the coverage was duly canceled for fraud or nonpayment of premiums.

(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 F of this Section.

(2)(a) 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 Paragraph (1) of this Subsection may be extended one time by the health insurance issuer for up to fifteen days, provided the health insurance issuer does the following:

(i) Determines that an extension is necessary due to matters beyond the health insurance issuer's control.

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

(b) If the extension under Subparagraph (a) of this Paragraph is necessary due to 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 shall include the following:

(i) A specific description of the required information necessary to complete the request.

(ii) Notice given to the covered person or, if applicable, the covered person's authorized representative, that he has at least forty-five days from the date of receipt of the notice to provide the specified information.

E.(1) For purposes of calculating the time periods within which a determination is required to be made pursuant to Subsections B and D of this Section, the time period within which the determination is required to be made shall

begin on the date the request is received by the health insurance issuer in accordance with the health insurance issuer's procedures established pursuant to R.S. 22:2406 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

(2)(a) If the time period for making the determination pursuant to Subsection B or D of this Section is extended due to the covered person's or, if applicable, the covered person's authorized representative's failure to submit the information necessary to make the determination, the time period for making the determination shall be 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.

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

(b) 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 B or D of this Section, the health insurance issuer may deny the certification of the requested benefit.

F.(1) A notification of an adverse determination under this Part shall, in a manner calculated to be understood by the covered person, set forth the following:

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

(b) The specific reason or 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 denying the benefit request or claim.

(c) 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 perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request.

(e) A description of the health insurance issuer's grievance procedures established pursuant to Part III of this Chapter, R.S. 22:2421 et seq., including any time limits applicable to those procedures.

(f) If the health insurance issuer relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request.

(g) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request including the following:

(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 item or health care service or treatment is more likely than not to be beneficial to the covered person than any available standard item or health care services or treatments and the adverse risks of the recommended or requested item or health care service or treatment would not be substantially increased over those of available standard items or 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.

(v) Information on whether the reviewer's rationale for the opinion is based on either:

(aa) The recommended or requested item or health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition.

(bb) Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested item or health care service or treatment is more likely than not to be beneficial to the covered person than any available standard item or health care service or treatment and the adverse risks of the recommended or requested item or health care service or treatment would not be substantially increased over those of available standard items or health care services or treatments.

(h) Either of the following:

(i) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, as provided in Subparagraph (f) of this Paragraph.

(ii) The written statement of the scientific or clinical rationale for the adverse determination, as provided in Subparagraph (g) of this Paragraph.

(i) A statement explaining the availability of and the right of the covered person, as appropriate, 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 Part III of this Chapter, R.S. 22:2421 et seq., to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the commissioner's office.

(j) The title and qualifying credentials of the physician affirming the adverse determination.

(2)(a) A health insurance issuer shall provide the notice required under this Section in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

(b) If a health insurance issuer is required to provide the notice required under this Section in a culturally and linguistically appropriate manner in accordance with federal regulations, the health insurance issuer shall do each of the following:

(i) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language.

(ii) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language.

(iii) To the extent the health insurance issuer maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing claims and appeals, the health insurance issuer shall provide this assistance in the non-English language.

(3) If the adverse determination is a rescission, in addition to the information required in Paragraph (1) of this Subsection, the health insurance issuer shall provide in the advance notice of the rescission determination:

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

(b) An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact.

(c) Notice that the covered person or the covered person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file a grievance to request a review of the adverse determination to rescind coverage pursuant to Part III of this Chapter, R.S. 22:2421 et seq.

(d) A description of the health insurance issuer's grievance procedures established pursuant to Part III of this Chapter, R.S. 22:2421 et seq., including any time limits applicable to those procedures.

(e) The date when the advance notice ends and the date back to which the coverage will be retroactively rescinded.

(4) A health insurance issuer may provide the notice required under this Section in writing or electronically.

§2409. Procedures for expedited utilization review and benefit determinations

A.(1) A health insurance issuer shall establish written procedures in accordance with this Section for receiving benefit requests from covered persons or their authorized representatives and for making and notifying covered persons or their authorized representatives of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgent care requests.

(2)(a) As part of the procedures required under Paragraph (1) of this Subsection, a health insurance issuer shall 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 shall be notified of the failure and the proper procedures to be followed for filing the request.

(b) The notice required pursuant to Subparagraph (a) of this Paragraph:

(i) Shall be provided to the covered person or the covered person's authorized representative, as appropriate, as soon as possible, but not later than twenty-four hours after receipt of the request.

(ii) May be oral, unless the covered person or the covered person's authorized representative requests the notice in writing.

(c) The provisions of this Paragraph shall apply only in the case of a failure that the communication is both:

(i) A communication by a covered person or, if applicable, the covered person's authorized representative that is received by a person or organizational unit of the health insurance issuer responsible for handling benefit matters.

(ii) A communication that refers 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.

B.(1)(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 benefit plan, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative of the health insurance issuer's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than twenty-four hours after the receipt of the request by the health insurance issuer.

(b) 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 E of this Section.

(2)(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 of this failure and state what specific information is needed as soon as possible, but in no event later than twenty-four hours after receipt of the request.

(b) The health insurance issuer shall provide the covered person or, if applicable, the covered person's authorized representative a reasonable period of time

to submit the necessary information, taking into account the circumstances, but in no event less than forty-eight hours after notifying the covered person or the covered person's authorized representative of the failure to submit sufficient information, as provided in Subparagraph (a) of this Paragraph.

(c) The health insurance issuer shall 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 in no event more than forty-eight hours after the earlier of:

(i) The health insurance issuer's receipt of the requested specified information.

(ii) The end of the period provided for the covered person or, if applicable, the covered person's authorized representative to submit the requested specified 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 Subparagraph (b) of this Paragraph, 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 E of this Section.

C.(1) 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 twenty-four 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 in no event more than twenty-four hours

after the health insurance issuer's receipt of the request. The covered person shall not be liable for the cost of any services delivered until the adverse determination is received by the covered person or a covered person's authorized representative other than a health care provider.

(2) 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 E of this Section.

D. For purposes of calculating the time periods within which a determination is required to be made under Subsection B or C of this Section, the time period within which the determination is required to be made shall begin on the date the request is filed with the health insurance issuer in accordance with the health insurance issuer's procedures established pursuant to R.S. 22:2406 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

E.(1) A notification of an adverse determination under this Section shall, in a manner calculated to be understood by the covered person, set forth each of the following:

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

(b) The specific reason or 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 denying the benefit request or claim.

(c) 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 Part III of this Chapter, R.S. 22:2421 et seq., including any time limits applicable to those procedures.

(f) A description of the health insurance issuer's expedited review procedures established pursuant to the Part III of this Chapter, R.S. 22:2421 et seq.

(g) If the health insurance issuer relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request.

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

(i) If applicable, instructions for requesting:

(aa) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination in accordance with Subparagraph (g) of this Paragraph.

(bb) The written statement of the scientific or clinical rationale for the adverse determination in accordance with Subparagraph (h) of this Paragraph.

(j) A statement explaining the availability of and the right of the covered person, as appropriate, 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 the Part III of this Chapter, R.S. 22:2421 et seq., to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the commissioner's office.

(k) The title and qualifying credentials of the physician affirming the adverse determination.

(2)(a) A health insurance issuer shall provide the notice required under this Section in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

(b) If a health insurance issuer is required to provide the notice required under this Section in a culturally and linguistically appropriate manner in accordance with federal regulations, the health insurance issuer shall do each of the following:

(i) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language.

(ii) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language.

(iii) To the extent the health insurance issuer maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing claims and appeals, the health insurance issuer shall provide this assistance in the non-English language.

(3) If the adverse determination is a rescission, the health insurance issuer shall provide each of the following, in addition to any applicable disclosures required under Paragraph (1) of this Subsection:

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

(b) An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact.

(c) The date the health insurance issuer made the decision to rescind the coverage.

(d) The date when the advance notice of the health insurance issuer's decision to rescind the coverage ends.

(4)(a) A health insurance issuer may provide the notice required under this Subsection 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 three days following the oral notification.

§2410. Emergency services

A. When conducting utilization review or making a benefit determination for emergency services, a health insurance issuer that provides benefits for such services shall follow the provisions of this Section.

B. A health insurance issuer shall cover emergency services to screen and stabilize a covered person in the following manner:

(1) Without the need for prior authorization of emergency services if a prudent layperson would have reasonably believed that an emergency medical condition existed even if the emergency services are provided on an out-of-network basis.

(2) Whether the health care provider furnishing the emergency services is a participating provider with respect to such emergency services.

(3) 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.

(4) If the emergency services are provided out-of-network, by complying with the cost-sharing requirements of Paragraph (C)(2) of this Section.

(5) Without regard to any other term or condition of coverage, other than:

(a) The exclusion of or coordination of benefits.

(b) An affiliation or waiting period as permitted under Section 2704 of the Public Health Service Act (PHSA).

(c) Applicable cost-sharing, as provided in Paragraph (C)(1) or (2) of this Section.

C.(1) For in-network emergency services, coverage of emergency services shall be subject to applicable copayments, coinsurance, and deductibles.

(2)(a) 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 shall not exceed the cost-sharing requirement imposed with respect to a covered person if the services were provided in-network.

(b) Notwithstanding Subparagraph (a) of this Paragraph, a covered person shall not be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the health insurance issuer is required to pay under this Subparagraph.

(c) A health insurance issuer complies with the requirements of this Subparagraph if it provides payment of emergency services provided by an out-of-network provider in an amount not less than the greatest of the following:

(i) The amount negotiated with in-network providers for emergency services, excluding any in-network copayments, deductibles, 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.

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

(d)(i) For capitated or other health benefit plans that do not have a negotiated per-service amount for in-network providers, Item (c)(i) of this Paragraph shall not apply.

(ii) If a health benefit plan has more than one negotiated amount for in-network providers for a particular emergency service, the amount in Item (c)(i) of this Paragraph is the median of these negotiated amounts.

(3)(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 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 shall apply to out-of-network emergency services.

D. For immediately required post-evaluation or post-stabilization services, a health insurance issuer shall provide access to a designated representative twenty-four hours a day, seven days a week, to facilitate review.

§2411. Disclosure requirements

A. 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 rights and responsibilities of covered persons with respect to those procedures.

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

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

PART III. HEALTH INSURANCE ISSUER GRIEVANCE PROCEDURE ACT

§2421. Short title

This Part shall be referred to as the "Health Insurance Issuer Grievance Procedure Act".

§2422. Purpose and intent

The purpose of this Part is to provide standards for the establishment and maintenance of procedures by health insurance issuers to assure that covered persons have the opportunity for the appropriate resolution of grievances, as defined in this Chapter.

§2423. Applicability and scope

Except as otherwise specified, this Part shall apply to all health insurance issuers offering a health benefit plan.

§2424. Grievance reporting and recordkeeping requirements

A.(1) A health insurance issuer shall maintain written records to document all grievances received, including the notices and claims associated with the grievances, during a calendar year, which shall be referred to as the register.

(2)(a) Notwithstanding the provisions under Subsection F of this Section, a health insurance issuer shall maintain the records required under Paragraph (1) of this Subsection for at least six years related to the notices provided pursuant to R.S. 22:2426(H) and 2429(H).

(b) The health insurance issuer shall make the records available for examination by covered persons and the commissioner and appropriate federal oversight agency upon request.

B. A request for a first level review of a grievance involving an adverse determination shall be processed in compliance with R.S. 22:2426 and shall be included in the register.

C. A request for an additional voluntary review of a grievance involving an adverse determination that may be conducted pursuant to R.S. 22:2428 shall be included in the register.

D. For each grievance the register shall contain, at a minimum, the following information:

(1) A general description of the reason for the grievance.

(2) The date received.

(3) The date of each review or, if applicable, review meeting.

(4) Resolution at each level of the grievance, if applicable.

(5) Date of resolution at each level, if applicable.

(6) Name of the covered person for whom the grievance was filed.

E. The register shall be maintained in a manner that is reasonably clear and accessible to the commissioner.

F.(1) Subject to the provisions of Subsection A of this Section, a health insurance issuer shall retain the register compiled for a calendar year for the longer of three years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.

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

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

(i) The certificate of compliance required by R.S. 22:2425.

(ii) The number of covered lives.

(iii) The total number of grievances.

(iv) The number of grievances for which a covered person requested an additional voluntary grievance review pursuant to R.S. 22:2428.

(v) The number of grievances resolved at each level, if applicable, and their resolution.

(vi) The number of grievances appealed to the commissioner of which the health insurance issuer has been informed.

(vii) The number of grievances referred to alternative dispute resolution procedures or resulting in litigation.

(viii) A synopsis of actions being taken to correct problems identified.

§2425. Grievance review procedures

A.(1) Except as specified in R.S. 22:2429, a health insurance issuer shall use written procedures for receiving and resolving grievances from covered persons, as provided in R.S. 22:2426 through 2428.

(2)(a) Whenever a health insurance issuer fails to strictly adhere to the requirements of R.S. 22:2426 through 2429 with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the provisions of this Part and may take action under Subparagraph (b) of this Paragraph regardless of whether the health insurance issuer asserts that it substantially complied with the requirements of R.S. 22:2426 or 2429, as applicable, or that any error it committed was de minimus.

(b)(i) A covered person may file a request for external review in accordance with the procedures outlined in the Part IV of this Chapter, R.S. 22:2431 et seq.

(ii) In addition to Item (i) of this Subparagraph, 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. A covered person or his representative, heirs, assign, or health care providers shall have a cause of action for benefits or damages against an utilization review organization, health insurance issuer, health benefit plan, or independent review organization for any action involving or resulting from a decision made pursuant to this Part if the determination or opinion was rendered in bad faith or involved negligence, gross negligence, or intentional misrepresentation of factual information about the covered person's medical condition.

B.(1) A health insurance issuer shall file a copy of the procedures required under Subsection A of this Section, including all forms used to process requests made pursuant to R.S. 22:2426 through 2428, with the commissioner. Any subsequent material modifications to the documents also shall be filed.

(2) The commissioner may disapprove a filing received in accordance with Paragraph (1) of this Subsection that fails to comply with this Part or applicable regulations.

C. In addition to Subsection B of this Section, a health insurance issuer shall file annually with the commissioner, as part of its annual report required by R.S. 22:2424, a certificate of compliance stating that the health insurance issuer has established and maintains, for each of its health benefit plans, grievance procedures that fully comply with the provisions of this Part.

D. A description of the grievance procedures required under this Section shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons.

E. The grievance procedure documents shall include a statement of a covered person's right to contact the commissioner's office for assistance at any time. The statement shall include the telephone number and address of the commissioner.

§2426. First level reviews of grievances involving an adverse determination

A. Within one hundred eighty days after the date of receipt of a notice of an adverse determination sent pursuant to Part II of this Chapter, R.S. 22:2421 et seq., a covered person or the covered person's authorized representative may file a grievance with the health insurance issuer requesting a first level review of the adverse determination.

B.(1) 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 first level review on behalf of the health insurance issuer.

(2)(a) In providing for a first level review pursuant to this Section, the health insurance issuer shall ensure that the review is conducted in a manner under this Section to ensure the independence and impartiality of the individuals involved in making the first level review decision.

(b) In ensuring the independence and impartiality of individuals involved in making the first level review decision, the health insurance issuer shall not make

decisions related to such individuals regarding hiring, compensation, termination, promotion, or other similar matters based upon the likelihood that the individual will support the denial of benefits.

C.(1)(a) In the case of an adverse determination involving utilization review, the health insurance issuer shall designate an appropriate clinical peer or peers of the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer shall not have been involved in the initial adverse determination.

(b) In designating an appropriate clinical peer or peers pursuant to Subparagraph (a) of this Paragraph, 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.

(2) In conducting a review under this Section, the reviewer or reviewers 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.

D.(1)(a) A covered person shall not have the right to attend, or to have a representative in attendance, at the first level 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.

(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 purposes of Item (a)(ii) of this Paragraph, a document, record, or other information shall be considered "relevant" to a covered person's request for benefits if 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) Demonstrates that, in making the benefit determination, the health insurance issuer or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons.

(iv) Constitutes a statement of policy or guidance with respect to the health benefit 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.

(2) The health insurance issuer shall make the provisions of Paragraph (1) of this Subsection known to the covered person or, if applicable, the covered person's authorized representative within three business days after the date of receipt of the grievance.

E. For purposes of calculating the time periods within which a determination is required to be made and notice provided under Subsection F of this Section, the time period shall begin on the date the grievance requesting the review is filed with the health insurance issuer in accordance with the health insurance issuer's procedures established pursuant to R.S. 22:2425 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

F.(1) 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 time frames provided in Paragraph (2) or (3) of this Subsection.

(2) With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, the health insurance issuer shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty days after the date of the health insurance issuer's receipt of the grievance requesting the first level review made pursuant to Subsection A of this Section.

(3) With respect to a grievance requesting a first level review of an adverse determination involving a retrospective review request, the health insurance issuer shall notify and issue a decision within a reasonable period of time, but no later than sixty days after the date of the health insurance issuer's receipt of the grievance requesting the first level review made pursuant to Subsection A of this Section.

G.(1) Prior to issuing a decision in accordance with the time frames provided in Subsection F of this Section, the health insurance issuer shall provide free of charge to the covered person, or the covered person's authorized representative, any new or additional evidence, relied upon or generated by the health insurance issuer, or at the direction of the health insurance issuer, in connection with the grievance sufficiently in advance of the date the decision is required to be provided to permit the covered person, or the covered person's authorized representative, a reasonable opportunity to respond prior to that date.

(2) Before the health insurance issuer issues or provides notice of a final adverse determination in accordance with the time frames provided in Subsection F of this Section that is based on new or additional rationale, the health insurance issuer shall provide the new or additional rationale to the covered person, or the covered person's authorized representative, free of charge as soon as possible and sufficiently in advance of the date the notice of final adverse determination is to be provided to permit the covered person, or the covered person's authorized representative a reasonable opportunity to respond prior to that date.

H. The decision issued pursuant to Subsection F shall set forth in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative all of the following:

(1) The titles and qualifying credentials of the person or persons participating in the first level review process, referred to as the reviewers.

(2) Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider, if applicable, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

(3) A statement of the reviewers' understanding of the covered person's grievance.

(4) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health insurance issuer's position.

(5) A reference to the evidence or documentation used as the basis for the decision.

(6) For a first level review decision issued pursuant to Subsection F of this Section that upholds the grievance:

(a) The specific reason or reasons for the final 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.

(b) The reference to the specific plan provisions on which the determination is based.

(c) 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, as the term "relevant" is defined in Subparagraph (D)(1)(b) of this Section to the covered person's benefit request.

(d) If the health insurance issuer relied upon an internal rule, guideline, protocol, or other similar criterion to make the final adverse determination, either the

specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the final adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request.

(e) If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request including the following:

(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 item or health care service or treatment is more likely than not to be beneficial to the covered person than any available standard item or health care services or treatments and the adverse risks of the recommended or requested item or health care service or treatment would not be substantially increased over those of available standard items or 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.

(v) Information on whether the reviewer's rationale for the opinion is based on either:

(aa) The recommended or requested item or health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition.

(bb) Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested item or health care

service or treatment is more likely than not to be beneficial to the covered person than any available standard item or health care service or treatment and the adverse risks of the recommended or requested item or health care service or treatment would not be substantially increased over those of available standard items or health care services or treatments.

(f) If applicable, instructions for requesting:

(i) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the final adverse determination, as provided in Subparagraph (d) of this Paragraph.

(ii) The written statement of the scientific or clinical rationale for the determination, as provided in Subparagraph (e) of this Paragraph.

(7) If applicable, a statement indicating:

(a) A description of the process to obtain an additional voluntary review of the first level review decision, if the covered person wishes to request a voluntary review pursuant to R.S. 22:2428.

(b) The written procedures governing the voluntary review, including any required time frame for the review.

(c) A description of the procedures for obtaining an independent external review of the final adverse determination pursuant to Part IV of this Chapter, R.S. 22:2431 et seq., if the covered person decides not to file for an additional voluntary review of the first level review decision involving an adverse determination.

(d) The covered person's right to bring a civil action in a court of competent jurisdiction.

(8) If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options. One way to find out what may be available is to contact your state insurance commissioner."

(9) Notice of the covered person's right to contact the commissioner's office for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the commissioner's office.

I.(1) A health insurance issuer shall provide the notice required under Subparagraph H of this Section in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

(2) If a health insurance issuer is required to provide the notice required under this Subsection in a culturally and linguistically appropriate manner in accordance with federal regulations, the health insurance issuer shall do each of the following:

(a) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language.

(b) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language.

(c) To the extent the health insurance issuer maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing claims and appeals, the health insurance issuer shall provide this assistance in the non-English language.

§2427. Standard reviews of grievances not involving an adverse determination

A. A health insurance issuer shall establish written procedures for a standard review of a grievance that does not involve an adverse determination.

B.(1) The procedures shall permit a covered person or the covered person's authorized representative to file a grievance that does not involve an adverse determination with the health insurance issuer under this Section.

(2)(a) A covered person shall not have the right to attend, or to have a representative in attendance at the standard review, but the covered person or the covered person's authorized representative is entitled to submit written material for the person or persons designated by the insurance issuer pursuant to Subsection C of this Section to consider when conducting the review.

(b) The health insurance issuer shall make the provisions of Subparagraph (a) of this Paragraph known to the covered person or, if applicable, the covered person's authorized representative within three business days after the date of receiving the grievance.

C.(1) Upon receipt of the grievance, a health insurance issuer shall designate a person or persons to conduct the standard review of the grievance.

(2) The health insurance issuer shall not designate the same person or persons to conduct the standard review of the grievance that denied the claim or handled the matter that is the subject of the grievance.

(3) The health insurance issuer shall provide the covered person or, if applicable, the covered person's authorized representative with the name, address, and telephone number of a person designated to coordinate the standard review on behalf of the health insurance issuer.

D.(1) The health insurance issuer shall notify in writing the covered person or, if applicable, the covered person's authorized representative of the decision within twenty days after the date of receipt of the request for a standard review of a grievance filed pursuant to Subsection B of this Section.

(2)(a) Subject to Subparagraph (b) of this Paragraph, if, due to circumstances beyond the insurance issuer's control, the health insurance issuer cannot make a decision and notify the covered person or, if applicable, the covered person's authorized representative pursuant to Paragraph (1) of this Subsection within twenty days, the health insurance issuer may take up to an additional ten days to issue a written decision.

(b) A health insurance issuer may extend the time for making and notifying the covered person or, if applicable, the covered person's authorized representative in accordance with Subparagraph (a) of this Paragraph, if, on or before the twentieth day after the date of receiving the request for a standard review of a grievance, the health insurance issuer provides written notice to the covered person or, if applicable,

the covered person's authorized representative of the extension and the reasons for the delay.

E. The written decision issued pursuant to Subsection D of this Section shall contain:

(1) The titles and qualifying credentials of the person or persons participating in the standard review process, referred to as the reviewers.

(2) A statement of the reviewers' understanding of the covered person's grievance.

(3) The reviewers' decision in clear terms and the contract basis in sufficient detail for the covered person to respond further to the health insurance issuer's position.

(4) A reference to the evidence or documentation used as the basis for the decision.

(5) If applicable, a statement indicating:

(a) A description of the process to obtain an additional review of the standard review decision if the covered person wishes to request a voluntary review pursuant to R.S. 22:2428.

(b) The written procedures governing the voluntary review, including any required time frame for the review.

(6) Notice of the covered person's right, at any time, to contact the commissioner's office, including the telephone number and address of the commissioner's office.

§2428. Voluntary level of reviews of grievances

A. A health insurance issuer shall establish a voluntary review process to give those covered persons who are dissatisfied with the first level review decision made pursuant to R.S. 22:2426, or who are dissatisfied with the standard review decision made pursuant to R.S. 22:2427, the option to request an additional voluntary review, at which the covered person or the covered person's authorized representative

has the right to appear in person at the review meeting before designated representatives of the health insurance issuer.

B.(1) A health insurance issuer required by this Section to establish a voluntary review process shall provide covered persons or their authorized representatives with notice pursuant to R.S. 22:2426(G)(6) or 2427(E)(5), as appropriate, of the option to file a request with the health insurance issuer for an additional voluntary review of the first level review decision received under R.S. 22:2426 or the standard review decision received under R.S. 22:2427.

(2) Upon receipt of a request for an additional voluntary review, the health insurance issuer shall send notice to the covered person or, if applicable, the covered person's authorized representative of the covered person's right to:

(a) Request, within the time frame specified in Subparagraph (3)(a) of this Subsection, the opportunity to appear in person before a review panel of the health insurance issuer's designated representatives.

(b) Receive from the health insurance issuer, upon request, copies of all documents, records, and other information that is not confidential or privileged relevant to the covered person's request for benefits.

(c) Present the covered person's case to the review panel.

(d) Submit written comments, documents, records, and other material relating to the request for benefits for the review panel to consider when conducting the review both before and, if applicable, at the review meeting.

(e) If applicable, ask questions of any representative of the health insurance issuer on the review panel.

(f) Be assisted or represented by an individual of the covered person's choice.

(3)(a) A covered person or the authorized representative of the covered person wishing to request to appear in person before the review panel of the health insurance issuer's designated representatives shall make the request to the health insurance issuer within five business days after the date of receipt of the notice sent in accordance with Paragraph (2) of this Subsection.

(b) The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.

C.(1)(a) With respect to a voluntary review of a first level review decision made pursuant to R.S. 22:2426, a health insurance issuer shall appoint a review panel to review the request.

(b) In conducting the review, the review panel shall take into consideration all comments, documents, records, and other information regarding the request for benefits submitted by the covered person or the covered person's authorized representative pursuant to Paragraph (B)(2) of this Section, without regard to whether the information was submitted or considered in reaching the first level review decision.

(c) The panel shall have the legal authority to bind the health insurance issuer to the panel's decision.

(2)(a) Except as provided in Subparagraph (b) of this Paragraph, a majority of the panel shall be comprised of individuals who were not involved in the first level review decision made pursuant to R.S. 22:2426.

(b) An individual who was involved with the first level review decision may be a member of the panel or appear before the panel to present information or answer questions.

(c) The health insurance issuer shall ensure that a majority of the individuals conducting the additional voluntary review of the first level review decision made pursuant to R.S. 22:2426 are health care professionals who have appropriate expertise.

(d) Except, when such a reviewing health care professional is not reasonably available, in cases where there has been a denial of a health care service, the reviewing health care professional shall not do both of the following:

(i) Be a provider in the covered person's health benefit plan.

(ii) Have a financial interest in the outcome of the review.

D.(1)(a) With respect to a voluntary review of a standard review decision made pursuant to R.S. 22:2427, a health insurance issuer shall appoint a review panel to review the request.

(b) The panel shall have the legal authority to bind the health insurance issuer to the panel's decision.

(2)(a) Except as provided in Subparagraph (b) of this Paragraph, a majority of the panel shall be comprised of employees or representatives of the health insurance issuer who were not involved in the standard review decision made pursuant to R.S. 22:2427.

(b) An employee or representative of the health insurance issuer who was involved with the standard review decision may be a member of the panel or appear before the panel to present information or answer questions.

E.(1)(a) Whenever a covered person or the covered person's authorized representative requests within the time frame specified in Subparagraph (B)(3)(a) of this Section, the opportunity to appear in person before the review panel appointed pursuant to Subsection C or D of this Section, the procedures for conducting the review shall include the provisions described in this Section.

(b)(i) The review panel shall schedule and hold a review meeting within forty-five days after the date of receipt of the request.

(ii) The covered person or, if applicable, the covered person's authorized representative shall be notified in writing at least fifteen days in advance of the date of the review meeting.

(iii) The health insurance issuer shall not unreasonably deny a request for postponement of the review made by the covered person or the covered person's authorized representative.

(c) The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person or, if applicable, the covered person's authorized representative.

(d) In cases where a face to face meeting is not practical for geographic reasons, a health insurance issuer shall offer the covered person or, if applicable, the covered person's authorized representative the opportunity to communicate with the review panel, at the health insurance issuer's expense, by conference call, video conferencing, or other appropriate technology.

(e) If the health insurance issuer desires to have an attorney present to represent the interests of the health insurance issuer, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative at least fifteen days in advance of the date of the review meeting that an attorney will be present and that the covered person may wish to obtain legal representation of his own.

(f) The review panel shall issue a written decision, as provided in Subsection F of this Section, to the covered person or, if applicable, the covered person's authorized representative within five business days of completing the review meeting.

(2) Whenever the covered person or, if applicable, the covered person's authorized representative does not request the opportunity to appear in person before the review panel within the specified time frame provided under Subparagraph (B)(3)(a) of this Section, the review panel shall issue a decision and notify the covered person or, if applicable, the covered person's authorized representative of the decision, as provided in Subsection F of this Section, in writing or electronically, within forty-five days after the earlier of:

(a) The date the covered person or the covered person's authorized representative notifies the health insurance issuer of the covered person's decision not to request the opportunity to appear in person before the review panel.

(b) The date on which the covered person's or the covered person's authorized representative's opportunity to request to appear in person before the review panel expires pursuant to Subparagraph (B)(3)(a) of this Section.

(3) For purposes of calculating the time periods within which a decision is required to be made and notice provided under Paragraphs (1) and (2) of this Subsection, the time period shall begin on the date the request for an additional voluntary review is filed with the health insurance issuer in accordance with the health insurance issuer's procedures established pursuant to R.S. 22:2425 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

F. A decision issued pursuant to Subsection E of this Section shall include all of the following:

(1) The titles and qualifying credentials of the members of the review panel.

(2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.

(3) The rationale for the review panel's decision.

(4) A reference to evidence or documentation considered by the review panel in making that decision.

(5) In cases concerning a grievance involving an adverse determination, both of the following:

(a) The instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination.

(b) If applicable, a statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to Part IV of this Chapter, R.S. 22:2431 et seq.

(6) Notice of the covered person's right to contact the commissioner's office for any assistance with respect to any claim, grievance, or appeal at any time, including the telephone number and address of the commissioner's office.

§2429. Expedited reviews of grievances involving an adverse determination

A. A health insurance issuer shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination.

B. In addition to Subsection A of this Section, a health insurance issuer shall provide expedited review of a grievance involving an adverse determination with respect to concurrent review urgent care requests 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.

C. The procedures shall allow a covered person or the covered person's authorized representative to request an expedited review under this Section orally or in writing.

D. A health insurance issuer shall appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer or peers shall not have been involved in making the initial adverse determination.

E. In an expedited review, all necessary information, including the health insurance issuer's decision, shall be transmitted between the health insurance issuer and the covered person or, if applicable, the covered person's authorized representative by telephone, facsimile, or the most expeditious method available.

F.(1) An expedited review decision shall be made and the covered person or, if applicable, the covered person's authorized representative shall be notified of the decision in accordance with Subsection H of this Section as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two hours after the receipt of the request for the expedited review.

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

G. For purposes of calculating the time periods within which a decision is required to be made under Subsection F of this Section, the time period within which the decision is required to be made shall begin on the date the request is filed with the health insurance issuer in accordance with the health insurance issuer's

procedures established pursuant to R.S. 22:2425 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

H.(1) A notification of a decision under this Section shall, in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative, set forth all of the following:

(a) The titles and qualifying credentials of the person or persons participating in the expedited review process, referred to as "the reviewers".

(b) Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider, if applicable, 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) The reviewers' decision in clear terms 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.

(f) If the decision involves a final adverse determination, the notice shall provide the following:

(i) The specific reasons or reasons for the final 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) Reference to the specific plan provisions on which the determination is based.

(iii) 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) If the health insurance issuer relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request.

(v) If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request.

(vi) If applicable, instructions for requesting:

(aa) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination in accordance with Item (iv) of this Subparagraph.

(bb) The written statement of the scientific or clinical rationale for the adverse determination in accordance with Item (v) of this Subparagraph.

(vii) A statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to Part IV of this Chapter, R.S. 22:2431 et seq.

(viii) A statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction.

(ix) The following statement: "You and your plan may have other voluntary alternative dispute resolution options. One way to find out what may be available is to contact your state insurance commissioner".

(x) A notice of the covered person's right to contact the commissioner's office for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the commissioner's office.

(2)(a) A health insurance issuer shall provide the notice required under this Section in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

(b) If a health insurance issuer is required to provide the notice required under this Section in a culturally and linguistically appropriate manner in accordance with federal regulations, the health insurance issuer shall include all of the following:

(i) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language.

(ii) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language.

(iii) To the extent the health insurance issuer maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing claims and appeals, the health insurance issuer shall provide this assistance in the non-English language.

(3)(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 three days following the oral notification.

PART IV. HEALTH INSURANCE ISSUER EXTERNAL REVIEW ACT

§2431. Short title

This Part shall be referred to as the "Health Insurance Issuer External Review Act".

§2432. Purpose and intent

The purpose of this Part is to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have

the opportunity for an independent review of an adverse determination or final adverse determination, as defined in this Chapter.

§2433. Applicability and scope

This Part shall apply to all health insurance issuers.

§2434. Notice of right to external review

A.(1) A health insurance issuer shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to R.S. 22:2437 through 2439 and include the appropriate statements and information set forth in Subsection B of this Section at the same time the health insurance issuer sends written notice of:

(a) An adverse determination upon completion of the health insurance issuer's utilization review process set forth in Part II of this Chapter, R.S. 22:2401 et seq.

(b) A final adverse determination.

(2) As part of the written notice required under Paragraph (1) of this Subsection, a health insurance issuer shall include 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 may have the right to have our decision reviewed by health care professionals who have no association with us. In order to request an external appeal, you should send your request in writing to our office at the designated address included in this notice."

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

B.(1) The health insurance issuer shall include in the notice required pursuant to Subsection A of this Section:

(a) For a notice related to an adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition where the time frame for completion of an expedited review of a grievance involving an adverse determination

set forth in R.S. 22:2429 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to R.S. 22:2438 or 2439 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 physician 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, 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 as set forth in R.S. 22:2429 but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review.

(ii) The covered person or the covered person's authorized representative may file a grievance under the health insurance issuer's internal grievance process as set forth in R.S. 22:2426, but if the health insurance issuer has not issued a written decision to the covered person or the covered person's authorized representative within thirty days following 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 R.S. 22:2435 and shall be considered to have exhausted the health insurance issuer's internal grievance process for purposes of R.S. 22:2436.

(b) For a notice related to a final adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition where the time frame for completion of a standard external review pursuant to R.S. 22:2437 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to R.S. 22:2438.

(ii) If the final adverse determination concerns either of the following:

(aa) 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, the covered person or the covered person's authorized representative may request an expedited external review pursuant to R.S. 22:2438.

(bb) A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person or the covered person's authorized representative may file a request for a standard external review to be conducted pursuant to R.S. 22:2439 or if the covered person's treating physician 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, the covered person or the covered person's authorized representative may request an expedited external review to be conducted under R.S. 22:2439.

(2) In addition to the information to be provided pursuant to Paragraph (1) of this Subsection, the health insurance issuer shall include a copy of the description of both the standard and expedited external review procedures the health insurance issuer is required to provide pursuant to R.S. 22:2446, 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.

(3) As part of any forms provided under Paragraph (2) of this Subsection, the health insurance issuer shall include an authorization form, or other document

approved by the commissioner that complies with the requirements of 45 CFR Section 164.508, by which the covered person, for purposes of conducting an external review under this Part, 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 that are pertinent to the external review, as provided below:

(a) A health insurance issuer that has collected protected health information pursuant to a valid authorization in accordance with state and federal law, may use and disclose the protected health information to a person acting on behalf of or at the direction of the health insurance issuer for the performance of the health insurance issuer's insurance functions: claims administration, claims adjustment and management, fraud investigation, underwriting, loss control, ratemaking functions, reinsurance, risk management, case management, disease management, quality assessment, quality improvement, provider credentialing verification, utilization review, peer review activities, grievance procedures, and internal administration of compliance, managerial, information systems, and policyholder service functions. Additional insurance functions may be allowed with the prior approval of the commissioner.

(b) The protected health information shall not be used or disclosed for any purpose other than in the performance of the health insurance issuer's insurance functions, except as otherwise permitted by state or federal law.

§2435. Request for external review

A.(1) All requests for external review shall be made in writing to the health insurance issuer.

(2) The commissioner may prescribe by regulation the form and content of external review requests required to be submitted under this Section.

B. 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.

§2436. Exhaustion of internal grievance process

A.(1) Except as provided in Subsection B of this Section, a request for an external review pursuant to R.S. 22:2437 through 2439 shall not be made until the covered person has exhausted the health insurance issuer's internal grievance process as set forth in Part III of this Chapter, R.S. 22:2421 et seq.

(2) A covered person shall be considered to have exhausted the health insurance issuer's internal grievance process for purposes of this Section, if the covered person or the covered person's authorized representative does both of the following:

(a) Has filed a grievance involving an adverse determination pursuant to R.S. 22:2426.

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

(3) Notwithstanding Paragraph (2) of this Subsection, a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination made pursuant to the Part II of this Chapter, R.S. 22:2401 et. seq., until the covered person has exhausted the health insurance issuer's internal grievance process.

B.(1)(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 as set forth in R.S. 22:2429, the covered person or the covered person's authorized representative may file a request for an expedited external review of the adverse determination for either of the following:

(i) Under R.S. 22:2438, if the covered person has a medical condition where the time frame for completion of an expedited review of the grievance involving an

adverse determination set forth in R.S. 22:2429 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

(ii) Under R.S. 22:2439, 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 physician 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 Subparagraph (a) of this Paragraph, the independent review organization conducting the external review in accordance with the provisions of R.S. 22:2438 or 2439 shall determine whether the covered person shall be required to complete the expedited review process set forth in R.S. 22:2429 before it conducts the expedited external review.

(c) Upon a determination made pursuant to Subparagraph (b) of this Paragraph that the covered person must first complete the expedited grievance review process set forth in R.S. 22:2429, the independent review organization immediately shall notify the covered person and, if applicable, the covered person's authorized representative of this determination and that it will not proceed with the expedited external review set forth in R.S. 22:2438 until completion of the expedited grievance review process and the covered person's grievance at the completion of the expedited grievance review process remains unresolved.

(2) 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 set forth in R.S. 22:2426 whenever the health insurance issuer agrees to waive the exhaustion requirement or fails to strictly adhere to the requirements of R.S. 22:2426 or 2429 with respect to receiving and resolving grievances involving an adverse determination regardless of whether the health

insurance issuer asserts that it substantially complied with the requirements of R.S. 22:2426 or 2429, as applicable, or that any error it committed was de minimus.

C. If the requirement to exhaust the health insurance issuer's internal grievance procedures is waived under Paragraph (B)(2) of this Section, the covered person or the covered person's authorized representative may file a request in writing for a standard external review as set forth in R.S. 22:2437 or 2439.

§2437. Standard external review

A. Within four months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to R.S. 22:2434 of this Part, a covered person or the covered person's authorized representative may file a request for an external review with the health insurance issuer, which shall notify the commissioner within one business day from the receipt of the request.

B. Within five business days following the date of receipt of the external review request from the covered person or the covered person's authorized representative under Subsection A of this Section, the health insurance issuer shall complete a preliminary review of the request to determine whether all of the following have been met:

(1) The individual is or was a covered person in the health benefit 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 benefit plan at the time the health care service was provided.

(2) The health care service is the subject of an adverse determination or a final adverse determination.

(3) The covered person has exhausted the health insurance issuer's internal grievance process as set forth in Part III of this Chapter, R.S. 22:2421 et seq., unless the covered person is not required to exhaust the health insurance issuer's internal grievance process pursuant to R.S. 22:2436.

(4) The covered person has provided all the information and forms required to process an external review, including the release form provided under R.S. 22:2434(B).

C.(1) Within the five business days allowed for the completion of the preliminary review, the health insurance issuer shall notify the commissioner as enumerated in Subsection D of this Section and notify the covered person and, if applicable, the covered person's authorized representative of all the following, in writing, whether:

(a) The request is complete.

(b) The request is eligible for external review.

(2) If the request:

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

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

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

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

(4)(a) If the covered person or the covered person's authorized representative makes a written request to the Department of Insurance after the receipt of the denial of an external review, the commissioner may determine that a request is eligible for

external review under Subsection B of this Section, notwithstanding a health insurance issuer's initial determination that the request is ineligible and require that it be referred for external review.

(b) In making a determination under Subparagraph (a) of this Paragraph, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Part.

(c) The commissioner shall notify the health insurance issuer and the covered person or the covered person's authorized representative of its determination about the eligibility of the request within five business days of the receipt of the request from the covered person. Within one business day of receipt of the commissioner's determination that a request is eligible for an external review, a health insurance issuer shall comply with Subsection D of this Section.

D.(1) A health insurance issuer shall notify the commissioner that a request is eligible for external review pursuant to Subsection C of this Section by inputting a request for assignment of an independent review organization through the Department of Insurance's website. Upon notification, the commissioner shall do the following:

(a) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to R.S. 22:2441 to conduct the external review and notify the health insurance issuer of the name of the assigned independent review organization.

(b) Within one business day, send written notice to the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review and the identity and contact information of the assigned independent review organization.

(2) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health insurance issuer's utilization review process as set forth in Part II of this Chapter, R.S. 22:2401

et seq., or the health insurance issuer's internal grievance process as set forth in Part III of this Chapter, R.S. 22:2421 et seq.

(3) 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 five business days following the date of receipt of the notice provided pursuant to Subparagraph (1)(b) of this Subsection additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five business days.

E.(1) Within five business days after the date of receipt of the notice provided pursuant to Paragraph (D)(1) of this Section, the health insurance issuer or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.

(2) Except as provided in Paragraph (3) of this Subsection, failure by the health insurance issuer or its utilization review organization to provide the documents and information within the time specified in Paragraph (1) of this Subsection shall not delay the conduct of the external review.

(3)(a) If the health insurance issuer or its utilization review organization fails to provide the documents and information within the time specified in Paragraph (1) of this Subsection, 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 one business day after making the decision under Subparagraph (a) of this Paragraph, the independent review organization shall notify the covered person in writing, if applicable, the covered person's authorized representative, the health insurance issuer, and the commissioner.

F.(1) The assigned independent review organization shall review all of the information and documents received pursuant to Subsection E of this Section 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 Paragraph (D)(3) of this Section.

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Paragraph (D)(3) of this Section, the assigned independent review organization shall within one business day forward the information to the health insurance issuer.

G.(1) Upon receipt of the information, if any, required to be forwarded pursuant to Paragraph (F)(2) of this Section, the health insurance issuer may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health insurance issuer of its adverse determination or final adverse determination pursuant to Paragraph (1) of this Subsection shall not delay or terminate the external review.

(3) The external review may only be terminated 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.

(4)(a) Within one business day after making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3) of this Subsection, the health insurance issuer shall notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

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

H. In addition to the documents and information provided pursuant to Subsection E of this Section, the assigned independent review organization, to the extent the information or documents are available and the independent review organization, shall consider the following in reaching a decision:

(1) The covered person's medical records.

(2) The attending health care professional's recommendation.

(3) 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 provider.

(4) The terms of coverage under the covered person's health benefit 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 benefit plan with the health insurance issuer.

(5) The most appropriate practice guidelines, which shall 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.

(6) Any applicable clinical review criteria developed and used by the health insurance issuer or its designee utilization review organization.

(7) The opinion of the independent review organization's clinical reviewer or reviewers after considering Paragraphs (1) through (6) of this Subsection to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

I.(1) Within forty-five 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 all of the following:

(a) The covered person.

(b) If applicable, the covered person's authorized representative.

(c) The health insurance issuer.

(d) The commissioner.

(2) The independent review organization shall include in the notice sent pursuant to Paragraph (1) of this Subsection, all of the following:

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

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

(c) The date the external review was conducted.

(d) The date of its decision.

(e) The principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision.

(f) The rationale for its decision.

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

(3) Upon receipt of a notice of a decision pursuant to Paragraph (1) of this Subsection reversing the adverse determination or final adverse determination, the health insurance issuer immediately shall approve the coverage or payment that was the subject of the adverse determination or final adverse determination.

J. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this Section shall be done on a random basis 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 R.S. 22:2442(D).

§2438. Expedited external review

A. Except as provided in Subsection F of this Section, a covered person or the covered person's authorized representative may make a request for an expedited

external review with the health insurance issuer at the time the covered person receives:

(1) An adverse determination if both of the following have occurred:

(a) The adverse determination involves a medical condition of the covered person for which the time frame for completion of an expedited internal review of a grievance involving an adverse determination set forth in R.S. 22:2429 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

(b) 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 set forth in R.S. 22:2429.

(2) A final adverse determination if either of the following exists:

(a) The covered person has a medical condition where the time frame for completion of a standard external review pursuant to R.S. 22:2437 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

(b) 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.

(3) The health insurance issuer shall notify the commissioner of the request for expedited external appeal within one business day of receiving the request by the covered person or the covered person's authorized representative.

B.(1) Immediately upon receipt of the request pursuant to Subsection A of this Section, the health insurance issuer shall determine whether the request meets the reviewability requirements set forth in R.S. 22:2437(B). 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.

(2)(a) The commissioner may specify the form and method 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 under this Subsection shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health insurance issuer's initial determination that an external review request is ineligible for review may be appealed to the commissioner.

(3)(a) If the covered person or the covered person's authorized representative makes a written request to the Department of Insurance after receipt of the denial of an external review, the commissioner may determine that a request is eligible for external review under R.S. 22:2437(B), notwithstanding a health insurance issuer's initial determination that the request is ineligible and require that it be referred for external review.

(b) In making a determination under Subparagraph (a) of this Paragraph, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Part.

(c) The commissioner shall immediately notify the health insurance issuer and the covered person or the covered person's authorized representative of its determination about the eligibility of the request. Following receipt of the commissioner's determination that a request is eligible for external review, a health insurance issuer shall immediately comply with Paragraph (4) of this Subsection.

(4) Immediately upon the health insurance issuer's determination that a request is eligible for external review or upon the determination by the commissioner that a request is eligible for external review, the health insurance issuer shall input a request for assignment of an independent review organization. Upon receipt of the notice that the request meets the reviewability requirements, the commissioner immediately shall assign an independent review organization to conduct the

expedited external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to R.S. 22:2441 of this Part. The commissioner shall immediately notify the health insurance issuer and the covered person or the covered person's authorized representative of the name and contact information of the assigned independent review organization.

(5) In reaching a decision in accordance with Subsection E of this Section, the assigned independent review organization is not bound by any decisions or conclusions reached during the health insurance issuer's utilization review process as set forth in Part II of this Chapter, R.S. 22:2401 et seq., or the health insurance issuer's internal grievance process as set forth in Part III of this Chapter, R.S. 22:2421 et seq.

C. Upon receipt of the notice from the commissioner of the name of the independent review organization assigned to conduct the expedited external review pursuant to Paragraph (B)(5) of this Section, the health insurance issuer or its designee utilization review organization shall provide or transmit all necessary documents and information considered 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.

D. In addition to the documents and information provided or transmitted pursuant to Subsection C of this Section, the assigned independent review organization, to the extent the information or documents are available and the independent review organization, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records.

(2) The attending health care professional's recommendation.

(3) 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 provider.

(4) The terms of coverage under the covered person's health benefit 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 benefit plan with the health insurance issuer.

(5) The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations.

(6) Any applicable clinical review criteria developed and used by the health insurance issuer or its designee utilization review organization in making adverse determinations.

(7) The opinion of the independent review organization's clinical reviewer or reviewers after considering Paragraphs (1) through (6) of this Subsection to the extent the information and documents are available and the clinical reviewer or reviewers consider appropriate.

E.(1) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two hours after the date the health insurance issuer receives the request for an expedited external review, the assigned independent review organization shall do both of the following:

(a) Make a decision to uphold or reverse the adverse determination or final adverse determination.

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

(2) If the notice provided pursuant to Paragraph (1) of this Subsection was not in writing, within forty-eight hours after the date of providing that notice, the assigned independent review organization shall do both of the following:

(a) Provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, the health insurance issuer, and the commissioner.

(b) Include the information set forth in R.S. 22:2437(I)(2).

(3) Upon receipt of the notice of a decision pursuant to Paragraph (1) of this Subsection reversing the adverse determination or final adverse determination, the health insurance issuer immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

F. An expedited external review may not be provided for retrospective adverse determinations or retrospective final adverse determinations.

G. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this Section shall be done on a random basis 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 R.S. 22:2442(D).

§2439. External review of experimental or investigational treatment adverse determinations

A.(1) Within four months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to R.S. 22:2434 that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the health insurance issuer, which shall notify the commissioner within one business day of the receipt of the request.

(2)(a) A covered person or the covered person's authorized representative may make an oral request to the health insurance issuer for an expedited external review of the adverse determination or final adverse determination pursuant to Paragraph (1) of this Subsection if the covered person's treating physician 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) The health insurance issuer shall notify the commissioner of the request for expedited external appeal within one day of receiving by the covered person or the covered person's authorized representative.

(c)(i) Upon notice of the request for expedited external review, the health insurance issuer immediately shall determine whether the request meets the reviewability requirements of Subsection B of this Section. 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.

(ii) The commissioner may specify the form and method for the health insurance issuer's notice of initial determination under Item (i) of this Subparagraph and any supporting information to be included in the notice.

(iii) The notice of initial determination under Item (i) of this Subparagraph shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health insurance issuer's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(d)(i) If the covered person or the covered person's authorized representative makes a written request to the Department of Insurance after receipt of the denial of an external review, the commissioner may determine that a request is eligible for external review under Paragraph (B)(2) of this Section notwithstanding a health insurance issuer's initial determination the request is ineligible and require that it be referred for external review.

(ii) In making a determination under Item (i) of this Subparagraph, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Part.

(iii) The commissioner shall immediately notify the health insurance issuer and the covered person or the covered person's authorized representative of its

determination about the eligibility of the request. Following receipt of the commissioner's determination that a request is eligible for external review, a health insurance issuer shall immediately comply with Subparagraph (e) of this Paragraph.

(e) Immediately upon the health insurance issuer's determination that a request is eligible for external review or upon the determination by the commissioner that a request is eligible for external review, the health insurance issuer shall input a request for assignment of an independent review organization. Upon receipt of the notice that the expedited external review request meets the reviewability requirements of Paragraph (B)(2) of this Section, the commissioner immediately shall assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to R.S. 22:2441 and notify the covered person or the covered person's authorized representative of the name and contact information of the assigned independent review organization.

(f) At the time the health insurance issuer receives the notice of the assigned independent review organization pursuant to Subparagraph (e) of this Paragraph, the health insurance issuer or its designee utilization review organization shall provide or transmit all necessary documents and information considered 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.

B.(1) Except for a request for an expedited external review made pursuant to Paragraph (A)(2) of this Section, within one business day after the date of receipt of the request for an external appeal, the health insurance issuer shall notify the commissioner of the request.

(2) Within five business days, the health insurance issuer shall conduct and complete a preliminary review of the request to determine whether all of the following have been met:

(a) The individual is or was a covered person in the health benefit 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 benefit 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 is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health insurance issuer.

(c) The covered person's treating physician 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.

(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 Subparagraph (d) of this Paragraph.

(d) The covered person's treating physician either:

(i) 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.

(ii) Is a licensed, board certified or board eligible physician 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 that is the subject of 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 as set forth in Part III of this Chapter, R.S. 22:2421 et seq., unless the covered person is not required to exhaust the health insurance issuer's internal grievance process pursuant to R.S. 22:2436.

(f) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under R.S. 22:2434(B).

C.(1) Within five business days after the 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 all of the following have been met:

(a) The request is complete.

(b) The request is eligible for external review.

(2) If the request:

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

(b) 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.

(3)(a) The commissioner may specify the form and method for the health insurance issuer's notice of initial determination under Paragraph (2) of this Subsection and any supporting information to be included in the notice.

(b) The notice of initial determination provided under Paragraph (2) of this Subsection shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health insurance issuer's initial

determination that the external review request is ineligible for review may be appealed to the commissioner.

(4)(a) If the covered person or the covered person's authorized representative makes a written request to the Department of Insurance after receipt of the denial of an external review, the commissioner may determine that a request is eligible for external review under Paragraph (B)(2) of this Section notwithstanding a health insurance issuer's initial determination that the request is ineligible and require that it be referred for external review.

(b) In making a determination under Subparagraph (a) of this Paragraph, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Part.

(c) The commissioner shall notify the health insurance issuer and the covered person or the covered person's authorized representative of its determination about the eligibility of the request within five business days. Following receipt of the commissioner's determination that a request is eligible for external review, a health insurance issuer shall comply with Subsection D of this Section.

D.(1) A health insurance issuer shall notify the commissioner that a request is eligible for external review pursuant to Subsection C of this Section by inputting a request for assignment of an independent review organization through the Department of Insurance's website. Upon notification, the commissioner shall do both of the following:

(a) Assign an independent review organization to conduct the external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to R.S. 22:2441 and notify the health insurance issuer of the name of the assigned independent review organization.

(b) Within one business day, 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 and the identity and contact information of the assigned independent review organization.

(2) 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 five business days following the date of receipt of the notice provided pursuant to Paragraph (1) of this Subsection additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five business days.

(3) Within one business day after the receipt of the notice of assignment to conduct the external review pursuant to Paragraph (1) of this Subsection, the assigned independent review organization shall do both of the following:

(a) Select one or more clinical reviewers, as it determines is appropriate, pursuant to Paragraph (4) of this Subsection to conduct the external review.

(b) Based on the opinion of the clinical reviewer, or opinions if more than one clinical reviewer has been selected to conduct the external review, make a decision to uphold or reverse the adverse determination or final adverse determination.

(4)(a) In selecting clinical reviewers pursuant to Subparagraph (3)(a) of this Subsection, the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in R.S. 22:2442 and, through clinical experience in the past three 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) Neither the covered person, the covered person's authorized representative, if applicable, nor the health insurance issuer shall choose or control

the choice of the physicians or other health care professionals to be selected to conduct the external review.

(5) In accordance with Subsection H of this Section, 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.

(6) In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health insurance issuer's utilization review process as set forth in Part II of this Chapter, R.S. 22:2401 et seq., or the health insurance issuer's internal grievance process as set forth in Part III of this Chapter, R.S. 22:2421 et seq.

E.(1) Within five business days after the date of receipt of the notice provided pursuant to Paragraph (D)(1) of this Section, the health insurance issuer or its designee utilization review organization shall provide to the assigned independent review organization, the documents and any information considered in making the adverse determination or the final adverse determination.

(2) Except as provided in Paragraph (3) of this Subsection, failure by the health insurance issuer or its designee utilization review organization to provide the documents and information within the time specified in Paragraph (1) of this Subsection shall not delay the conduct of the external review.

(3)(a) If the health insurance issuer or its designee utilization review organization has failed to provide the documents and information within the time specified in Paragraph (1) of this Subsection, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the decision under Subparagraph (a) of this Paragraph, the independent review organization shall notify the covered person, the covered person's authorized representative, if applicable, the health insurance issuer, and the commissioner.

F.(1) Each clinical reviewer selected pursuant to Subsection D of this Section shall review all of the information and documents received pursuant to Subsection E of this Section and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to Paragraph (D)(2) of this Section.

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Paragraph (D)(2) of this Section, within one business day after the receipt of the information, the assigned independent review organization shall forward the information to the health insurance issuer.

G.(1) Upon receipt of the information required to be forwarded pursuant to Paragraph (F)(2) of this Section, the health insurance issuer may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health insurance issuer of its adverse determination or final adverse determination pursuant to Paragraph (1) of this Subsection shall not delay or terminate the external review.

(3) The external review may terminate 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.

(4)(a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3) of this Subsection, 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.

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

H.(1) Except as provided in Paragraph (3) of this Subsection, within twenty days after being selected in accordance with Subsection D of this Section to conduct the external review, each clinical reviewer shall provide an opinion to the assigned independent review organization pursuant to Subsection I of this Section on whether the recommended or requested health care service or treatment should be covered.

(2) Except for an opinion provided pursuant to Paragraph (3) of this Subsection, each clinical reviewer's opinion shall be in writing and include the following information:

(a) A description of the covered person's medical condition.

(b) 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.

(c) A description and analysis of any medical or scientific evidence considered in reaching the opinion.

(d) A description and analysis of any evidence-based standard.

(e) Information on whether the reviewer's rationale for the opinion is based on Subparagraph (I)(5)(a) or (b) of this Section.

(3)(a) 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 requires, but in no event more than five days after being selected in accordance with Subsection D of this Section.

(b) If the opinion provided pursuant to Subparagraph (a) of this Paragraph was not in writing, within forty-eight hours following the date the opinion was provided, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under Paragraph (2) of this Subsection.

I. In addition to the documents and information provided pursuant to Paragraph (A)(2) of this Section or Subsection E of this Section, each clinical reviewer selected pursuant to Subsection D of this Section, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to Subsection H of this Section:

(1) The covered person's pertinent medical records.

(2) The attending physician or health care professional's recommendation.

(3) 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 physician or health care professional.

(4) The terms of coverage under the covered person's health benefit plan with the health insurance issuer 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 reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health insurance issuer.

(5) Either of the following:

(a) Whether the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition.

(b) 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.

J.(1)(a) Except as provided in Subparagraph (b) of this Paragraph, within twenty days after the date it receives the opinion of each clinical reviewer pursuant to Subsection I of this Section, the assigned independent review organization, in accordance with Paragraph (2) of this Subsection, shall make a decision and provide written notice of the decision to:

(i) The covered person.

(ii) If applicable, the covered person's authorized representative.

(iii) The health insurance issuer.

(iv) The commissioner.

(b)(i) For an expedited external review, within forty-eight hours after the date it receives the opinion of each clinical reviewer pursuant to Subsection I of this Section, the assigned independent review organization, in accordance with Paragraph (2) of this Subsection, shall make a decision and provide notice of the decision orally or in writing to the persons listed in Subparagraph (a) of this Paragraph.

(ii) If the notice provided under Item (i) of this Subparagraph was not in writing, within forty-eight 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 Subparagraph (a) of this Paragraph and include the information set forth in Paragraph (3) of this Subsection.

(2)(a) If a majority of the clinical reviewers recommend 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.

(b) If a majority of the clinical reviewers recommend 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.

(c)(i) 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 in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to Subparagraph (a) or (b) of this Paragraph.

(ii) The additional clinical reviewer selected under Item (i) of this Subparagraph shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to Subsection I of this Section.

(iii) The selection of the additional clinical reviewer under Subparagraph (c) of this Paragraph shall 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 selected under Subsection D of this Section pursuant to Paragraph (1) of this Subsection.

(3) The independent review organization shall include in the notice provided pursuant to Paragraph (1) of this Subsection:

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

(b) The written opinion of each clinical reviewer, including the recommendation 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.

(c) The date the independent review organization was assigned by the commissioner to conduct the external review.

(d) The date the external review was conducted.

(e) The date of its decision.

(f) The principal reason or reasons for its decision.

(g) The rationale for its decision.

(4) Upon receipt of a notice of a decision pursuant to Paragraph (1) of this Subsection reversing the adverse determination or final adverse determination, the health insurance issuer immediately shall approve coverage and payment of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

K. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this Section shall be done on a random basis 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 R.S. 22:2442(D).

§2440. Binding nature of external review decision

A. An external review decision is binding on the health insurance issuer except to the extent the health insurance issuer has other remedies available under applicable federal or state law.

B. An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

C. 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 this Part.

§2441. Approval of independent review organizations

A. The commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this Part, this Section, and in accordance with R.S. 22:2393 and 2394.

B. In order to be eligible for approval by the commissioner under this Section to conduct external reviews under this Part an independent review organization shall do both of the following:

(1) Except as otherwise provided in this Section, be accredited by a nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under R.S. 22:2442.

(2) Submit an application for approval in accordance with Subsection D of this Section.

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

D.(1) Any independent review organization wishing to be approved to conduct external reviews under this Part 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 R.S. 22:2442.

(2)(a) Subject to Subparagraph (b) of this Paragraph, an independent review organization is eligible for approval under this Section only if it is accredited by a nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under R.S. 22:2442.

(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.

(3) The commissioner may charge a filing fee that independent review organizations shall submit to the commissioner with an application for approval and re-approval.

E.(1) An approval is effective for two years, unless the commissioner determines before its expiration that the independent review organization is not satisfying the minimum qualifications established under R.S. 22:2442.

(2) Whenever the commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under R.S. 22:2442, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Part that is maintained by the commissioner pursuant to Subsection F of this Section.

F. The commissioner shall maintain and periodically update a list of approved independent review organizations.

§2442. Minimum qualifications for independent review organizations

A. To be approved under R.S. 22:2441 to conduct external reviews, an independent review organization shall have 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 this Part as well as R.S. 22:2393 and 2394. At a minimum, these include:

(1) A quality assurance mechanism in place that:

(a) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner.

(b) Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective.

(c) Ensures the confidentiality of medical and treatment records and clinical review criteria.

(d) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this Part.

(2) A toll-free telephone service to receive information on a twenty-four-hour-a-day, seven-day-a-week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours.

(3) Agree to maintain and provide to the commissioner the information set out in R.S. 22:2444.

B. All clinical reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review.

(2) 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.

(3) Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

(4) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial

question as to the clinical reviewer's physical, mental, or professional competence or moral character.

C. In addition to the requirements set forth in Subsection A of this Section, 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 with a health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.

D.(1) In addition to the requirements set forth in Subsections A, B, and C of this Section, to be approved pursuant to R.S. 22:2441 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:

(a) The health insurance issuer that is the subject of the external review.

(b) The covered person whose treatment is the subject of the external review or the covered person's authorized representative.

(c) Any officer, director, or management employee of the health insurance issuer that is the subject of the external review.

(d) The health care provider, 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.

(e) The facility at which the recommended health care service or treatment would be provided.

(f) 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.

(2) 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 for purposes of Paragraph (1) of this

Subsection, the commissioner shall take into consideration situations where 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 Paragraph (1) of this Subsection, but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

E.(1) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the commissioner has determined are equivalent to or exceed the minimum qualifications of this Section shall be presumed in compliance with this Section to be eligible for approval under R.S. 22:2441.

(2) The commissioner shall initially review 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 purpose of the determination under this Paragraph.

(3) Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the NAIC in order for 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.

F. An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this Section.

§2443. Hold harmless for independent review organizations

No 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 shall be liable in damages 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 this Part, unless the opinion was rendered or act or omission performed in bad faith, negligence, or involved gross negligence.

§2444. External review reporting requirements

A.(1) An independent review organization assigned pursuant to R.S. 22:2437 through 2439 to conduct an external review shall maintain written records in the aggregate by state and by health insurance issuer on all requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the commissioner, as required under Paragraph (2) of this Subsection.

(2) Each independent review organization required to maintain written records on all requests for external review pursuant to Paragraph (1) of this Subsection for which it was assigned to conduct an external review shall submit to the commissioner an annual report and pay the associated filing fee as set forth in R.S. 22:821. The annual report shall include all of the following:

(a) The total number of requests for external review.

(b) The number of requests for external review resolved and their resolution.

(c) A synopsis of actions being taken to correct problems identified.

(3) The report shall include in the aggregate, by state, and for each 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, as provided in the format required by the commissioner.

(e) The number of external reviews pursuant to R.S. 22:2437(G), that were terminated 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.

(f) A general description for each request for external review including:

(i) A general description of the reason for the request for external review.

(ii) The date received.

(iii) The date of each review.

(iv) The resolution.

(v) The date of the resolution.

(vi) The name of the covered person for whom the request for external review was filed.

(g) Any other information the commissioner may request or require.

(4) The independent review organization shall retain the written records required pursuant to this Paragraph for at least three years.

B.(1) Each health insurance issuer shall maintain written records in the aggregate, by state and for each type of health benefit plan offered by the health insurance issuer, on all requests for external review that the health insurance issuer receives notice of from the commissioner pursuant to this Part.

(2) Each health insurance issuer required to maintain written records on all requests for external review pursuant to Paragraph (1) of this Subsection shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(3) The report shall include in the aggregate, by state, and by type of health benefit plan:

(a) The total number of requests for external review.

(b) From the total number of requests for external review reported under Subparagraph (a) of this Paragraph, the number of requests determined eligible for a full external review.

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

(4) The health insurance issuer shall retain the written records required pursuant to this paragraph for at least three years.

§2445. 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.

§2446. Disclosure requirements

A.(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 it provides to covered persons.

(2) The disclosure required by Paragraph (1) of this Subsection shall be in a format prescribed by the commissioner.

B. The description required under Subsection A of this Section shall 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 effectiveness. The statement shall include the telephone number and address of the commissioner.

C. In addition to Subsection B of this Section, the statement shall inform the covered person that, when filing a request for an external review, the covered person

will be 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.

PART V. COMPLIANCE, PENALTIES, AND OTHER REGULATORY MATTERS

§2451. Confidentiality requirements

A health insurance issuer shall annually certify in writing to the commissioner that the utilization review program of the health carrier or its designee complies with all applicable state and federal law establishing confidentiality and reporting requirements.

§2452. Regulations

The commissioner may promulgate such rules and regulations as may be necessary or proper to carry out the provisions of R.S. 22:2391 through 2453. Such rules and regulations shall be promulgated and adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

§2453. Penalties; fines; cease and desist orders; grounds for suspension or revocation of licensure or certificate of authority

A. Whenever the commissioner has reason to believe that any health insurance issuer or utilization or independent review organization is not in full compliance with the provisions of this Chapter, he shall notify such person in accordance and compliance with R.S. 49:961 and the commissioner shall, in accordance and compliance with R.S. 49:961, issue and cause to be served an order requiring the health insurance issuer or utilization review organization to cease and desist from any violation and order any one or more of the following:

(1) Payment of a monetary penalty of not more than twenty-five dollars for each day that a determination was not made within the time frames established by this Chapter.

(2) Payment of a monetary penalty of not more than one thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of one hundred thousand dollars; however, if the health insurance issuer or utilization

review organization knew or reasonably should have known it was in violation of this Chapter, the penalty shall be not more than twenty-five thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of two hundred fifty thousand dollars in any six-month period.

(3) Suspension or revocation of the license of the health insurance issuer's certificate of authority to operate in this state or the license of a utilization or independent review organization if the health insurance issuer or utilization review organization knew or reasonably should have known it was in violation of this Chapter.

B. Any health insurance issuer or licensed utilization or independent review organization who violates a cease and desist order issued by the commissioner pursuant to this Chapter while such order is in effect shall be subject at the discretion of the commissioner to any one or more of the following:

(1) A monetary penalty of not more than twenty-five thousand dollars for each and every act or violation, not to exceed an aggregate of two hundred fifty thousand dollars.

(2) Suspension or revocation of the health insurance issuer's certificate of authority to operate in this state or the license of the utilization or independent review organization to operate in this state.

C. The license of an utilization or independent review organization or authorization of a health insurance issuer to act as a utilization or independent review organization shall be suspended or revoked, or, in lieu of such revocation, a fine may be imposed for each separate violation, not to exceed five thousand dollars per violation, or twenty-five thousand dollars in the aggregate, if the commissioner finds that the utilization or independent review organization has engaged in any of the following:

(1) Using such methods or practices in the conduct of its business so as to render its further determinations of medical necessity in this state hazardous or injurious to covered persons or the public.

(2) Failing to comply with any independent review organization determination after the applicable time period pursuant to this Chapter.

D. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

E. Whenever the commissioner believes, from evidence satisfactory to him, that any utilization or independent review organization is violating or about to violate any provision of this Chapter or any order or requirement of the commissioner issued or promulgated pursuant to authority granted the commissioner by any provision of this Code or by law, he may bring an action in the name of the people of the State of Louisiana in the District Court for the Nineteenth Judicial District, Baton Rouge, Louisiana, against such utilization or independent review organization to enjoin such utilization or independent review organization from continuing such violation or engaging therein or doing any act in furtherance thereof. In such action an order or judgment may be entered awarding such preliminary or final injunction as is proper.

Section 2. Subpart F of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1121 through 1144, is hereby repealed in its entirety.

Section 3. This Act shall become effective upon signature by the governor or, if not signed by the governor, upon expiration of the time for bills to become law without signature by the governor, as provided by Article III, Section 18 of the Constitution of Louisiana. If vetoed by the governor and subsequently approved by the legislature, this Act shall become effective on the day following such approval.

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

Huval HB No. 978

Abstract: Deletes the existing medical necessity appeals process and external review process and replaces it with a utilization appeals process, grievance appeals process, and external review process.

Present law generally establishes minimum standards required for entities that determine what medical services or procedures will be covered under a health benefit plan based on medical necessity. Designates such entities as medical necessity organizations (MNROs) and independent review organizations (IROs).

Proposed law revises these standards and additionally provides for grievances and review of adverse determinations not limited to those solely based on medical necessity, as follows:

(1) Present law requires the licensing of MNROs and requires IROs to be certified by the department.

Proposed law requires the licensing of any entity that conducts an utilization review and requires the licensing of IROs. Additionally provides standards and criteria for an IRO.

(2) Present law requires a licensing and an annual report filing fee for MNROs other than a health insurance issuer.

Proposed law instead requires a licensing and an annual report filing fee for an utilization review organization or an IRO.

(3) Proposed law repeals the existing medical necessity appeals process and external review process and replaces it with a utilization appeals process, grievance appeals process, and external review process. Establishes utilization and benefit determination procedures, standards, and criteria for the structure and operation of utilization review and benefit determination processes designed to facilitate ongoing assessment and management of health services. Also provides standards for the establishment and maintenance of procedures by health insurance issuers to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination. Provides uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination.

(4) Present law establishes minimum standards for informal consideration and first level and second level appeals required for entities that determine what medical services or procedures will be covered under a health benefit plan based on medical necessity. Provides for informal reconsideration and a two-level internal appeals process all for review of adverse determinations based on a lack of medical necessity.

Proposed law requires only one level of appeal in the internal grievance process, under new time frames consistent with federal law for making benefit determinations which is now considered a utilization review. Expands such utilization review to include rescission, denial, or reduction in payment and eligibility issues. Provides for timely notification to health care providers and covered persons or their authorized

representatives of the health insurance issuers' determinations. Additionally establishes new procedures for a first level review of grievances involving an adverse determination, a standard review of grievances not involving an adverse determination, and a voluntary internal second level of review of grievances at the discretion of the covered person, which may include an adverse determination or a grievance not involving an adverse determination.

(5) Present law provides for an expedited internal appeal for emergency services.

Proposed law adds an expedited internal appeal for urgent care requests.

(6) Present law requires that a request for internal review be filed by the covered person within 60 days of receipt of the adverse determination.

Proposed law allows for at least 180 days to file a request for internal review after the receipt of notice of an adverse benefit determination and four months to file a request for an external appeal for a final adverse benefit determination.

(7) Present law provides for an expedited external appeal for emergency services or investigational or experimental services.

Proposed law additionally provides for an expedited external appeal for urgent care requests.

(8) Present law restricts requests for an internal or external review of experimental or investigational appeals to a minimum claim of $500 before being eligible for external review.

Proposed law provides that there shall be no restriction on the minimum dollar amount of a claim in order to be eligible for an external review.

(9) Present law provides that unless the covered person has an emergency medical condition or the MNRO agrees to waive the requirements for the first level appeal, the second level appeal, or both, then the MNRO shall not be required to grant a request for an external review until the second level appeal process has been exhausted.

Proposed law states that if exhaustion of internal appeals is required prior to external review, exhaustion shall be unnecessary if: (a) the issuer (or plan) waives the exhaustion requirement; (b) the issuer (or plan) is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process except those failures that are based on de minimus violations that do not cause, and are not likely to cause, prejudice, or harm to the covered person; or (c) the covered person simultaneously requests an expedited internal appeal and an expedited external review.

(10) Present law is silent on the issue of what person or entity is responsible for the cost of an external review.

Proposed law provides that the cost of an IRO to conduct an external review must be borne by the issuer (or plan), although the process may require a nominal filing fee from the covered person requesting external review.

(11) Present law provides that a request for an external review must be filed by the covered person within 60 days of receipt of the second level appeal adverse determination.

Proposed law allows for at least four months to file a request for external review after the receipt of notice of an adverse benefit determination or final internal adverse benefit determination.

(12) Present law requires the MNRO to provide the covered person with a notice explaining their rights to an external review.

Proposed law requires the issuers (or plans) to provide effective written notice to covered persons of their rights to external review.

(13) Present law requires the health benefit plan to provide an independent review process to examine the plan's coverage decision based on medical necessity and requires the MNRO to forward documents and any information used in making the second level appeal adverse determination to its designated IRO.

Proposed law requires that the IRO be assigned by the state or an independent entity, on a random basis or another method of assignment that ensures the independence and impartiality of the assignment process, such as rotational assignment, and in no event be assigned by the issuer, the plan, or the individual.

(14) Present law requires that the IRO hold a nonrestricted license in a state of the U.S. and, in the case of a physician, hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review. Does not require the IRO to be accredited by a nationally recognized private accrediting organization.

Proposed law requires that the process for assigning the IRO provide for the maintenance of a list of approved IROs (only those that are accredited by a nationally recognized private accrediting organization) qualified to conduct the external review based on the nature of the health care service that is the subject of the review.

(15) Present law requires the IRO to review all of the information and documents received and any other information submitted in writing by the covered person or the covered person's health care provider.

Proposed law provides that covered person must be allowed to submit information to the IRO that the IRO must consider when conducting the external review, and the claimant must be notified of the right to submit additional information to the IRO. Additionally provides that the IRO must allow the covered person at least five business days to submit any additional information and any additional information submitted by the covered person must be forwarded to the issuer (or plan) within one business day of receipt by the IRO.

(16) Present law provides that the covered person's health care provider may request an expedited external review at the time that a covered person receives an adverse determination involving an emergency medical condition. Within 72 hours after receiving appropriate medical information, requires the IRO to make a decision to uphold or reverse the adverse determination and notify the covered person, the MNRO, and the covered person's health care provider of the decision.

Proposed law requires that the process provide for an expedited external review in certain circumstances and, in such cases, provide notice of the decision as expeditiously as possible, but not later than 72 hours after receipt of the request for external review. Provides that if notice of the IRO's decision is not in writing, the IRO must provide written confirmation of its decision within 48 hours after the date of the notice of the decision.

(17) Present law provides that an MNRO shall maintain written records in the aggregate and by health insurance issuer and health benefit plan on all requests for external review for which an external review was conducted during a calendar year, referred to as the "register".

Proposed law requires that an IRO retain written records and make them accessible and available upon request to the commissioner of insurance. Further requires the IRO to submit an annual report on all requests for external review to the commissioner.

(18) Proposed law requires issuers (or plans) to provide a description of the external review process in or attached to the summary plan descriptions, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons.

(19) Present law provides for penalties for violations such as fines, suspension, or revocation.

Proposed law provides for penalties for violation such as fines, suspension, or revocation as well as cease and desist authority.

Effective upon signature of governor or lapse of time for gubernatorial action.

(Amends R.S. 22:821(B)(28); Adds R.S. 22:2391-2453; Repeals R.S. 22:1121-1144)