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Final Reading

Introduced by Gloor, 35.

Read first time January 11, 2013

Committee: Banking, Commerce and Insurance

A BILL

1 FOR AN ACT relating to insurance; to amend sections 44-7306, 44-7308,
2 44-7310, and 44-7311, Reissue Revised Statutes of
3 Nebraska; to adopt the Health Carrier External Review
4 Act; to eliminate certain grievance review provisions; to
5 harmonize provisions; to repeal the original sections;
6 and to outright repeal section 44-7309, Reissue Revised
7 Statutes of Nebraska.
8 Be it enacted by the people of the State of Nebraska,

1 Section 1. Sections 1 to 18 of this act shall be known
2 and may be cited as the Health Carrier External Review Act.

3 Sec. 2. The purpose of the Health Carrier External Review
4 Act is to provide uniform standards for the establishment and
5 maintenance of external review procedures to assure that covered
6 persons have the opportunity for an independent review of an adverse
7 determination or final adverse determination.

8 Sec. 3. For purposes of the Health Carrier External
9 Review Act:

10 (1) Adverse determination means a determination by a
11 health carrier or its designee utilization review organization that
12 an admission, the availability of care, a continued stay, or other
13 health care service that is a covered benefit has been reviewed and,
14 based upon the information provided, does not meet the health
15 carrier's requirements for medical necessity, appropriateness, health
16 care setting, level of care, or effectiveness, and the requested
17 service or payment for the service is therefor denied, reduced, or
18 terminated;

19 (2) Ambulatory review means the utilization review of
20 health care services performed or provided in an outpatient setting;

21 (3) Authorized representative means:

22 (a) A person to whom a covered person has given express
23 written consent to represent the covered person in an external
24 review;

25 (b) A person authorized by law to provide substituted

1 consent for a covered person; or

2 (c) A family member of the covered person or the covered
3 person's treating health care professional only when the covered
4 person is unable to provide consent;

5 (4) Benefits or covered benefits means those health care
6 services to which a covered person is entitled under the terms of a
7 health benefit plan;

8 (5) Best evidence means evidence based on:

9 (a) Randomized clinical trials;

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

12 (c) If the criteria described in subdivisions (5)(a) and
13 (b) of this section are not available, case-series; or

14 (d) If the criteria described in subdivisions (5)(a),
15 (b), and (c) of this section are not available, expert opinions;

16 (6) Case-control study means a retrospective evaluation
17 of two groups of patients with different outcomes to determine which
18 specific interventions the patients received;

19 (7) Case management means a coordinated set of activities
20 conducted for individual patient management of serious, complicated,
21 protracted, or other health conditions;

22 (8) Case-series means an evaluation of a series of
23 patients with a particular outcome, without the use of a control
24 group;

25 (9) Certification means a determination by a health

1 carrier or its designee utilization review organization that an
2 admission, the availability of care, a continued stay, or other
3 health care service has been reviewed and, based upon the information
4 provided, satisfies the health carrier's requirements for medical
5 necessity, appropriateness, health care setting, level of care, and
6 effectiveness;

7 (10) Clinical review criteria means the written screening
8 procedures, decision abstracts, clinical protocols, and practice
9 guidelines used by a health carrier to determine the necessity and
10 appropriateness of health care services;

11 (11) Cohort study means a prospective evaluation of two
12 groups of patients with only one group of patients receiving a
13 specific intervention;

14 (12) Concurrent review means a utilization review
15 conducted during a patient's hospital stay or course of treatment;

16 (13) Covered person means a policyholder, subscriber,
17 enrollee, or other individual participating in a health benefit plan;

18 (14) Director means the Director of Insurance;

19 (15) Discharge planning means the formal process for
20 determining, prior to discharge from a facility, the coordination and
21 management of the care that a patient receives following discharge
22 from a facility;

23 (16) Disclose means to release, transfer, or otherwise
24 divulge protected health information to any person other than the
25 individual who is the subject of the protected health information;

1 (17) Emergency medical condition means the sudden and, at
2 the time, unexpected onset of a health condition or illness that
3 requires immediate medical attention if failure to provide such
4 medical attention would result in a serious impairment to bodily
5 functions or serious dysfunction of a bodily organ or part or would
6 place the person's health in serious jeopardy;

7 (18) Emergency services means health care items and
8 services furnished or required to evaluate and treat an emergency
9 medical condition;

10 (19) Evidence-based standard means the conscientious,
11 explicit, and judicious use of the current best evidence based on the
12 overall systematic review of the research in making decisions about
13 the care of an individual patient;

14 (20) Expert opinion means a belief or an interpretation
15 by a specialist with experience in a specific area about the
16 scientific evidence pertaining to a particular service, intervention,
17 or therapy;

18 (21) Facility means an institution providing health care
19 services or a health care setting, including, but not limited to,
20 hospitals and other licensed inpatient centers, ambulatory surgical
21 or treatment centers, skilled nursing centers, residential treatment
22 centers, diagnostic, laboratory and imaging centers, and
23 rehabilitation and other therapeutic health settings;

24 (22) Final adverse determination means an adverse
25 determination involving a covered benefit that has been upheld by a

1 health carrier, or its designee utilization review organization, at
2 the completion of the health carrier's internal grievance process
3 procedures as set forth in the Health Carrier Grievance Procedure
4 Act;

5 (23) Health benefit plan means a policy, contract,
6 certificate, or agreement offered or issued by a health carrier to
7 provide, deliver, arrange for, pay for, or reimburse any of the costs
8 of health care services;

9 (24) Health care professional means a physician or other
10 health care practitioner licensed, accredited, or certified to
11 perform specified health care services consistent with state law;

12 (25) Health care provider or provider means a health care
13 professional or a facility;

14 (26) Health care services means services for the
15 diagnosis, prevention, treatment, cure, or relief of a health
16 condition, illness, injury, or disease;

17 (27) Health carrier means an entity subject to the
18 insurance laws and regulations of this state, or subject to the
19 jurisdiction of the director, that contracts or offers to contract to
20 provide, deliver, arrange for, pay for, or reimburse any of the costs
21 of health care services, including a sickness and accident insurance
22 company, a health maintenance organization, a nonprofit hospital and
23 health service corporation, or any other entity providing a plan of
24 health insurance, health benefits, or health care services;

25 (28) Health information means information or data,

1 whether oral or recorded in any form or medium, and personal facts or
2 information about events or relationships that relates to:

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

6 (b) The provision of health care services to an
7 individual; or

8 (c) Payment for the provision of health care services to
9 an individual;

10 (29) Independent review organization means an entity that
11 conducts independent external reviews of adverse determinations and
12 final adverse determinations;

13 (30) Medical or scientific evidence means evidence found
14 in the following sources:

15 (a) Peer-reviewed scientific studies published in or
16 accepted for publication by medical journals that meet nationally
17 recognized requirements for scientific manuscripts and that submit
18 most of their published articles for review by experts who are not
19 part of the editorial staff;

20 (b) Peer-reviewed medical literature, including
21 literature relating to therapies reviewed and approved by a qualified
22 institutional review board, biomedical compendia, and other medical
23 literature that meet the criteria of the National Institutes of
24 Health's United States National Library of Medicine for indexing in
25 Index Medicus, known as Medline, and Elsevier Science Ltd. for

1 indexing in Excerpta Medica, known as Embase;

2 (c) Medical journals recognized by the Secretary of
3 Health and Human Services under section 1861(t)(2) of the federal
4 Social Security Act;

5 (d) The following standard reference compendia:

6 (i) The AHFS Drug Information;

7 (ii) Drug Facts and Comparisons;

8 (iii) The American Dental Association Guide to Dental
9 Therapeutics; and

10 (iv) The United States Pharmacopoeia Drug Information;

11 (e) Findings, studies, or research conducted by or under
12 the auspices of federal government agencies and nationally recognized
13 federal research institutes, including:

14 (i) The federal Agency for Healthcare Research and
15 Quality of the United States Department of Health and Human Services;

16 (ii) The National Institutes of Health;

17 (iii) The National Cancer Institute;

18 (iv) The National Academy of Sciences;

19 (v) The Centers for Medicare and Medicaid Services of the
20 United States Department of Health and Human Services;

21 (vi) The federal Food and Drug Administration; and

22 (vii) Any national board recognized by the National
23 Institutes of Health for the purpose of evaluating the medical value
24 of health care services; or

25 (f) Any other medical or scientific evidence that is

1 comparable to the sources listed in subdivisions (30)(a) through (e)
2 of this section;

3 (31) Prospective review means a utilization review
4 conducted prior to an admission or a course of treatment;

5 (32) Protected health information means health
6 information:

7 (a) That identifies an individual who is the subject of
8 the information; or

9 (b) With respect to which there is a reasonable basis to
10 believe that the information could be used to identify an individual;

11 (33) Randomized clinical trial means a controlled,
12 prospective study of patients that have been randomized into an
13 experimental group and a control group at the beginning of the study
14 with only the experimental group of patients receiving a specific
15 intervention, which includes study of the groups for variables and
16 anticipated outcomes over time;

17 (34) Retrospective review means a review of medical
18 necessity conducted after health care services have been provided to
19 a patient, but does not include the review of a claim that is limited
20 to an evaluation of reimbursement levels, veracity of documentation,
21 accuracy of coding, or adjudication for payment;

22 (35) Second opinion means an opportunity or requirement
23 to obtain a clinical evaluation by a provider other than the one
24 originally making a recommendation for a proposed health care service
25 to assess the clinical necessity and appropriateness of the initial

1 proposed health care service;

2 (36) Utilization review means a set of formal techniques
3 designed to monitor the use or evaluate the clinical necessity,
4 appropriateness, efficacy, or efficiency of health care services,
5 procedures, or settings. Techniques may include ambulatory review,
6 prospective review, second opinion, certification, concurrent review,
7 case management, discharge planning, or retrospective review; and

8 (37) Utilization review organization means an entity that
9 conducts a utilization review, other than a health carrier performing
10 a review for its own health benefit plans.

11 Sec. 4. (1) Except as provided in subsection (2) of this
12 section, the Health Carrier External Review Act shall apply to all
13 health carriers.

14 (2)(a) The act shall not apply to a policy or certificate
15 that provides coverage for:

16 (i) A specified disease, specified accident, or accident-
17 only coverage;

18 (ii) Credit;

19 (iii) Dental;

20 (iv) Disability income;

21 (v) Hospital indemnity;

22 (vi) Long-term care insurance as defined in section
23 44-4509;

24 (vii) Vision care; or

25 (viii) Any other limited supplemental benefit.

- 1 (b) The act shall not apply to:
- 2 (i) A medicare supplement policy of insurance as defined
3 in section 44-3602;
- 4 (ii) Coverage under a plan through medicare, medicaid, or
5 the Federal Employees Health Benefits Program;
- 6 (iii) Any coverage issued under Chapter 55 of Title 10 of
7 the United States Code and any coverage issued as a supplement to
8 that coverage;
- 9 (iv) Any coverage issued as supplemental to liability
10 insurance;
- 11 (v) Workers' compensation or similar insurance;
- 12 (vi) Automobile medical-payment insurance; or
- 13 (vii) Any insurance under which benefits are payable with
14 or without regard to fault, whether written on a group blanket or
15 individual basis.
- 16 Sec. 5. (1)(a) A health carrier shall notify the covered
17 person in writing of the covered person's right to request an
18 external review to be conducted pursuant to section 8, 9, or 10 of
19 this act and include the appropriate statements and information as
20 set forth in subsection (2) of this section at the same time that the
21 health carrier sends written notice of:
- 22 (i) An adverse determination upon completion of the
23 health carrier's utilization review process set forth in the
24 Utilization Review Act; and
- 25 (ii) A final adverse determination.

1 (b) As part of the written notice required under
2 subdivision (1)(a) of this section, a health carrier shall include
3 the following, or substantially equivalent, language: We have denied
4 your request for the provision of or payment for a health care
5 service or course of treatment. You may have the right to have our
6 decision reviewed by health care professionals who have no
7 association with us if our decision involved making a judgment as to
8 the medical necessity, appropriateness, health care setting, level of
9 care, or effectiveness of the health care service or treatment you
10 requested by submitting a request for external review to the Director
11 of Insurance (insert address and telephone number of the office of
12 the director).

13 (c) The director may prescribe by rule and regulation the
14 form and content of the notice required under this section.

15 (2)(a) The health carrier shall include in the notice
16 required under subsection (1) of this section:

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

19 (A) If the covered person has a medical condition in
20 which the timeframe for completion of an expedited review of a
21 grievance involving an adverse determination as set forth in section
22 44-7311 would seriously jeopardize the life or health of the covered
23 person or would jeopardize the covered person's ability to regain
24 maximum function, the covered person or the covered person's
25 authorized representative may file a request for an expedited

1 external review to be conducted pursuant to section 9 or 10 of this
2 act if the adverse determination involves a denial of coverage based
3 on a determination that the recommended or requested health care
4 service or treatment is experimental or investigational and the
5 covered person's treating physician certifies in writing that the
6 recommended or requested health care service or treatment that is the
7 subject of the adverse determination would be significantly less
8 effective if not promptly initiated, at the same time the covered
9 person or the covered person's authorized representative files a
10 request for an expedited review of a grievance involving an adverse
11 determination as set forth in section 44-7311, but that the
12 independent review organization assigned to conduct the expedited
13 external review will determine whether the covered person shall be
14 required to complete the expedited review of the grievance prior to
15 conducting the expedited external review; and

16 (B) The covered person or the covered person's authorized
17 representative may file a grievance under the health carrier's
18 internal grievance process as set forth in section 44-7308, but if
19 the health carrier has not issued a written decision to the covered
20 person or his or her authorized representative within thirty days
21 following the date that the covered person or his or her authorized
22 representative files the grievance with the health carrier and the
23 covered person or his or her authorized representative has not
24 requested or agreed to a delay, the covered person or his or her
25 authorized representative may file a request for external review

1 pursuant to section 6 of this act and shall be considered to have
2 exhausted the health carrier's internal grievance process for
3 purposes of section 7 of this act; and

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

6 (A) If the covered person has a medical condition in
7 which the timeframe for completion of a standard external review
8 pursuant to section 8 of this act would seriously jeopardize the life
9 or health of the covered person or would jeopardize the covered
10 person's ability to regain maximum function, the covered person or
11 the covered person's authorized representative may file a request for
12 an expedited external review pursuant to section 9 of this act; or

13 (B) If the final adverse determination concerns:

14 (I) An admission, availability of care, continued stay,
15 or health care service for which the covered person received
16 emergency services, but has not been discharged from a facility, the
17 covered person or the covered person's authorized representative may
18 request an expedited external review pursuant to section 9 of this
19 act; or

20 (II) A denial of coverage based on a determination that
21 the recommended or requested health care service or treatment is
22 experimental or investigational, the covered person or the covered
23 person's authorized representative may file a request for a standard
24 external review to be conducted pursuant to section 10 of this act or
25 if the covered person's treating physician certifies in writing that

1 the recommended or requested health care service or treatment that is
2 the subject of the request would be significantly less effective if
3 not promptly initiated, the covered person or his or her authorized
4 representative may request an expedited external review to be
5 conducted under section 10 of this act.

6 (b) In addition to the information to be provided
7 pursuant to subdivision (2)(a) of this section, the health carrier
8 shall include a copy of the description of both the standard and
9 expedited external review procedures that the health carrier is
10 required to provide pursuant to section 17 of this act and shall
11 highlight the provisions in the external review procedures that give
12 the covered person or the covered person's authorized representative
13 the opportunity to submit additional information and include any
14 forms used to process an external review.

15 (c) As part of any forms provided under subdivision (2)
16 (b) of this section, the health carrier shall include an
17 authorization form or other document approved by the director that
18 complies with the requirements of 45 C.F.R. 164.508, by which the
19 covered person, for purposes of conducting an external review under
20 the Health Carrier External Review Act, authorizes the health carrier
21 and the covered person's treating health care provider to disclose
22 protected health information, including medical records, concerning
23 the covered person that are pertinent to the external review.

24 Sec. 6. (1)(a) Except for a request for an expedited
25 external review as set forth in section 9 of this act, all requests

1 for external review shall be made in writing to the director.

2 (b) The director may prescribe by rule and regulation the
3 form and content of external review requests required to be submitted
4 under this section.

5 (2) A covered person or the covered person's authorized
6 representative may make a request for an external review of an
7 adverse determination or final adverse determination.

8 Sec. 7. (1)(a) Except as provided in subsection (2) of
9 this section, a request for an external review pursuant to section 8,
10 9, or 10 of this act shall not be made until the covered person has
11 exhausted the health carrier's internal grievance process as set
12 forth in the Health Carrier Grievance Procedure Act.

13 (b) A covered person shall be considered to have
14 exhausted the health carrier's internal grievance process for
15 purposes of this section if the covered person or the covered
16 person's authorized representative:

17 (i) Has filed a grievance involving an adverse
18 determination pursuant to section 44-7308; and

19 (ii) Except to the extent that the covered person or the
20 covered person's authorized representative requested or agreed to a
21 delay, has not received a written decision on the grievance from the
22 health carrier within thirty days following the date that the covered
23 person or the covered person's authorized representative filed the
24 grievance with the health carrier.

25 (c) Notwithstanding subdivision (1)(b) of this section, a

1 covered person or the covered person's authorized representative may
2 not make a request for an external review of an adverse determination
3 involving a retrospective review determination made pursuant to the
4 Utilization Review Act until the covered person has exhausted the
5 health carrier's internal grievance process.

6 (2)(a)(i) At the same time that a covered person or the
7 covered person's authorized representative files a request for an
8 expedited review of a grievance involving an adverse determination as
9 set forth in section 44-7311, the covered person or his or her
10 authorized representative may file a request for an expedited
11 external review of the adverse determination:

12 (A) Under section 9 of this act if the covered person has
13 a medical condition in which the timeframe for completion of an
14 expedited review of the grievance involving an adverse determination
15 set forth in section 44-7311 would seriously jeopardize the life or
16 health of the covered person or would jeopardize the covered person's
17 ability to regain maximum function; or

18 (B) Under section 10 of this act if the adverse
19 determination involves a denial of coverage based upon a
20 determination that the recommended or requested health care service
21 or treatment is experimental or investigational and the covered
22 person's treating physician certifies in writing that the recommended
23 or requested health care service or treatment that is the subject of
24 the adverse determination would be significantly less effective if
25 not promptly initiated.

1 (ii) Upon receipt of a request for an expedited external
2 review under subdivision (2)(a)(i) of this section, the independent
3 review organization conducting the external review in accordance with
4 the provisions of section 9 or 10 of this act shall determine whether
5 the covered person shall be required to complete the expedited
6 grievance review process set forth in section 44-7311 before it
7 conducts the expedited external review.

8 (iii) Upon a determination made pursuant to subdivision
9 (2)(a)(ii) of this section that the covered person must first
10 complete the expedited grievance review process set forth in section
11 44-7311, the independent review organization shall immediately notify
12 the covered person and, if applicable, the covered person's
13 authorized representative of such determination and the fact that it
14 will not proceed with the expedited external review set forth in
15 section 9 of this act until completion of the expedited grievance
16 review process and the covered person's grievance at the completion
17 of the expedited grievance review process remains unresolved.

18 (b) A request for an external review of an adverse
19 determination may be made before the covered person has exhausted the
20 health carrier's internal grievance procedures as set forth in
21 section 44-7308 if the health carrier agrees to waive the exhaustion
22 requirement.

23 (3) If the requirement to exhaust the health carrier's
24 internal grievance procedures is waived under subdivision (2)(b) of
25 this section, the covered person or the covered person's authorized

1 representative may file a request in writing for a standard external
2 review as set forth in section 8 or 10 of this act.

3 Sec. 8. (1)(a) Within four months after the date of
4 receipt of a notice of an adverse determination or final adverse
5 determination pursuant to section 5 of this act, a covered person or
6 the covered person's authorized representative may file a request for
7 an external review with the director.

8 (b) Within one business day after the date of receipt of
9 a request for an external review pursuant to subdivision (1)(a) of
10 this section, the director shall send a copy of the request to the
11 health carrier.

12 (2) Within five business days following the date of
13 receipt of the copy of the external review request from the director
14 under subdivision (1)(b) of this section, the health carrier shall
15 complete a preliminary review of the request to determine whether:

16 (a) The individual is or was a covered person in the
17 health benefit plan at the time that the health care service was
18 requested or, in the case of a retrospective review, was a covered
19 person in the health benefit plan at the time that the health care
20 service was provided;

21 (b) The health care service that is the subject of the
22 adverse determination or the final adverse determination is a covered
23 service under the covered person's health benefit plan, but for a
24 determination by the health carrier that the health care service is
25 not covered because it does not meet the health carrier's

1 requirements for medical necessity, appropriateness, health care
2 setting, level of care, or effectiveness;

3 (c) The covered person has exhausted the health carrier's
4 internal grievance process as set forth in the Health Carrier
5 Grievance Procedure Act unless the covered person is not required to
6 exhaust the health carrier's internal grievance process pursuant to
7 section 7 of this act; and

8 (d) The covered person has provided all the information
9 and forms required to process an external review, including the
10 release form provided under subsection (2) of section 5 of this act.

11 (3)(a) Within one business day after completion of the
12 preliminary review, the health carrier shall notify the director and
13 covered person and, if applicable, the covered person's authorized
14 representative, in writing whether:

15 (i) The request is complete; and

16 (ii) The request is eligible for external review.

17 (b) If the request:

18 (i) Is not complete, the health carrier shall inform the
19 covered person and, if applicable, the covered person's authorized
20 representative and the director in writing and include in the notice
21 what information or materials are needed to make the request
22 complete; or

23 (ii) Is not eligible for external review, the health
24 carrier shall inform the covered person and, if applicable, the
25 covered person's authorized representative and the director in

1 writing and include in the notice the reasons for its ineligibility.

2 (c)(i) The director may specify the form for the health
3 carrier's notice of initial determination under this subsection and
4 any supporting information to be included in the notice.

5 (ii) The notice of initial determination shall include a
6 statement informing the covered person and, if applicable, the
7 covered person's authorized representative that a health carrier's
8 initial determination that the external review request is ineligible
9 for review may be appealed to the director.

10 (d)(i) The director may determine that a request is
11 eligible for external review under subsection (2) of this section
12 notwithstanding a health carrier's initial determination that the
13 request is ineligible and require that it be referred for external
14 review.

15 (ii) In making a determination under subdivision (3)(d)
16 (i) of this section, the director's decision shall be made in
17 accordance with the terms of the covered person's health benefit plan
18 and shall be subject to all applicable provisions of the Health
19 Carrier External Review Act.

20 (4)(a) Whenever the director receives a notice that a
21 request is eligible for external review following the preliminary
22 review conducted pursuant to subsection (3) of this section, the
23 director shall, within one business day after the date of receipt of
24 the notice:

25 (i) Assign an independent review organization from the

1 list of approved independent review organizations compiled and
2 maintained by the director pursuant to section 12 of this act to
3 conduct the external review and notify the health carrier of the name
4 of the assigned independent review organization; and

5 (ii) Notify in writing the covered person and, if
6 applicable, the covered person's authorized representative of the
7 request's eligibility and acceptance for external review.

8 (b) In reaching a decision, the assigned independent
9 review organization is not bound by any decisions or conclusions
10 reached during the health carrier's utilization review process as set
11 forth in the Utilization Review Act or the health carrier's internal
12 grievance process as set forth in the Health Carrier Grievance
13 Procedure Act.

14 (c) The director shall include in the notice provided to
15 the covered person and, if applicable, the covered person's
16 authorized representative a statement that the covered person or his
17 or her authorized representative may submit in writing to the
18 assigned independent review organization within five business days
19 following the date of receipt of the notice provided pursuant to
20 subdivision (4)(a) of this section additional information that the
21 independent review organization shall consider when conducting the
22 external review. The independent review organization is not required
23 to but may accept and consider additional information submitted after
24 five business days.

25 (5)(a) Within five business days after the date of

1 receipt of the notice provided pursuant to subdivision (4)(a) of this
2 section, the health carrier or its designee utilization review
3 organization shall provide to the assigned independent review
4 organization the documents and any information considered in making
5 the adverse determination or final adverse determination.

6 (b) Except as provided in subdivision (5)(c) of this
7 section, failure by the health carrier or its utilization review
8 organization to provide the documents and information within the time
9 specified in subdivision (5)(a) of this section shall not delay the
10 conduct of the external review.

11 (c)(i) If the health carrier or its utilization review
12 organization fails to provide the documents and information within
13 the time specified in subdivision (5)(a) of this section, the
14 assigned independent review organization may terminate the external
15 review and make a decision to reverse the adverse determination or
16 final adverse determination.

17 (ii) Within one business day after making the decision
18 under subdivision (5)(c)(i) of this section, the independent review
19 organization shall notify the covered person and, if applicable, the
20 covered person's authorized representative, the health carrier, and
21 the director.

22 (6)(a) The assigned independent review organization shall
23 review all of the information and documents received pursuant to
24 subsection (5) of this section and any other information submitted in
25 writing to the independent review organization by the covered person

1 or the covered person's authorized representative pursuant to
2 subdivision (4)(c) of this section.

3 (b) Upon receipt of any information submitted by the
4 covered person or the covered person's authorized representative
5 pursuant to subdivision (4)(c) of this section, the assigned
6 independent review organization shall forward the information to the
7 health carrier within one business day.

8 (7)(a) Upon receipt of the information, if any, required
9 to be forwarded pursuant to subdivision (6)(b) of this section, the
10 health carrier may reconsider its adverse determination or final
11 adverse determination that is the subject of the external review.

12 (b) Reconsideration by the health carrier of its adverse
13 determination or final adverse determination pursuant to subdivision
14 (7)(a) of this section shall not delay or terminate the external
15 review.

16 (c) The external review may only be terminated if the
17 health carrier decides, upon completion of its reconsideration, to
18 reverse its adverse determination or final adverse determination and
19 provide coverage or payment for the health care service that is the
20 subject of the adverse determination or final adverse determination.

21 (d)(i) Within one business day after making the decision
22 to reverse its adverse determination or final adverse determination
23 as provided in subdivision (7)(c) of this section, the health carrier
24 shall notify the covered person and, if applicable, the covered
25 person's authorized representative, the assigned independent review

1 organization, and the director in writing of its decision.

2 (ii) The assigned independent review organization shall
3 terminate the external review upon receipt of the notice from the
4 health carrier sent pursuant to subdivision (7)(d)(i) of this
5 section.

6 (8) In addition to the documents and information provided
7 pursuant to subsection (5) of this section, the assigned independent
8 review organization, to the extent the information or documents are
9 available and the independent review organization considers them
10 appropriate, shall consider the following in reaching a decision:

11 (a) The covered person's medical records;

12 (b) The attending health care professional's
13 recommendation;

14 (c) Consulting reports from appropriate health care
15 professionals and other documents submitted by the health carrier,
16 covered person, the covered person's authorized representative, or
17 the covered person's treating provider;

18 (d) The terms of coverage under the covered person's
19 health benefit plan with the health carrier to ensure that the
20 independent review organization's decision is not contrary to the
21 terms of coverage under the covered person's health benefit plan with
22 the health carrier;

23 (e) The most appropriate practice guidelines, which shall
24 include applicable evidence-based standards and may include any other
25 practice guidelines developed by the federal government, national or

1 professional medical societies, boards, or associations;

2 (f) Any applicable clinical review criteria developed and
3 used by the health carrier or its designee utilization review
4 organization; and

5 (g) The opinion of the independent review organization's
6 clinical reviewer or reviewers after considering subdivisions (8)(a)
7 through (f) of this section to the extent that the information or
8 documents are available and the clinical reviewer or reviewers
9 consider it appropriate.

10 (9)(a) Within forty-five days after the date of receipt
11 of the request for an external review, the assigned independent
12 review organization shall provide written notice of its decision to
13 uphold or reverse the adverse determination or the final adverse
14 determination to the covered person, if applicable, the covered
15 person's authorized representative, the health carrier, and the
16 director.

17 (b) The independent review organization shall include in
18 the notice sent pursuant to subdivision (9)(a) of this section:

19 (i) A general description of the reason for the request
20 for external review;

21 (ii) The date that the independent review organization
22 received the assignment from the director to conduct the external
23 review;

24 (iii) The date that the external review was conducted;

25 (iv) The date of its decision;

1 (v) The principal reason or reasons for its decision,
2 including what applicable, if any, evidence-based standards were a
3 basis for its decision;

4 (vi) The rationale for its decision; and

5 (vii) References to the evidence or documentation,
6 including the evidence-based standards, considered in reaching its
7 decision.

8 (c) Upon receipt of a notice of a decision pursuant to
9 subdivision (9)(a) of this section reversing the adverse
10 determination or final adverse determination, the health carrier
11 shall immediately approve the coverage that was the subject of the
12 adverse determination or final adverse determination.

13 (10) The assignment by the director of an approved
14 independent review organization to conduct an external review in
15 accordance with this section shall be done on a random basis among
16 those approved independent review organizations qualified to conduct
17 the particular external review based on the nature of the health care
18 service that is the subject of the adverse determination or final
19 adverse determination and other circumstances, including conflict of
20 interest concerns pursuant to subsection (4) of section 13 of this
21 act.

22 Sec. 9. (1) Except as provided in subsection (6) of this
23 section, a covered person or the covered person's authorized
24 representative may make a request for an expedited external review
25 with the director at the time that the covered person receives:

1 (a) An adverse determination if:

2 (i) The adverse determination involves a medical
3 condition of the covered person for which the timeframe for
4 completion of an expedited internal review of a grievance involving
5 an adverse determination set forth in section 44-7311 would seriously
6 jeopardize the life or health of the covered person or would
7 jeopardize the covered person's ability to regain maximum function;
8 and

9 (ii) The covered person or the covered person's
10 authorized representative has filed a request for an expedited review
11 of a grievance involving an adverse determination as set forth in
12 section 44-7311; or

13 (b) A final adverse determination:

14 (i) If the covered person has a medical condition in
15 which the timeframe for completion of a standard external review
16 pursuant to section 8 of this act would seriously jeopardize the life
17 or health of the covered person or would jeopardize the covered
18 person's ability to regain maximum function; or

19 (ii) If the final adverse determination concerns an
20 admission, availability of care, continued stay, or health care
21 service for which the covered person received emergency services, but
22 has not been discharged from a facility.

23 (2)(a) Upon receipt of a request for an expedited
24 external review, the director shall immediately send a copy of the
25 request to the health carrier.

1 (b) Immediately upon receipt of the request pursuant to
2 subdivision (2)(a) of this section, the health carrier shall
3 determine whether the request meets the reviewability requirements
4 set forth in subsection (2) of section 8 of this act. The health
5 carrier shall immediately notify the director and the covered person
6 and, if applicable, the covered person's authorized representative of
7 its eligibility determination.

8 (c)(i) The director may specify the form for the health
9 carrier's notice of initial determination under this subsection and
10 any supporting information to be included in the notice.

11 (ii) The notice of initial determination shall include a
12 statement informing the covered person and, if applicable, the
13 covered person's authorized representative that a health carrier's
14 initial determination that an external review request is ineligible
15 for review may be appealed to the director.

16 (d)(i) The director may determine that a request is
17 eligible for external review under subsection (2) of section 8 of
18 this act notwithstanding a health carrier's initial determination
19 that the request is ineligible and require that it be referred for
20 external review.

21 (ii) In making a determination under subdivision (2)(d)
22 (i) of this section, the director's decision shall be made in
23 accordance with the terms of the covered person's health benefit plan
24 and shall be subject to all applicable provisions of the Health
25 Carrier External Review Act.

1 (e) Upon receipt of the notice that the request meets the
2 reviewability requirements, the director shall immediately assign an
3 independent review organization to conduct the expedited external
4 review from the list of approved independent review organizations
5 compiled and maintained by the director pursuant to section 12 of
6 this act. The director shall immediately notify the health carrier of
7 the name of the assigned independent review organization.

8 (f) In reaching a decision in accordance with subsection
9 (5) of this section, the assigned independent review organization is
10 not bound by any decisions or conclusions reached during the health
11 carrier's utilization review process as set forth in the Health
12 Carrier Grievance Procedure Act or the Utilization Review Act.

13 (3) Upon receipt of the notice from the director of the
14 name of the independent review organization assigned to conduct the
15 expedited external review pursuant to subdivision (2)(e) of this
16 section, the health carrier or its designee utilization review
17 organization shall provide or transmit all necessary documents and
18 information considered in making the adverse determination or final
19 adverse determination to the assigned independent review organization
20 electronically or by telephone or facsimile or any other available
21 expeditious method.

22 (4) In addition to the documents and information provided
23 or transmitted pursuant to subsection (3) of this section, the
24 assigned independent review organization, to the extent that the
25 information or documents are available and the independent review

1 organization considers them appropriate, shall consider the following
2 in reaching a decision:

3 (a) The covered person's pertinent medical records;

4 (b) The attending health care professional's
5 recommendation;

6 (c) Consulting reports from appropriate health care
7 professionals and other documents submitted by the health carrier,
8 covered person, the covered person's authorized representative, or
9 the covered person's treating provider;

10 (d) The terms of coverage under the covered person's
11 health benefit plan with the health carrier to ensure that the
12 independent review organization's decision is not contrary to the
13 terms of coverage under the covered person's health benefit plan with
14 the health carrier;

15 (e) The most appropriate practice guidelines, which shall
16 include evidence-based standards, and may include any other practice
17 guidelines developed by the federal government, national or
18 professional medical societies, boards, or associations;

19 (f) Any applicable clinical review criteria developed and
20 used by the health carrier or its designee utilization review
21 organization in making adverse determinations; and

22 (g) The opinion of the independent review organization's
23 clinical reviewer or reviewers after considering subdivisions (4)(a)
24 through (f) of this section to the extent that the information and
25 documents are available and the clinical reviewer or reviewers

1 consider it appropriate.

2 (5)(a) As expeditiously as the covered person's medical
3 condition or circumstances requires, but in no event more than
4 seventy-two hours after the date of receipt of the request for an
5 expedited external review that meets the reviewability requirements
6 set forth in subsection (2) of section 8 of this act, the assigned
7 independent review organization shall:

8 (i) Make a decision to uphold or reverse the adverse
9 determination or final adverse determination; and

10 (ii) Notify the covered person and, if applicable, the
11 covered person's authorized representative, the health carrier, and
12 the director of the decision.

13 (b) If the notice provided pursuant to subdivision (5)(a)
14 of this section was not in writing, within forty-eight hours after
15 the date of providing that notice, the assigned independent review
16 organization shall:

17 (i) Provide written confirmation of the decision to the
18 covered person and, if applicable, the covered person's authorized
19 representative, the health carrier, and the director; and

20 (ii) Include the information set forth in subdivision (9)
21 (b) of section 8 of this act.

22 (c) Upon receipt of the notice of a decision pursuant to
23 subdivision (5)(a) of this section reversing the adverse
24 determination or final adverse determination, the health carrier
25 shall immediately approve the coverage that was the subject of the

1 adverse determination or final adverse determination.

2 (6) An expedited external review may not be provided for
3 retrospective adverse or final adverse determinations.

4 (7) The assignment by the director of an approved
5 independent review organization to conduct an external review in
6 accordance with this section shall be done on a random basis among
7 those approved independent review organizations qualified to conduct
8 the particular external review based on the nature of the health care
9 service that is the subject of the adverse determination or final
10 adverse determination and other circumstances, including conflict of
11 interest concerns pursuant to subsection (4) of section 13 of this
12 act.

13 Sec. 10. (1)(a) Within four months after the date of
14 receipt of a notice of an adverse determination or final adverse
15 determination pursuant to section 5 of this act that involves a
16 denial of coverage based on a determination that the health care
17 service or treatment recommended or requested is experimental or
18 investigational, a covered person or the covered person's authorized
19 representative may file a request for external review with the
20 director.

21 (b)(i) A covered person or the covered person's
22 authorized representative may make an oral request for an expedited
23 external review of the adverse determination or final adverse
24 determination pursuant to subdivision (1)(a) of this section if the
25 covered person's treating physician certifies, in writing, that the

1 recommended or requested health care service or treatment that is the
2 subject of the request would be significantly less effective if not
3 promptly initiated.

4 (ii) Upon receipt of a request for an expedited external
5 review, the director shall immediately notify the health carrier.

6 (iii)(A) Upon notice of the request for expedited
7 external review, the health carrier shall immediately determine
8 whether the request meets the reviewability requirements of
9 subdivision (2)(b) of this section. The health carrier shall
10 immediately notify the director and the covered person and, if
11 applicable, the covered person's authorized representative of its
12 eligibility determination.

13 (B) The director may specify the form for the health
14 carrier's notice of initial determination under subdivision (1)(b)
15 (iii)(A) of this section and any supporting information to be
16 included in the notice.

17 (C) The notice of initial determination under subdivision
18 (1)(b)(iii)(A) of this section shall include a statement informing
19 the covered person and, if applicable, the covered person's
20 authorized representative that a health carrier's initial
21 determination that the external review request is ineligible for
22 review may be appealed to the director.

23 (iv)(A) The director may determine that a request is
24 eligible for external review under subdivision (2)(b) of this section
25 notwithstanding a health carrier's initial determination that the

1 request is ineligible and require that it be referred for external
2 review.

3 (B) In making a determination under subdivision (1)(b)
4 (iii)(A) of this section, the director's decision shall be made in
5 accordance with the terms of the covered person's health benefit plan
6 and shall be subject to all applicable provisions of the Health
7 Carrier External Review Act.

8 (v) Upon receipt of the notice that the expedited
9 external review request meets the reviewability requirements of
10 subdivision (2)(b) of this section, the director shall immediately
11 assign an independent review organization to review the expedited
12 request from the list of approved independent review organizations
13 compiled and maintained by the director pursuant to section 12 of
14 this act and notify the health carrier of the name of the assigned
15 independent review organization.

16 (vi) At the time the health carrier receives the notice
17 of the assigned independent review organization pursuant to
18 subdivision (1)(b)(v) of this section, the health carrier or its
19 designee utilization review organization shall provide or transmit
20 all necessary documents and information considered in making the
21 adverse determination or final adverse determination to the assigned
22 independent review organization electronically or by telephone or
23 facsimile or any other available expeditious method.

24 (2)(a) Except for a request for an expedited external
25 review made pursuant to subdivision (1)(b) of this section, within

1 one business day after the date of receipt of the request the
2 director receives a request for an external review, the director
3 shall notify the health carrier.

4 (b) Within five business days following the date of
5 receipt of the notice sent pursuant to subdivision (2)(a) of this
6 section, the health carrier shall conduct and complete a preliminary
7 review of the request to determine whether:

8 (i) The individual is or was a covered person in the
9 health benefit plan at the time that the health care service or
10 treatment was recommended or requested or, in the case of a
11 retrospective review, was a covered person in the health benefit plan
12 at the time that the health care service or treatment was provided;

13 (ii) The recommended or requested health care service or
14 treatment that is the subject of the adverse determination or final
15 adverse determination:

16 (A) Is a covered benefit under the covered person's
17 health benefit plan except for the health carrier's determination
18 that the service or treatment is experimental or investigational for
19 a particular medical condition; and

20 (B) Is not explicitly listed as an excluded benefit under
21 the covered person's health benefit plan with the health carrier;

22 (iii) The covered person's treating physician has
23 certified that one of the following situations is applicable:

24 (A) Standard health care services or treatments have not
25 been effective in improving the condition of the covered person;

1 (B) Standard health care services or treatments are not
2 medically appropriate for the covered person; or

3 (C) There is no available standard health care service or
4 treatment covered by the health carrier that is more beneficial than
5 the recommended or requested health care service or treatment
6 described in subdivision (2)(b)(iv) of this section;

7 (iv) The covered person's treating physician:

8 (A) Has recommended a health care service or treatment
9 that the physician certifies, in writing, is likely to be more
10 beneficial to the covered person, in the physician's opinion, than
11 any available standard health care service or treatment; or

12 (B) Who is a licensed, board-certified or board-eligible
13 physician qualified to practice in the area of medicine appropriate
14 to treat the covered person's condition, has certified in writing
15 that scientifically valid studies using accepted protocols
16 demonstrate that the health care service or treatment requested by
17 the covered person that is the subject of the adverse determination
18 or final adverse determination is likely to be more beneficial to the
19 covered person than any available standard health care service or
20 treatment;

21 (v) The covered person has exhausted the health carrier's
22 internal grievance process as set forth in the Health Carrier
23 Grievance Procedure Act unless the covered person is not required to
24 exhaust the health carrier's internal grievance process pursuant to
25 section 7 of this act; and

1 (vi) The covered person has provided all the information
2 and forms required by the director that are necessary to process an
3 external review, including the release form provided under subsection
4 (2) of section 5 of this act.

5 (3)(a) Within one business day after completion of the
6 preliminary review, the health carrier shall notify the director and
7 the covered person and, if applicable, the covered person's
8 authorized representative in writing whether the request is complete
9 and the request is eligible for external review.

10 (b) If the request:

11 (i) Is not complete, the health carrier shall inform, in
12 writing, the director and the covered person and, if applicable, the
13 covered person's authorized representative and include in the notice
14 what information or materials are needed to make the request
15 complete; or

16 (ii) Is not eligible for external review, the health
17 carrier shall inform the covered person, the covered person's
18 authorized representative, if applicable, and the director in writing
19 and include in the notice the reasons for its ineligibility.

20 (c)(i) The director may specify the form for the health
21 carrier's notice of initial determination under subdivision (3)(b) of
22 this section and any supporting information to be included in the
23 notice.

24 (ii) The notice of initial determination provided under
25 subdivision (3)(b) of this section shall include a statement

1 informing the covered person and, if applicable, the covered person's
2 authorized representative that a health carrier's initial
3 determination that the external review request is ineligible for
4 review may be appealed to the director.

5 (d)(i) The director may determine that a request is
6 eligible for external review under subdivision (2)(b) of this section
7 notwithstanding a health carrier's initial determination that the
8 request is ineligible and require that it be referred for external
9 review.

10 (ii) In making a determination under subdivision (3)(d)
11 (i) of this section, the director's decision shall be made in
12 accordance with the terms of the covered person's health benefit plan
13 and shall be subject to all applicable provisions of the Health
14 Carrier External Review Act.

15 (e) Whenever a request for external review is determined
16 eligible for external review, the health carrier shall notify the
17 director and the covered person and, if applicable, the covered
18 person's authorized representative.

19 (4)(a) Within one business day after the receipt of the
20 notice from the health carrier that the external review request is
21 eligible for external review pursuant to subdivision (1)(b)(iv) of
22 this section or subdivision (3)(e) of this section, the director
23 shall:

24 (i) Assign an independent review organization to conduct
25 the external review from the list of approved independent review

1 organizations compiled and maintained by the director pursuant to
2 section 12 of this act and notify the health carrier of the name of
3 the assigned independent review organization; and

4 (ii) Notify in writing the covered person and, if
5 applicable, the covered person's authorized representative of the
6 request's eligibility and acceptance for external review.

7 (b) The director shall include in the notice provided to
8 the covered person and, if applicable, the covered person's
9 authorized representative a statement that the covered person or the
10 covered person's authorized representative may submit in writing to
11 the assigned independent review organization within five business
12 days following the date of receipt of the notice provided pursuant to
13 subdivision (4)(a) of this section additional information that the
14 independent review organization shall consider when conducting the
15 external review. The independent review organization may accept and
16 consider additional information submitted after five business days.

17 (c) Within one business day after the receipt of the
18 notice of assignment to conduct the external review pursuant to
19 subdivision (4)(a) of this section, the assigned independent review
20 organization shall:

21 (i) Select one or more clinical reviewers, as it
22 determines is appropriate, pursuant to subdivision (4)(d) of this
23 section to conduct the external review; and

24 (ii) Based upon the opinion of the clinical reviewer, or
25 opinions if more than one clinical reviewer has been selected to

1 conduct the external review, make a decision to uphold or reverse the
2 adverse determination or final adverse determination.

3 (d)(i) In selecting clinical reviewers pursuant to
4 subdivision (4)(c)(i) of this section, the assigned independent
5 review organization shall select physicians or other health care
6 professionals who meet the minimum qualifications described in
7 section 13 of this act and, through clinical experience in the past
8 three years, are experts in the treatment of the covered person's
9 condition and knowledgeable about the recommended or requested health
10 care service or treatment.

11 (ii) Neither the covered person, the covered person's
12 authorized representative, if applicable, nor the health carrier
13 shall choose or control the choice of the physicians or other health
14 care professionals to be selected to conduct the external review.

15 (e) In accordance with subsection (8) of this section,
16 each clinical reviewer shall provide a written opinion to the
17 assigned independent review organization on whether the recommended
18 or requested health care service or treatment should be covered.

19 (f) In reaching an opinion, a clinical reviewer is not
20 bound by any decisions or conclusions reached during the health
21 carrier's utilization review process as set forth in the Utilization
22 Review Act or the health carrier's internal grievance process as set
23 forth in the Health Carrier Grievance Procedure Act.

24 (5)(a) Within five business days after the date of
25 receipt of the notice provided pursuant to subdivision (4)(a) of this

1 section, the health carrier or its designee utilization review
2 organization shall provide to the assigned independent review
3 organization the documents and any information considered in making
4 the adverse determination or the final adverse determination.

5 (b) Except as provided in subdivision (5)(c) of this
6 section, failure by the health carrier or its designee utilization
7 review organization to provide the documents and information within
8 the time specified in subdivision (5)(a) of this section shall not
9 delay the conduct of the external review.

10 (c)(i) If the health carrier or its designee utilization
11 review organization has failed to provide the documents and
12 information within the time specified in subdivision (5)(a) of this
13 section, the assigned independent review organization may terminate
14 the external review and make a decision to reverse the adverse
15 determination or final adverse determination.

16 (ii) Immediately upon making the decision under
17 subdivision (5)(c)(i) of this section, the independent review
18 organization shall notify the covered person, the covered person's
19 authorized representative, if applicable, the health carrier, and the
20 director.

21 (6)(a) Each clinical reviewer selected pursuant to
22 subsection (4) of this section shall review all of the information
23 and documents received pursuant to subsection (5) of this section and
24 any other information submitted in writing by the covered person or
25 the covered person's authorized representative pursuant to

1 subdivision (4)(b) of this section.

2 (b) Upon receipt of any information submitted by the
3 covered person or the covered person's authorized representative
4 pursuant to subdivision (4)(b) of this section, within one business
5 day after the receipt of the information, the assigned independent
6 review organization shall forward the information to the health
7 carrier.

8 (7)(a) Upon receipt of the information required to be
9 forwarded pursuant to subdivision (6)(b) of this section, the health
10 carrier may reconsider its adverse determination or final adverse
11 determination that is the subject of the external review.

12 (b) Reconsideration by the health carrier of its adverse
13 determination or final adverse determination pursuant to subdivision
14 (7)(a) of this section shall not delay or terminate the external
15 review.

16 (c) The external review may be terminated only if the
17 health carrier decides, upon completion of its reconsideration, to
18 reverse its adverse determination or final adverse determination and
19 provide coverage or payment for the recommended or requested health
20 care service or treatment that is the subject of the adverse
21 determination or final adverse determination.

22 (d)(i) Immediately upon making the decision to reverse
23 its adverse determination or final adverse determination as provided
24 in subdivision (7)(c) of this section, the health carrier shall
25 notify the covered person, the covered person's authorized

1 representative, if applicable, the assigned independent review
2 organization, and the director in writing of its decision.

3 (ii) The assigned independent review organization shall
4 terminate the external review upon receipt of the notice from the
5 health carrier sent pursuant to subdivision (7)(d)(i) of this
6 section.

7 (8)(a) Except as provided in subdivision (8)(c) of this
8 section, within twenty days after being selected in accordance with
9 subsection (4) of this section to conduct the external review, each
10 clinical reviewer shall provide an opinion to the assigned
11 independent review organization pursuant to subsection (9) of this
12 section on whether the recommended or requested health care service
13 or treatment should be covered.

14 (b) Except for an opinion provided pursuant to
15 subdivision (8)(c) of this section, each clinical reviewer's opinion
16 shall be in writing and include the following information:

17 (i) A description of the covered person's medical
18 condition;

19 (ii) A description of the indicators relevant to
20 determining whether there is sufficient evidence to demonstrate that
21 the recommended or requested health care service or treatment is more
22 likely than not to be beneficial to the covered person than any
23 available standard health care service or treatment and the adverse
24 risk of the recommended or requested health care service or treatment
25 would not be substantially increased over that of available standard

1 health care service or treatment;

2 (iii) A description and analysis of any medical or
3 scientific evidence considered in reaching the opinion;

4 (iv) A description and analysis of any evidence-based
5 standard; and

6 (v) Information on whether the reviewer's rationale for
7 the opinion is based on subdivision (9)(e)(i) or (ii) of this
8 section.

9 (c) For an expedited external review, each clinical
10 reviewer shall provide an opinion orally or in writing to the
11 assigned independent review organization as expeditiously as the
12 covered person's medical condition or circumstances requires, but in
13 no event more than five calendar days after being selected in
14 accordance with subsection (4) of this section.

15 (d) If the opinion provided pursuant to subdivision (8)
16 (a) of this section was not in writing, within forty-eight hours
17 following the date that the opinion was provided, the clinical
18 reviewer shall provide written confirmation of the opinion to the
19 assigned independent review organization and include the information
20 required under subdivision (8)(b) of this section.

21 (9) In addition to the documents and information provided
22 pursuant to subdivision (1)(b) of this section or subsection (5) of
23 this section, each clinical reviewer selected pursuant to subsection
24 (4) of this section, to the extent the information or documents are
25 available and the reviewer considers appropriate, shall consider the

1 following in reaching an opinion pursuant to subsection (8) of this
2 section:

3 (a) The covered person's pertinent medical records;

4 (b) The attending physician or health care professional's
5 recommendation;

6 (c) Consulting reports from appropriate health care
7 professionals and other documents submitted by the health carrier,
8 covered person, the covered person's authorized representative, if
9 applicable, or the covered person's treating physician or health care
10 professional;

11 (d) The terms of coverage under the covered person's
12 health benefit plan with the health carrier to ensure that, but for
13 the health carrier's determination that the recommended or requested
14 health care service or treatment that is the subject of the opinion
15 is experimental or investigational, the reviewer's opinion is not
16 contrary to the terms of coverage under the covered person's health
17 benefit plan with the health carrier; and

18 (e) Whether:

19 (i) The recommended or requested health care service or
20 treatment has been approved by the federal Food and Drug
21 Administration, if applicable, for the condition; or

22 (ii) Medical or scientific evidence or evidence-based
23 standards demonstrate that the expected benefits of the recommended
24 or requested health care service or treatment is more likely than not
25 to be beneficial to the covered person than any available standard

1 health care service or treatment and the adverse risks of the
2 recommended or requested health care service or treatment would not
3 be substantially increased over those of available standard health
4 care service or treatment.

5 (10)(a)(i) Except as provided in subdivision (10)(a)(ii)
6 of this section, within twenty days after the date it receives the
7 opinion of each clinical reviewer pursuant to subsection (9) of this
8 section, the assigned independent review organization, in accordance
9 with subdivision (10)(b) of this section, shall make a decision and
10 provide written notice of the decision to the covered person, if
11 applicable, the covered person's authorized representative, the
12 health carrier, and the director.

13 (ii)(A) For an expedited external review, within forty-
14 eight hours after the date it receives the opinion of each clinical
15 reviewer pursuant to subsection (9) of this section, the assigned
16 independent review organization, in accordance with subdivision (10)
17 (b) of this section, shall make a decision and provide notice of the
18 decision orally or in writing to the persons listed in subdivision
19 (10)(a)(i) of this section.

20 (B) If the notice provided under subdivision (10)(a)(ii)
21 (A) of this section was not in writing, within forty-eight hours
22 after the date of providing that notice, the assigned independent
23 review organization shall provide written confirmation of the
24 decision to the persons listed in subdivision (10)(a)(i) of this
25 section and include the information set forth in subdivision (10)(c)

1 of this section.

2 (b)(i) If a majority of the clinical reviewers recommend
3 that the recommended or requested health care service or treatment
4 should be covered, the independent review organization shall make a
5 decision to reverse the health carrier's adverse determination or
6 final adverse determination.

7 (ii) If a majority of the clinical reviewers recommend
8 that the recommended or requested health care service or treatment
9 should not be covered, the independent review organization shall make
10 a decision to uphold the health carrier's adverse determination or
11 final adverse determination.

12 (iii)(A) If the clinical reviewers are evenly split as to
13 whether the recommended or requested health care service or treatment
14 should be covered, the independent review organization shall obtain
15 the opinion of an additional clinical reviewer in order for the
16 independent review organization to make a decision based on the
17 opinions of a majority of the clinical reviewers pursuant to
18 subdivision (10)(b)(i) or (ii) of this section.

19 (B) The additional clinical reviewer selected under
20 subdivision (10)(b)(iii)(A) of this section shall use the same
21 information to reach an opinion as the clinical reviewers who have
22 already submitted their opinions pursuant to subsection (9) of this
23 section.

24 (C) The selection of the additional clinical reviewer
25 shall not extend the time within which the assigned independent

1 review organization is required to make a decision based on the
2 opinions of the clinical reviewers selected under subsection (4) of
3 this section pursuant to subdivision (4)(a) of this section.

4 (c) The independent review organization shall include in
5 the notice provided pursuant to subdivision (10)(a) of this section:

6 (i) A general description of the reason for the request
7 for external review;

8 (ii) The written opinion of each clinical reviewer,
9 including the recommendation of each clinical reviewer as to whether
10 the recommended or requested health care service or treatment should
11 be covered and the rationale for the reviewer's recommendation;

12 (iii) The date the independent review organization was
13 assigned by the director to conduct the external review;

14 (iv) The date the external review was conducted;

15 (v) The date of its decision;

16 (vi) The principal reason or reasons for its decision;

17 and

18 (vii) The rationale for its decision.

19 (d) Upon receipt of a notice of a decision pursuant to
20 subdivision (10)(a) of this section reversing the adverse
21 determination or final adverse determination, the health carrier
22 shall immediately approve coverage of the recommended or requested
23 health care service or treatment that was the subject of the adverse
24 determination or final adverse determination.

25 (11) The assignment by the director of an approved

1 independent review organization to conduct an external review in
2 accordance with this section shall be done on a random basis among
3 those approved independent review organizations qualified to conduct
4 the particular external review based on the nature of the health care
5 service that is the subject of the adverse determination or final
6 adverse determination and other circumstances, including conflict of
7 interest concerns pursuant to subsection (4) of section 13 of this
8 act.

9 Sec. 11. (1) An external review decision is binding on
10 the health carrier except to the extent the health carrier has other
11 remedies available under applicable state law.

12 (2) An external review decision is binding on the covered
13 person except to the extent the covered person has other remedies
14 available under applicable federal or state law.

15 (3) A covered person or the covered person's authorized
16 representative, if applicable, shall not file a subsequent request
17 for external review involving the same adverse determination or final
18 adverse determination for which the covered person has already
19 received an external review decision pursuant to the Health Carrier
20 External Review Act.

21 Sec. 12. (1) The director shall approve independent
22 review organizations eligible to be assigned to conduct external
23 reviews under the Health Carrier External Review Act.

24 (2) In order to be eligible for approval by the director
25 under this section to conduct external reviews under the act, an

1 independent review organization:

2 (a) Except as otherwise provided in this section, shall
3 be accredited by a nationally recognized private accrediting entity
4 that the director has determined has independent review organization
5 accreditation standards that are equivalent to or exceed the minimum
6 qualifications for independent review organizations established under
7 section 13 of this act; and

8 (b) Shall submit an application for approval in
9 accordance with subsection (4) of this section.

10 (3) The director shall develop an application form for
11 initially approving and for reapproving independent review
12 organizations to conduct external reviews.

13 (4)(a) Any independent review organization wishing to be
14 approved to conduct external reviews under the act shall submit the
15 application form and include with the form all documentation and
16 information necessary for the director to determine if the
17 independent review organization satisfies the minimum qualifications
18 established under section 13 of this act.

19 (b)(i) Subject to subdivision (4)(b)(ii) of this section,
20 an independent review organization is eligible for approval under
21 this section only if it is accredited by a nationally recognized
22 private accrediting entity that the director has determined has
23 independent review organization accreditation standards that are
24 equivalent to or exceed the minimum qualifications for independent
25 review organizations under section 13 of this act.

1 (ii) The director may approve independent review
2 organizations that are not accredited by a nationally recognized
3 private accrediting entity if there are no acceptable nationally
4 recognized private accrediting entities providing independent review
5 organization accreditation.

6 (c) The director may charge an application fee that
7 independent review organizations shall submit to the director with an
8 application for approval and reapproval.

9 (5)(a) An approval is effective for two years, unless the
10 director determines before its expiration that the independent review
11 organization is not satisfying the minimum qualifications established
12 under section 13 of this act.

13 (b) Whenever the director determines that an independent
14 review organization has lost its accreditation or no longer satisfies
15 the minimum requirements established under section 13 of this act,
16 the director shall terminate the approval of the independent review
17 organization and remove the independent review organization from the
18 list of independent review organizations approved to conduct external
19 reviews under the act that is maintained by the director pursuant to
20 subsection (6) of this section.

21 (6) The director shall maintain and periodically update a
22 list of approved independent review organizations.

23 (7) The director may adopt and promulgate rules and
24 regulations to carry out the provisions of this section.

25 Sec. 13. (1) To be approved under section 12 of this act

1 to conduct external reviews, an independent review organization shall
2 have and maintain written policies and procedures that govern all
3 aspects of both the standard external review process and the
4 expedited external review process set forth in the Health Carrier
5 External Review Act that include, at a minimum:

6 (a) A quality assurance mechanism in place that:

7 (i) Ensures that external reviews are conducted within
8 the specified timeframes and that required notices are provided in a
9 timely manner;

10 (ii) Ensures the selection of qualified and impartial
11 clinical reviewers to conduct external reviews on behalf of the
12 independent review organization and suitable matching of reviewers to
13 specific cases and that the independent review organization employs
14 or contracts with an adequate number of clinical reviewers to meet
15 this objective;

16 (iii) Ensures the confidentiality of medical and
17 treatment records and clinical review criteria; and

18 (iv) Ensures that any person employed by or under
19 contract with the independent review organization adheres to the
20 requirements of the act;

21 (b) A toll-free telephone service to receive information
22 on a twenty-four-hours-per-day, seven-days-per-week basis related to
23 external reviews that is capable of accepting, recording, or
24 providing appropriate instruction to incoming telephone callers
25 during other than normal business hours; and

1 (c) An agreement to maintain and provide to the director
2 the information set out in section 15 of this act.

3 (2) All clinical reviewers assigned by an independent
4 review organization to conduct external reviews shall be physicians
5 or other appropriate health care providers who meet the following
6 minimum qualifications:

7 (a) Be an expert in the treatment of the covered person's
8 medical condition that is the subject of the external review;

9 (b) Be knowledgeable about the recommended health care
10 service or treatment through recent or current actual clinical
11 experience treating patients with the same or similar medical
12 condition of the covered person;

13 (c) Hold a nonrestricted license in a state of the United
14 States and, for physicians, a current certification by a recognized
15 medical specialty board in the United States in the area or areas
16 appropriate to the subject of the external review; and

17 (d) Have no history of disciplinary actions or sanctions,
18 including loss of staff privileges or participation restrictions,
19 that have been taken or are pending by any hospital, governmental
20 agency or unit, or regulatory body that raise a substantial question
21 as to the clinical reviewer's physical, mental, or professional
22 competence or moral character.

23 (3) In addition to the requirements set forth in
24 subsection (1) of this section, an independent review organization
25 may not own or control, be a subsidiary of, in any way be owned or

1 controlled by, or exercise control with a health benefit plan, a
2 national, state, or local trade association of health benefit plans,
3 or a national, state, or local trade association of health care
4 providers.

5 (4)(a) In addition to the requirements set forth in
6 subsections (1), (2), and (3) of this section, to be approved
7 pursuant to section 12 of this act to conduct an external review of a
8 specified case, neither the independent review organization selected
9 to conduct the external review nor any clinical reviewer assigned by
10 the independent review organization to conduct the external review
11 may have a material professional, familial, or financial conflict of
12 interest with any of the following:

13 (i) The health carrier that is the subject of the
14 external review;

15 (ii) The covered person whose treatment is the subject of
16 the external review or the covered person's authorized
17 representative, if applicable;

18 (iii) Any officer, director, or management employee of
19 the health carrier that is the subject of the external review;

20 (iv) The health care provider or the health care
21 provider's medical group or independent practice association
22 recommending the health care service or treatment that is the subject
23 of the external review;

24 (v) The facility at which the recommended health care
25 service or treatment would be provided; or

1 (vi) The developer or manufacturer of the principal drug,
2 device, procedure, or other therapy being recommended for the covered
3 person whose treatment is the subject of the external review.

4 (b) In determining whether an independent review
5 organization or a clinical reviewer of the independent review
6 organization has a material professional, familial, or financial
7 conflict of interest for purposes of subdivision (4)(a) of this
8 section, the director shall take into consideration situations in
9 which the independent review organization to be assigned to conduct
10 an external review of a specified case or a clinical reviewer to be
11 assigned by the independent review organization to conduct an
12 external review of a specified case may have an apparent
13 professional, familial, or financial relationship or connection with
14 a person described in subdivision (4)(a) of this section, but that
15 the characteristics of that relationship or connection are such that
16 they are not a material professional, familial, or financial conflict
17 of interest that results in the disapproval of the independent review
18 organization or the clinical reviewer from conducting the external
19 review.

20 (5)(a) An independent review organization that is
21 accredited by a nationally recognized private accrediting entity that
22 has independent review accreditation standards that the director has
23 determined are equivalent to or exceed the minimum qualifications of
24 this section shall be presumed in compliance with this section to be
25 eligible for approval under section 12 of this act.

1 (b) The director shall initially review and periodically
2 review the independent review organization accreditation standards of
3 a nationally recognized private accrediting entity to determine
4 whether the entity's standards are, and continue to be, equivalent to
5 or exceed the minimum qualifications established under this section.
6 The director may accept a review conducted by the National
7 Association of Insurance Commissioners for the purpose of the
8 determination under this subdivision.

9 (c) Upon request, a nationally recognized private
10 accrediting entity shall make its current independent review
11 organization accreditation standards available to the director or the
12 National Association of Insurance Commissioners in order for the
13 director to determine if the entity's standards are equivalent to or
14 exceed the minimum qualifications established under this section. The
15 director may exclude any private accrediting entity that is not
16 reviewed by the National Association of Insurance Commissioners.

17 (6) An independent review organization shall be unbiased.
18 An independent review organization shall establish and maintain
19 written procedures to ensure that it is unbiased in addition to any
20 other procedures required under this section.

21 Sec. 14. No independent review organization, clinical
22 reviewer working on behalf of an independent review organization, or
23 employee, agent, or contractor of an independent review organization
24 shall be liable in damages to any person for any opinions rendered or
25 acts or omissions performed within the scope of the organization's or

1 person's duties under the law during or upon completion of an
2 external review conducted pursuant to the Health Carrier External
3 Review Act, unless the opinion was rendered or act or omission
4 performed in bad faith or involved gross negligence.

5 Sec. 15. (1)(a) An independent review organization
6 assigned pursuant to section 8, 9, or 10 of this act to conduct an
7 external review shall maintain written records in the aggregate by
8 state and by health carrier on all requests for external review for
9 which it conducted an external review during a calendar year and,
10 upon request, submit a report to the director as required under
11 subdivision (1)(b) of this section.

12 (b) Each independent review organization required to
13 maintain written records on all requests for external review pursuant
14 to subdivision (1)(a) of this section for which it was assigned to
15 conduct an external review shall submit to the director, upon
16 request, a report in the format specified by the director.

17 (c) The report shall include in the aggregate by state,
18 and for each health carrier:

19 (i) The total number of requests for external review;

20 (ii) The number of requests for external review resolved
21 and, of those resolved, the number resolved upholding the adverse
22 determination or final adverse determination and the number resolved
23 reversing the adverse determination or final adverse determination;

24 (iii) The average length of time for resolution;

25 (iv) A summary of the types of coverages or cases for

1 which an external review was sought, as provided in the format
2 required by the director;

3 (v) The number of external reviews pursuant to section 8
4 of this act that were terminated as the result of a reconsideration
5 by the health carrier of its adverse determination or final adverse
6 determination after the receipt of additional information from the
7 covered person or the covered person's authorized representative; and

8 (vi) Any other information the director may request or
9 require.

10 (d) The independent review organization shall retain the
11 written records required pursuant to this subsection for at least
12 three years.

13 (2)(a) Each health carrier shall maintain written records
14 in the aggregate, by state and for each type of health benefit plan
15 offered by the health carrier, on all requests for external review
16 that the health carrier receives notice of from the director pursuant
17 to the Health Carrier External Review Act.

18 (b) Each health carrier required to maintain written
19 records on all requests for external review pursuant to subdivision
20 (2)(a) of this section shall submit to the director, upon request, a
21 report in the format specified by the director.

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

24 (i) The total number of requests for external review;

25 (ii) From the total number of requests for external

1 review reported under subdivision (2)(c)(i) of this section, the
2 number of requests determined eligible for a full external review;
3 and

4 (iii) Any other information the director may request or
5 require.

6 (d) The health carrier shall retain the written records
7 required pursuant to this section for at least three years.

8 Sec. 16. The health carrier against which a request for a
9 standard external review or an expedited external review is filed
10 shall pay the cost of the independent review organization for
11 conducting the external review.

12 Sec. 17. (1)(a) Each health carrier shall include a
13 description of the external review procedures in or attached to the
14 policy, certificate, membership booklet, outline of coverage, or
15 other evidence of coverage it provides to covered persons.

16 (b) The disclosure required by subdivision (1)(a) of this
17 section shall be in a format prescribed by the director.

18 (2) The description required under subsection (1) of this
19 section shall include a statement that informs the covered person of
20 the right of the covered person to file a request for an external
21 review of an adverse determination or final adverse determination
22 with the director. The statement may explain that external review is
23 available when the adverse determination or final adverse
24 determination involves an issue of medical necessity,
25 appropriateness, health care setting, level of care, or

1 effectiveness. The statement shall include the telephone number and
2 address of the director.

3 (3) In addition to the contents required by subsection
4 (2) of this section, the statement shall inform the covered person
5 that, when filing a request for an external review, the covered
6 person will be required to authorize the release of any medical
7 records of the covered person that may be required to be reviewed for
8 the purpose of reaching a decision on the external review.

9 Sec. 18. The Health Carrier External Review Act applies
10 to any claim submitted on and after January 1, 2014.

11 Sec. 19. Section 44-7306, Reissue Revised Statutes of
12 Nebraska, is amended to read:

13 44-7306 (1) A health carrier shall maintain in a
14 grievance register written records to document all grievances
15 received during a calendar year. A request for a ~~first-level~~ review
16 of an adverse determination shall be processed in compliance with
17 section 44-7308 but not considered a grievance for purposes of the
18 grievance register unless such request includes a written grievance.
19 ~~A request for a second-level review of an adverse determination shall~~
20 ~~be considered a grievance for purposes of the grievance register. For~~
21 each grievance required to be recorded in the grievance register, the
22 grievance register shall contain, at a minimum, the following
23 information:

24 (a) A general description of the reason for the
25 grievance;

- 1 (b) Date received;
- 2 (c) Date of each review or hearing;
- 3 (d) Resolution ~~at each level~~ of the grievance;
- 4 (e) Date of resolution; ~~at each level~~; and
- 5 (f) Name of the covered person for whom the grievance was
- 6 filed.

7 (2) The grievance register shall be maintained in a

8 manner that is reasonably clear and accessible to the director. A

9 grievance register maintained by a health maintenance organization

10 shall also be accessible to the Department of Health and Human

11 Services.

12 (3) A health carrier shall retain the grievance register

13 compiled for a calendar year for the longer of three years or until

14 the director has adopted a final report of an examination that

15 contains a review of the grievance register for that calendar year.

16 Sec. 20. Section 44-7308, Reissue Revised Statutes of

17 Nebraska, is amended to read:

18 44-7308 (1) If a covered person makes a request to a

19 health carrier for a health care service and the request is denied,

20 the health carrier shall provide the covered person with an

21 explanation of the reasons for the denial, a written notice of how to

22 submit a grievance, and the telephone number to call for information

23 and assistance. The health carrier, at the time of a determination

24 not to certify an admission, a continued stay, or other health care

25 service, shall inform the attending or ordering provider of the right

1 to submit a grievance or a request for an expedited review and, upon
2 request, shall explain the procedures established by the health
3 carrier for initiating a review. A grievance involving an adverse
4 determination may be submitted by the covered person, the covered
5 person's representative, or a provider acting on behalf of a covered
6 person, except that a provider may not submit a grievance involving
7 an adverse determination on behalf of a covered person in a situation
8 in which federal or other state law prohibits a provider from taking
9 that action. A health carrier shall ensure that a majority of the
10 persons reviewing a grievance involving an adverse determination have
11 appropriate expertise. A health carrier shall issue a copy of the
12 written decision to a provider who submits a grievance on behalf of a
13 covered person. A health carrier shall conduct a ~~first-level~~ review
14 of a grievance involving an adverse determination in accordance with
15 subsection (3) of this section and section 44-7310, but such a
16 grievance is not subject to the grievance register reporting
17 requirements of section 44-7306 unless it is a written grievance.

18 (2)(a) A grievance concerning any matter except an
19 adverse determination may be submitted by a covered person or a
20 covered person's representative. A health carrier shall issue a
21 written decision to the covered person or the covered person's
22 representative within fifteen working days after receiving a
23 grievance. The person or persons reviewing the grievance shall not be
24 the same person or persons who made the initial determination denying
25 a claim or handling the matter that is the subject of the grievance.

1 If the health carrier cannot make a decision within fifteen working
2 days due to circumstances beyond the health carrier's control, the
3 health carrier may take up to an additional fifteen working days to
4 issue a written decision, if the health carrier provides written
5 notice to the covered person of the extension and the reasons for the
6 delay on or before the fifteenth working day after receiving a
7 grievance.

8 (b) A covered person does not have the right to attend,
9 or to have a representative in attendance, at the ~~first-level~~
10 grievance review. A covered person is entitled to submit written
11 material. The health carrier shall provide the covered person the
12 name, address, and telephone number of a person designated to
13 coordinate the grievance review on behalf of the health carrier. The
14 health carrier shall make these rights known to the covered person
15 within three working days after receiving a grievance.

16 (3) The written decision issued pursuant to the
17 procedures described in subsections (1) and (2) of this section and
18 section 44-7310 shall contain:

19 (a) The names, titles, and qualifying credentials of the
20 person or persons acting as the reviewer or reviewers participating
21 in the ~~first-level~~ grievance review process;

22 (b) A statement of the reviewers' understanding of the
23 covered person's grievance;

24 (c) The reviewers' decision in clear terms and the
25 contract basis or medical rationale in sufficient detail for the

1 covered person to respond further to the health carrier's position;

2 (d) A reference to the evidence or documentation used as
3 the basis for the decision;

4 (e) In cases involving an adverse determination, the
5 instructions for requesting a written statement of the clinical
6 rationale, including the clinical review criteria used to make the
7 determination; and

8 ~~(f) If applicable, a statement indicating:~~

9 ~~(i) A description of the process to obtain a second level
10 grievance review of a decision; and~~

11 ~~(ii) The written procedures governing a second level
12 review, including any required timeframe for review; and~~

13 ~~(g)-(f)~~ Notice of the covered person's right to contact
14 the director's office. The notice shall contain the telephone number
15 and address of the director's office.

16 Sec. 21. Section 44-7310, Reissue Revised Statutes of
17 Nebraska, is amended to read:

18 44-7310 (1) A health carrier shall establish written
19 procedures for a standard review of an adverse determination. Review
20 procedures shall be available to a covered person and to the provider
21 acting on behalf of a covered person. For purposes of this section,
22 covered person includes the representative of a covered person.

23 (2) When reasonably necessary or when requested by the
24 provider acting on behalf of a covered person, standard reviews shall
25 be evaluated by an appropriate clinical peer or peers in the same or

1 similar specialty as would typically manage the case being reviewed.
2 The clinical peer shall not have been involved in the initial adverse
3 determination.

4 (3) For standard reviews the health carrier shall notify
5 in writing both the covered person and the attending or ordering
6 provider of the decision within fifteen working days after the
7 request for a review. The written decision shall contain the
8 provisions required in subsection (3) of section 44-7308.

9 (4) In any case in which the standard review process does
10 not resolve a difference of opinion between the health carrier and
11 the covered person or the provider acting on behalf of the covered
12 person, the covered person or the provider acting on behalf of the
13 covered person may submit a written grievance, unless the provider is
14 prohibited from filing a grievance by federal or other state law. A
15 ~~health carrier that offers managed care plans shall review it as a~~
16 ~~second level grievance.~~

17 Sec. 22. Section 44-7311, Reissue Revised Statutes of
18 Nebraska, is amended to read:

19 44-7311 (1) A health carrier shall establish written
20 procedures for the expedited review of a grievance involving a
21 situation in which the timeframe of the standard grievance procedures
22 set forth in sections 44-7308 to 44-7310 would seriously jeopardize
23 the life or health of a covered person or would jeopardize the
24 covered person's ability to regain maximum function. A request for an
25 expedited review may be submitted orally or in writing. A request for

1 an expedited review of an adverse determination may be submitted
2 orally or in writing and shall be subject to the review procedures of
3 this section, if it meets the criteria of this section. However, for
4 purposes of the grievance register requirements of section 44-7306, a
5 request for an expedited review shall not be included in the
6 grievance register unless the request is submitted in writing.
7 Expedited review procedures shall be available to a covered person
8 and to the provider acting on behalf of a covered person. For
9 purposes of this section, covered person includes the representative
10 of a covered person.

11 (2) Expedited reviews which result in an adverse
12 determination shall be evaluated by an appropriate clinical peer or
13 peers in the same or similar specialty as would typically manage the
14 case being reviewed. The clinical peer or peers shall not have been
15 involved in the initial adverse determination.

16 (3) A health carrier shall provide expedited review to
17 all requests concerning an admission, availability of care, continued
18 stay, or health care service for a covered person who has received
19 emergency services but has not been discharged from a facility.

20 (4) An expedited review may be initiated by a covered
21 person or a provider acting on behalf of a covered person.

22 (5) In an expedited review, all necessary information,
23 including the health carrier's decision, shall be transmitted between
24 the health carrier and the covered person or the provider acting on
25 behalf of a covered person by telephone, facsimile, or the most

1 expeditious method available.

2 (6) In an expedited review, a health carrier shall make a
3 decision and notify the covered person or the provider acting on
4 behalf of the covered person as expeditiously as the covered person's
5 medical condition requires, but in no event more than seventy-two
6 hours after the review is commenced. If the expedited review is a
7 concurrent review determination, the health care service shall be
8 continued without liability to the covered person until the covered
9 person has been notified of the determination.

10 (7) A health carrier shall provide written confirmation
11 of its decision concerning an expedited review within two working
12 days after providing notification of that decision, if the initial
13 notification was not in writing. The written decision shall contain
14 the provisions required in subsection (3) of section 44-7308.

15 (8) A health carrier shall provide reasonable access, not
16 to exceed one business day after receiving a request for an expedited
17 review, to a clinical peer who can perform the expedited review.

18 (9) In any case in which the expedited review process
19 does not resolve a difference of opinion between the health carrier
20 and the covered person or the provider acting on behalf of the
21 covered person, the covered person or the provider acting on behalf
22 of the covered person may submit a written grievance, unless the
23 provider is prohibited from filing a grievance by federal or other
24 state law. ~~A health carrier that offers managed care plans shall~~
25 ~~review it as a second level grievance.~~ Except as expressly provided

1 in this section, in conducting the review, the health carrier shall
2 adhere to timeframes that are reasonable under the circumstances.

3 (10) A health carrier shall not be required to provide an
4 expedited review for retrospective adverse determinations.

5 Sec. 23. Original sections 44-7306, 44-7308, 44-7310, and
6 44-7311, Reissue Revised Statutes of Nebraska, are repealed.

7 Sec. 24. The following section is outright repealed:
8 Section 44-7309, Reissue Revised Statutes of Nebraska.