LEGISLATIVE BILL 147

Approved by the Governor March 7, 2013

Introduced by Gloor, 35.

FOR AN ACT relating to insurance; to amend sections 44-7306, 44-7308, 44-7310, and 44-7311, Reissue Revised Statutes of Nebraska; to adopt the Health Carrier External Review Act; to eliminate certain grievance review provisions; to harmonize provisions; to repeal the original sections; and to outright repeal section 44-7309, Reissue Revised Statutes of Nebraska.

Be it enacted by the people of the State of Nebraska,

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

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

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

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

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

(3) Authorized representative means:

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

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

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

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

(5) Best evidence means evidence based on:

(a) Randomized clinical trials;

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

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

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

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

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

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

(9) Certification means a determination by a health carrier or its designee utilization review organization that an admission, the availability of care, a continued stay, or other health care service has been reviewed and, based upon the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness;

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

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

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

(13) Covered person means a policyholder, subscriber, enrollee, or

other individual participating in a health benefit plan;

(14) Director means the Director of Insurance;

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

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

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

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

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

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

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

(22) Final adverse determination means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth in the Health Carrier Grievance Procedure Act;

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

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

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

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

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

(28) Health information means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

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

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

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

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

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

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

(b) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's United States National Library of Medicine

for indexing in Index Medicus, known as Medline, and Elsevier Science Ltd. for indexing in Excerpta Medica, known as Embase;

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

(d) The following standard reference compendia:

(i) The AHFS Drug Information;

(ii) Drug Facts and Comparisons;

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

(iv) The United States Pharmacopoeia Drug Information;

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

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

(ii) The National Institutes of Health;

(iii) The National Cancer Institute;

(iv) The National Academy of Sciences;

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

(vi) The federal Food and Drug Administration; and

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

(f) Any other medical or scientific evidence that is comparable to the sources listed in subdivisions (30)(a) through (e) of this section;

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

(32) Protected health information means health information:

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

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

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

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

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

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

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

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

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

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

(ii) Credit;

(iii) Dental;

(iv) Disability income;

(v) Hospital indemnity;

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

(vii) Vision care; or

(viii) Any other limited supplemental benefit.

(b) The act shall not apply to:

(i) A medicare supplement policy of insurance as defined in section 44-3602;

(ii) Coverage under a plan through medicare, medicaid, or the Federal Employees Health Benefits Program;

(iii) Any coverage issued under Chapter 55 of Title 10 of the United States Code and any coverage issued as a supplement to that coverage;

(iv) Any coverage issued as supplemental to liability insurance;

(v) Workers' compensation or similar insurance;

(vi) Automobile medical-payment insurance; or

(vii) Any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Sec. 5. (1)(a) A health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to section 8, 9, or 10 of this act and include the appropriate statements and information as set forth in subsection (2) of this section at the same time that the health carrier sends written notice of:

(i) An adverse determination upon completion of the health carrier's utilization review process set forth in the Utilization Review Act; and

(ii) A final adverse determination.

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

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

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

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

(A) If the covered person has a medical condition in which the timeframe for completion of an expedited review of a grievance involving an adverse determination as set forth in section 44-7311 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to section 9 or 10 of this act if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, at the same time the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in section 44-7311, but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review; and

(B) The covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process as set forth in section 44-7308, but if the health carrier has not issued a written decision to the covered person or his or her authorized representative within thirty days following the date that the covered person or his or her authorized representative files the grievance with the health carrier and the covered person or his or her authorized representative has not requested or agreed to a delay, the covered person or his or her authorized representative may file a request for external review pursuant to section 6 of this act and shall be considered to have exhausted the health carrier's internal grievance process for purposes of section 7 of this act; and

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

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

this act; or

(B) If the final adverse determination concerns:

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

(II) A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person or the covered person's authorized representative may file a request for a standard external review to be conducted pursuant to section 10 of this act or if the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, the covered person or his or her authorized representative may request an expedited external review to be conducted under section 10 of this act.

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

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

Sec. 6. (1)(a) Except for a request for an expedited external review as set forth in section 9 of this act, all requests for external review shall be made in writing to the director.

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

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

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

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

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

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

(c) Notwithstanding subdivision (1)(b) of this section, a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination made pursuant to the Utilization Review Act until the covered person has exhausted the health carrier's internal grievance process.

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

(A) Under section 9 of this act if the covered person has a medical condition in which the timeframe for completion of an expedited review of the grievance involving an adverse determination set forth in section 44-7311 would seriously jeopardize the life or health of the covered person or would

jeopardize the covered person's ability to regain maximum function; or

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

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

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

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

(3) If the requirement to exhaust the health carrier's internal grievance procedures is waived under subdivision (2)(b) of this section, the covered person or the covered person's authorized representative may file a request in writing for a standard external review as set forth in section 8 or 10 of this act.

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

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

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

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

(b) The health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;

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

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

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

(i) The request is complete; and

(ii) The request is eligible for external review.

(b) If the request:

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

(ii) Is not eligible for external review, the health carrier shall

inform the covered person and, if applicable, the covered person's authorized representative and the director in writing and include in the notice the reasons for its ineligibility.

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

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

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

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

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

(i) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the director pursuant to section 12 of this act to conduct the external review and notify the health carrier of the name of the assigned independent review organization; and

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

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

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

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

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

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

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

(6)(a) The assigned independent review organization shall review all of the information and documents received pursuant to subsection (5) of this section and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to subdivision (4)(c) of this section.

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

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

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

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

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

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

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

(a) The covered person's medical records;

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

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

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

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

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

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

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

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

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

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

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

(iv) The date of its decision;

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

(vi) The rationale for its decision; and

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

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

(10) The assignment by the director of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent

review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to subsection (4) of section 13 of this act.

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

(a) An adverse determination if:

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

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

(b) A final adverse determination:

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

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

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

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

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

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

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

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

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

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

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

available expeditious method.

(4) In addition to the documents and information provided or transmitted pursuant to subsection (3) of this section, the assigned independent review organization, to the extent that the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b)(i) A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to subdivision (1)(a) of this section if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less

effective if not promptly initiated.

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

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

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

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

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

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

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

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

(2)(a) Except for a request for an expedited external review made pursuant to subdivision (1)(b) of this section, within one business day after the date of receipt of the request the director receives a request for an external review, the director shall notify the health carrier.

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

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

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

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

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

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

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

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

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

(iv) The covered person's treating physician:

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

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

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

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

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

(b) If the request:

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

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

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

(ii) The notice of initial determination provided under subdivision (3)(b) of this section shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the director.

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

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

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

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

(i) Assign an independent review organization to conduct the external review from the list of approved independent review organizations compiled and maintained by the director pursuant to section 12 of this act and notify the health carrier of the name of the assigned independent review organization; and

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

(b) The director shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five business days following the date of receipt of the notice provided pursuant to subdivision (4)(a) of this section additional

information that the independent review organization shall consider when conducting the external review. The independent review organization may accept and consider additional information submitted after five business days.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The external review may be terminated only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse

determination or final adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.

(d)(i) Immediately upon making the decision to reverse its adverse determination or final adverse determination as provided in subdivision (7)(c) of this section, the health carrier shall notify the covered person, the covered person's authorized representative, if applicable, the assigned independent review organization, and the director in writing of its decision.

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

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

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

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

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

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

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

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

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

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

(9) In addition to the documents and information provided pursuant to subdivision (1)(b) of this section or subsection (5) of this section, each clinical reviewer selected pursuant to subsection (4) of this section, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to subsection (8) of this section:

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

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

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

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

(e) Whether:

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

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

or treatment would not be substantially increased over those of available standard health care service or treatment.

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

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

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

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

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

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

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

(C) The selection of the additional clinical reviewer shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers selected under subsection (4) of this section pursuant to subdivision (4)(a) of this section.

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

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

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

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

(iv) The date the external review was conducted;

(v) The date of its decision;

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

(vii) The rationale for its decision.

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

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

Sec. 11. (1) An external review decision is binding on the health

carrier except to the extent the health carrier has other remedies available under applicable state law.

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

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

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

(2) In order to be eligible for approval by the director under this section to conduct external reviews under the act, an independent review organization:

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

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

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

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

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

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

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

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

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

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

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

Sec. 13. (1) To be approved under section 12 of this act to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in the Health Carrier External Review Act that include, at a minimum:

(a) A quality assurance mechanism in place that:

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

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

of clinical reviewers to meet this objective;

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

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

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

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

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

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

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

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

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

(3) In addition to the requirements set forth in subsection (1) of this section, an independent review organization may not own or control, be a subsidiary of, in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.

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

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

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

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

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

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

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

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

(5)(a) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review

accreditation standards that the director has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for approval under section 12 of this act.

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

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

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

Sec. 14. No independent review organization, clinical reviewer working on behalf of an independent review organization, or employee, agent, or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to the Health Carrier External Review Act, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

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

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

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

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

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

(iii) The average length of time for resolution;

(iv) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the director;

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) The description required under subsection (1) of this section shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the director. The statement may explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness. The statement shall include the telephone number and address of the director.

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

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

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

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

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

(b) Date received;

(c) Date of each review or hearing;

(d) Resolution ~~at each level~~ of the grievance;

(e) Date of resolution; ~~at each level;~~ and

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

(2) The grievance register shall be maintained in a manner that is reasonably clear and accessible to the director. A grievance register maintained by a health maintenance organization shall also be accessible to the Department of Health and Human Services.

(3) A health carrier shall retain the grievance register compiled for a calendar year for the longer of three years or until the director has adopted a final report of an examination that contains a review of the grievance register for that calendar year.

Sec. 20. Section 44-7308, Reissue Revised Statutes of Nebraska, is amended to read:

44-7308 (1) If a covered person makes a request to a health carrier for a health care service and the request is denied, the health carrier shall provide the covered person with an explanation of the reasons for the denial, a written notice of how to submit a grievance, and the telephone number to call for information and assistance. The health carrier, at the time of a determination not to certify an admission, a continued stay, or other health care service, shall inform the attending or ordering provider of the right to submit a grievance or a request for an expedited review and, upon request, shall explain the procedures established by the health carrier for initiating a review. A grievance involving an adverse determination may be submitted by the covered person, the covered person's representative, or a provider acting on behalf of a covered person, except that a provider may not submit a grievance involving an adverse determination on behalf of a covered person in a situation in which federal or other state law prohibits a provider

from taking that action. A health carrier shall ensure that a majority of the persons reviewing a grievance involving an adverse determination have appropriate expertise. A health carrier shall issue a copy of the written decision to a provider who submits a grievance on behalf of a covered person. A health carrier shall conduct a ~~first-level~~ review of a grievance involving an adverse determination in accordance with subsection (3) of this section and section 44-7310, but such a grievance is not subject to the grievance register reporting requirements of section 44-7306 unless it is a written grievance.

(2)(a) A grievance concerning any matter except an adverse determination may be submitted by a covered person or a covered person's representative. A health carrier shall issue a written decision to the covered person or the covered person's representative within fifteen working days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance. If the health carrier cannot make a decision within fifteen working days due to circumstances beyond the health carrier's control, the health carrier may take up to an additional fifteen working days to issue a written decision, if the health carrier provides written notice to the covered person of the extension and the reasons for the delay on or before the fifteenth working day after receiving a grievance.

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

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

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

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

(c) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

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

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

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

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

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

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

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

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

(2) When reasonably necessary or when requested by the provider acting on behalf of a covered person, standard reviews shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer shall not have been involved in the initial adverse determination.

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

(4) In any case in which the standard review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may submit a

written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. ~~A health carrier that offers managed care plans shall review it as a second-level grievance.~~

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

44-7311 (1) A health carrier shall establish written procedures for the expedited review of a grievance involving a situation in which the timeframe of the standard grievance procedures set forth in sections 44-7308 to 44-7310 would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. A request for an expedited review may be submitted orally or in writing. A request for an expedited review of an adverse determination may be submitted orally or in writing and shall be subject to the review procedures of this section, if it meets the criteria of this section. However, for purposes of the grievance register requirements of section 44-7306, a request for an expedited review shall not be included in the grievance register unless the request is submitted in writing. Expedited review procedures shall be available to a covered person and to the provider acting on behalf of a covered person. For purposes of this section, covered person includes the representative of a covered person.

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

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

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

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

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

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

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

(9) In any case in which the expedited review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. ~~A health carrier that offers managed care plans shall review it as a second-level grievance.~~ Except as expressly provided in this section, in conducting the review, the health carrier shall adhere to timeframes that are reasonable under the circumstances.

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

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

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