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

The definition of "emergency services" has been revised to reflect the definition of that term in the interim final rules on emergency services published in the Federal Register June 28, 2010.

O. "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.

P. (1)

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(5) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(6) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental hea

U. "Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

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

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

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

Y. "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

The DOL final rule, which was unchanged by the interim final rules on internal claims and appeals and external review processes published in the Federal Register July 23, 2010, uses the term "pre-service claim" instead of "prospective review." The DOL final rule defines a "pre-service claim" as "any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care." The definition of "prospective review," as defined in Subsection Y, has been amended to be consistent with the intent of the definition of "pre-service claim" because both require prior approval of the benefit prior to its provision. The DOL final rule does not state what process the cl

This Act shall apply to a health carrier offering a health benefit plan that provides or performs utilization review services. The requirements of this Act also shall apply to any designee of the health carrier or utilization review organization that performs utilization review functions on the carrier's behalf. This Act also shall apply to a health carrier or its designee utilization review organization that provides or performs prospective review or retrospective review benefit determinations.

The DOL final rule expands the scope and application of this model to include initial benefit determinations based on whether a covered person is eligible to participate in the health carrier's health benefit plan, as well as any other determination that results in a denial, reduction or termination of, or a failure to provide payment, in whole or in part, for a benefit. To be consistent with the DOL final rule, this section was revised to include these types of determinations as well as utilization review determinations that involve medical necessity. The definition of "adverse determination" in Section 3A has been revised to reflect the DOL final rule's definition of "adverse benefit determination." That term has also been revised to reflect the inclusion of rescission of coverage determinations, as provided in the interim final rules on internal claims and appeals and external review processes published in the Federal Register July 23, 2010. Any denial, reduction, termination of or failure to provide or make payment, in whole or in part, based on a determination of the covered person's eligibility to participate in the health carrier's health benefit plan and any other determination that results in a denial, reduction or termination of, or a failure to provide payment, in whole or in part, for a benefit will be an adverse determination under this Act and, consequently, eligible for an appeal under the NAIC Health Carrier Grievance Procedure Model Act. Rescission of coverage determinations are also eligible for an appeal under the NAIC Health Carrier Grievance Procedure Model Act.

The provisions of this Act are consistent with the provisions in the interim final regulations on internal claims and appeals and external review processes, as published in the Federal Register July 23, 2010 and, as those regulations were amended by the interim final regulations published in the Federal Register June 24, 2011. However, states should be aware that the Affordable Care Act's preemption standards permit States to impose more stringent, consumer protection requirements.

States that regulate utilization review organizations pursuant to statut /MCIDt2.7 (w)-7 (o)-86that (w)-7 (r2.9 MCID)ren MCID

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

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

(a) The filing of benefit requests;

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

(c) The review of adverse determinations in accordance with [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

(2) The program document shall describe the following:

(a) Procedures to evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services;

(b) Data sources and clinical review criteria used in decision-making;

(c) Mechanisms to ensure consistent application of clinical review criteria and compatible decisions;

(d) Data collection processes and analytical methods used in assessing utilization of health care services;

(e)

(d) (i) If an independent reviewer or a court of competent jurisdiction rejects the benefit request or claim for immediate review on the basis that the health carrier met the requirements of the exception provided in subparagraph (a) of this paragraph, the covered person has the right to resubmit and, as appropriate, pursue a review of the benefit request or claim under this Act or file a grievance pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act].

(ii) In this case, within a reasonable time, after the independent reviewer or the court rejects the benefit request or claim for immediate review, but

I. A health carrier shall provide covered persons and participating providers with access to its review staff by a toll-free number or collect call telephone line.

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

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

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

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

B. (1) (a) (i) Subject to Subparagraph (b) of this paragraph, for prospective review determinations, a health carrier shall make the determination and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen (15) days after the date the health carrier receives the request.

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

(b) The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative of the determination pursuant to Subparagraph (a) of this paragraph may be extended one time by the health carrier for up to fifteen (15) days, provided the health carrier:

(i) Determines that an extension is necessary due to matters beyond the health carrier's control; and

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

(c) If the extension under Subparagraph (b) of this paragraph is necessary due to the failure of the covered person or the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension shall:

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

(ii) Give the covered person or, if applicable, the covered person's authorized representative at least forty-five (45) days from the date of receipt of the notice to provide the specified information.

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this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

(2) (a) If the time period for making the determination under Subsection B or D is extended due to the covered person's or, if applicable, the covered person's authorized representative's failure to submit the information necessary to make the determination, the time period for making the determination shall be tolled from the date on which the health carrier sends the notification of the extension to the covered person or, if applicable, the covered person's authorized representative until the earlier of:

(i)

Procedure Model Act sets out a process, including timeframes, for covered persons to file a grievance requesting a review of an adverse determination made by a health carrier under this Act.

A. (1) A health carrier shall establish written procedures in accordance with this section for receiving benefit requests from covered persons or their authorized representatives and for making and notifying covered persons or their authorized representatives of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgt rer0 ar2.8 (e) (T*-1.7 t(e)-34s)-4.4 (1[(A)0.9 (.)]Te)-3 (w)T.2(r)8-

(b) If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with Subsection E.

(2) (a) If the covered person or, if applicable, the covered person's authorized representative has failed to provide sufficient information for the health carrier to make a determination, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative either orally or, if requested by the covered person or the covered person's authorized representative, in writing of this failure and state what specific information is needed as soon as possible, but in no event later than twenty-four (24) hours after receipt of the request.

(b) The health carrier shall provide the covered person or, if applicable, the covered person's authorized representative a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than forty-eight (48) hours after notifying the covered person or the covered person's authorized representative of the failure to submit sufficient information, as provided in Subparagraph (a) of this paragraph.

(c) The health carrier shall notify the covered person or, if applicable, the covered

the request and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but in no event more than twenty-four (24) hours after the health carrier's receipt of the request.

(2) If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with Subsection E.

D. For purposes of calculating the time periods within which a determination is required to be made under Subsection B or C, the time period within which the determination is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to Section 7 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

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

(a) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care provider and the claim amount, if applicable;

(b) A statement describing the availability, upon request, of the diagnosis code and its

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

(i) The amount negotiated with in-network providers for emergency services, excluding any in-network copayment or coinsurance imposed with respect to the covered person;

(ii) The amount of the emergency service calculated using the same method the plan uses to determine payments for out-of-network services, but using the in-network cost-sharing provisions instead of the out-of-network cost-sharing provisions;o 9.4 (p)11 0 Tw 247 (t)]Tng-0.7 (t)-6 (h)8-6.6

A. In the certificate of coverage or member handbook provided to covered persons, a health carrier shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations, and a statement of rights and responsibilities of covered persons with respect to those procedures.

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

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

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rule making and review of regulations].

A violation of this Act shall [insert appropriate administrative penalty from state law].

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