HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

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Section 1. Title

This Act shall be known and may be cited as the Health Carrier External Review Act.

Drafting Note:

Section 3. Definitions

For purposes of this Act:

A. "Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, 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 therefore denied, reduced or terminated.

Drafting Note: The definition of "adverse determination" should be interpreted broadly to ensure that all adverse determinations where the covered person believes the treatment or service is medically necessary are eligible for external review in accordance with the provisions of this Act. It includes, for example, adverse determinations regarding cosmetic procedures, when the covered person requests the health care service on medical necessity grounds rather than for cosmetic reasons. It also includes adverse determinations related to out-of-network services, when the covered person requests health care services from a provider that does not participate in the health carrier's provider network because the clinical expertise of the provider may be medically necessary for treatment of the covered person's medical condition and that expertise is not available in the health carrier's provider network. States may wish to consider carving out adverse determinations related to out-of-network servic p t 01a-0.6 (t)p84/ (eu t)2.7 Td [8-fP8n0.002 T(t)3.7 (he 6cr

(b) Drug Facts and Comparisons;

(c)

Section 6. Request for External Review

Option 1.

Drafting Note: The following Option 1 for Section 6A applies to states that choose to establish the external grievance process in the office of the commissioner and require that covered persons file all requests for external review with the commissioner.

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 commissioner.

Option 2.

Drafting Note: The following Option 2 for Section 6A applies to states that choose to establish responsibility for the external grievance process with the health carrier and require that covered persons file requests for external review with the health carrier.

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 health carrier.

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

Section 7. Exhaustion of Internal Grievance Process

A. (1) Except as provided in Subsection B, 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 [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

(2) 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:

(2) In reaching a recommendation, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization

(c) The date the external review was conducted;

(d) The date of its recommendation;

(e) The principal reason or reasons for its recommendation;

(f) The rationale for its recommendation; and

(g) References to the evidence or documentation, including the practice guidelines, considered in reaching its recommendation.

(3) Upon receipt of the assigned independent review organization's recommendation pursuant to Paragraph (1), the commissioner immediately shall review the recommendation to ensure that it is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

J. (1) The commissioner shall notify the covered person, if applicable, the covered person's authorized representative, and the health carrier in writing of the decision to uphold or reverse the adverse determination or the final adverse determination within fifteen (15) days after the date of receipt of the selected independent review organization's recommendation provided pursuant to Subsection I(1).

(2) The commissioner shall include in the notice sent pursuant to Paragraph (1):

(a) The principal reason or reasons for the decision, including, as an attachment to the notice or in any other manner the commissioner considers appropriate, the information provided by the selected independent review organization in regard to its recommendation pursuant to Subsection I(2); and

(b) If appropriate, the principal reason or reasons why the commissioner did not follow the assigned independent review organization's recommendation.

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

Option 2.

Drafting Note: Option 2 for this section of this Act applies to states that choose not to review the external review decision of an independent review organization as in Option 1. Option 2 requires covered persons to file all requests for external review with the commissioner. The commissioner then conducts a preliminary review of the request for external review to ensure that it meets all of the requirements to be eligible for external review. If the commissioner determines that the request meets specified requirements to be eligible for external review, the commissioner then assigns an independent review organization to conduct the external review

A. (1) Within sixty (60) days 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 commissioner.

(2) Upon receipt of a request for an external review pursuant to Paragraph (1), the commissioner immediately shall notify and send a copy of the request to the health carrier that made the adverse determination or fi

(b) Immediately notify the health carrier in writing of the acceptance of the request for external review.

(3) If the request:

(a) Is not complete, the commissioner shall inform the covered person and, if applicable, the covered person's authorized representative what information or materials are needed to make the request complete; or

(b) Is not accepted for external review, the commissioner shall inform the covered person, if applicable, the covered person's authorized representative, and the health carrier in writing of the reasons for its nonacceptance.

D. (1) At the time a request for external review is accepted pursuant to Subsection C, the commissioner shall assign an independent review organization to conduct the external review that has been approved pursuant to Section 13 of this Act.

(2) 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 [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

E. (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Subsection C(2), 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.

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

(3) (a) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in Paragraph (1), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

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

F. (1) The assigned independent review organization shall review all of the information and documents received pursuant to Subsection E and any other information submitted in writing by the covered person or the covered person's authorized representative

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection C(2), at the same time the commissioner forwards the information to the independent review organization, the commissioner shall forward the information to the health carrier.

G. (1) Upon receipt of the information required to be forwarded pursuant to Subsection F(2), the C9rrier2eo5rie1perc J 0 T mie1pperc)ci2.9 (r)s(h)-0.6 (e .-4 (dvw 26.574.6 8e

Option 3.

Drafting Note:

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F. (1) The assigned independent review organization shall review all of the information and documents received pursuant to Subsection E 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 Subsection C(2).

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection C(2), the assigned independent review organization immediately shall forward the information to the health carrier

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

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

(3) 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.

(4) (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3), the health carrier shall notify the covered person , if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

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

H. In addition to the documents and information provided pursuant to Subsection E, 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:

(1) The covered person's medical records;

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

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

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is 1.2 (ci)1 (i)-1.52.9 (r

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines “medical necessity” because of the effect of such a definition on the rights

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

J. The assignment by a health carrier from an approved independent review organization to conduct an external review in accordance with this section shall be fair and impartial. The health carrier and the independent review organization shall comply with standards promulgated by the commissioner by regulation to ensure fairness and impartiality in the assignment by health carriers of approved independent review organizations to conduct external reviews, including its term, its termination and payment arrangement

Section 9. Expedited External Review

Option 1.

Drafting Note: Option 1 for this section of this Act applies to states that choose to establish the expedited external review process in the office of the commissioner and require covered persons make all requests for an expedited external review with the commissioner. This option requires the commissioner to assign the conduct of the expedited external review to an independent review organization that has met specified requirements to be eligible for an expedited external review. The assigned independent review organization is required to provide to the commissioner with a recommendation on whether to uphold or reverse the adverse determination or final adverse determination.

A. Except as provided in Subsection H, a cover /P2.6 (e)ianafi

(b) 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.

B. At the time the commissioner receives a request for an expedited external review, the commissioner immediately shall:

(1) Notify and provide a copy of the request to the health carrier that made the adverse determination or final adverse determination that is the subject of the request; and

(2) For a request that the commissioner has determined meets the reviewability requirements set forth in Section 8B of this Act, assign an independent review organization that has been approved pursuant to Section 12 of this Act to conduct the expedited external review and provide a written recommendation to the commissioner on whether to uphold or reverse the adverse determination or final adverse determination.

C. In reaching a recommendation, 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 [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert state law equivalent to the Health Carrier Grievance Procedure Model Act].

D. At the time the health carrier receives the notice pursuant to Subsection B, 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.

E. In addition to the documents and information provided or transmitted pursuant to Subsection D, 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 recommendation:

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

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

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

(4) The terms of coverage under the covered person's health benefit plan with the health carrier;

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

A. Except as provided in Subsection G, a covered person or the covered person's authorized representative may make a request for an expedited external review with the commissioner at the time the covered person receives:

(1) An adverse determination if:

(a) 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 [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(b) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act]; or

(2) A final adverse determination:

(a) If the covered person has a medical condition where 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

(b) 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 (f)-1-2.4 (,)8 ofvriarisp Ap.7 c5 (i2 (i)-0.6 (lit)1.7 Deermination Mod.5 (i)-l Act] or the healthcarri.5 (8 (r)-0.8 (')-1.3 (s)-2.5 (int)-3.8 (.5 (

D. At the time the health carrier receives the notice pursuant to Subsection B, the health carr
its designee utilization review organization shall provide or transmit all necessary documents
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(a) Provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner; and

(b) Include the information set forth in Section 8 I(2) of this Act.

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

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

Option 3.

Drafting Note: Option 3 for this section of this Act applies to states that choose to establish responsibility for the expedited external review process with the health carrier and require that covered persons file requests for an expedited external review with the health carrier. This option also requires the health carrier to assign an approved independent review organization to conduct an expedited external review of the request if the request has satisfied specified requirements to be eligible for an expedited external review.

A. Except as provided in Subsection F, a covered person or the covered person's authorized representative may make a request for an expedited external review with the health carrier at the time the covered person receives:

(1) An adverse determination if:

(a) 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 [insert reference in state law (generally Section 7 of the Uniform Health Carrier Grievance and External Review Model Act)] would seriously jeopardize the life or health of the covered person or would jeopardize the ability of the covered person to regain maximum function, as determined by a physician with knowledge of the medical condition; or

B. (1) At the time the health carrier receives a request for an expedited external review, the health carrier immediately shall:

(a) Assign an independent review organization from the list compiled and h.8 1.i.8 (6 (9 (l r)-0.7 7( )-6 0 Tw .37.2 7 0.7 (g(6 (l (e)0 EM-(h c)-3 /P <</M)]ia)-1.i0

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

E. (1) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receip

A. (1) Within sixty (60) days 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 commissioner.

(2) (a) 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 Paragraph (1) if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(b) Upon receipt of a request for an expedited external review that meets the reviewability requirements of Subsection C, the commissioner immediately shall assign an independent review organization as set forth in Subsection E to conduct the review.

B. (1) Upon receipt of a request for external review pursuant to Subsection A, the commissioner immediately shall notify and send a copy of the request to the health carrier that made the adverse determination or final adverse determination that is the subject of the request.

(2) For an expedited external review request made pursuant to Subsection A(2), at the time the health carrier receives the notice pursuant to Paragraph (1), 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 expwernicad (t)0.7 ((y)-1.6 (y)-1.6 e(a)-2.

(a) Include in the notice provided pursuant to Paragraph (1) a statement that the covered person or the covered person's authorized representative may submit to the commissioner in writing within seven (7) days following the date of receipt of the notice additional information and supporting documentation that each clinical peer reviewer selected by the assigned independent review organization pursuant to Subsection E shall consider when conducting the external review; and

(b) Immediately notify the health carrier in writing of the acceptance of the request for external review.

(3) If the request:

(a) Is not complete, the commissioner shall inform the covered person and, if applicable, the covered person's authorized representative what information or materials are needed to make the request complete; or

(b) Is not accepted for external review, the commissioner shall inform the covered person, the covered person's authorized representative, if applicable, and the health carrier in writing of the reasons for its nonacceptance.

E. (1) At the time a request is accepted for external review pursuant to Subsection A(2) or Subsection D, the commissioner shall assign an independent review organization that has been approved pursuant to Section 13 of this Act that:

(a) Will be responsible for selecting one or more clinical peer reviewers, as it determines is appropriate, to conduct the external review; and

(b) Based on the opinion of n Td ( )Tj 0.031 Tw 2.148 0 Td6 m i an-2.6 (e9T[(B)-2.4)1.7

(b) 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.

(4) In reaching an opinion, clinical peer reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

. (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Subsection D(2), 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.

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

(3) (a) Upon receipt of a notice from the assigned independent review organization that the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in Paragraph (1), the commissioner may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

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

G. (1) Each clinical peer reviewer selected pursuant to Subsection E shall review all of the information and documents received pursuant to Subsection F and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to Subsection D(2) that has been forwarded to the independent review organization by the commissioner.

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection D(2), at the same time the

(3) 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.

(4) (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, e o6.6 (h)-5 (e)minahteio16.6 (h)-5Bd3(4)-de

recommendation is experimental or investigational, the recommendation is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "experimental" or "investigational" because of the effect that such definition on the rights of covered persons to receive benefits under the health benefit plan.

L. (1) (a)

(3) 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 Paragraph (4);

(4) 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 services or treatments; 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 services or treatments;

(5) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not requiD [(f)-1 (o)-3..5 (a)-1.9 (r)-04(r)-0

(b) 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.

(4) In reaching an opinion, clinical peer reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

F. (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Subsection D(2), 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.

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

(3) (a) Upon receipt of a notice from the assigned independent review organization that the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in Paragraph (1), the commissioner may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the decision under Subparagraph (a), the commissioa c csi)

(c) At the time the health carrier assigns an independent review organization to review the request and, if appropriate, conduct the expedited external review pursuant to Subparagraph (b), 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.

B. Upon receipt of a request for external review under Subsection A, the health carrier shall send a copy of the request to the commissioner.

I. (1) Except as provided in Paragraph (3), within twenty (20) days after being selected in accordance with Subsection E to conduct the external review, each clinical peer reviewer shall provide an opinion to the assigned independent review organization pursuant to Subsection J on whether the recommended or requested health care service or treatment should be covered.

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

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

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

(c) A description and analysis of any medical or scientific evidence, as that term is defined in Section 3X of this Act, considered in reaching the opinion; and

(d) Information on whether the reviewer's rationale for the opinion is based on Subsection J(5)(a) or (b).

(3) (a) For an expedited external review, each clinical peer reviewer shall provide an opinion orally or in writing to the assigned independent review organization within five (nhaw -7.716 -1.224 -1.7 (g*)ot

(d)

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

Drafting Note:

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

(g) The rationale for its decision.

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

L. The assignment by a health carrier of an approved independent review organization to conduct an external review in accordance with this section shall be fair and impartial. The health carrier

C. A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to this Act

Drafting Note: Regardless of whether a state uses Option 1 or Option 2 for this section of this Act, states may wish to add a provision that specifies whether an external review decision made in accordance with this Act is subject to the state's Administrative Procedure Act.

Section 12. Filing Fees (Optional)

A. Except in the case of a request for an expedited external review, at the time of filing a request for external review, the covered person or the covered person's authorized representative shall submit to the commissioner with the request a filing fee of [$25].

B. The commissioner may waive the filing fee upon a showing of undue financial hardship.

C. The filing fee shall be refunded to the person who paid the fee if the external review results in the reversal of the health carrier's adverse determination or final adverse determination that was the subject of the external review.

Drafting Note: This section is optional. Many states do not require filing fees for external reviews.

Section 13. Approval of Independent Review Organizations

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

F. The commissioner may promulgate regulations to carry out the provisions of this section.

Drafting Note: Instead of requiring the commissioner to appr

(3) The report shall include in the aggregate and for each health carrier

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

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

(c) The average length of time for resolution;

Section 21. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 22. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1999 Proc. 3rd Quarter 8, 21, 856, 856-878, 954 (adopted).
2000 Proc. 2nd Quarter 21, 22, 163, 172, 175, 176-194 (amended).
2003 Proc. 4th Quarter 389, 527, 534-572 (amended, adopted by parent committee).
2004 Proc. 1st Quarter 52 (adopted by Plenary).