UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

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C. “Authorized representative” means:

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Y. “Health care provider” or “provider” means a health care professional or a facility.

Z. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of

(c) The American Dental Association Accepted Dental Therapeutics; and

(d) The United States Pharmacopoeia–Drug Information;

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

(a)

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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 Office of the Insurance Commissioner [insert address and telephone number of the office of the insurance commissioner or other unit in the office that administers the external review program]."

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

Drafting Note: States are encouraged to use the model notice the NAIC Regulatory Framework Task Force plans to develop.

B. (1) The health carrier shall include in the notice required under subsection A:

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

(i) If the covered person has a medical condition where the timeframe for completion of an expedited 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, 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 of this Act, or section 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 [insert reference in State law equivalent to section 10 of the Health Carrier Grievance Procedure Model Act], 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

(ii) 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 [insert reference in State law equivalent to section 7 of the Health Carrier Grievance Procedure Model Act], but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within thirty (30) days following the date the covered person or the covered person's

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authorized representative files the grievance with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review pursuant to 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

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

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

(ii) 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 A

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(3) As part of any forms provided under paragraph (2), the health carrier shall include an authorization form, or other document approved by the commissioner that complies with the requirements of 45 CFR Section 164.508, by which the covered person, for purposes of conducting an external review under this 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, as provided in [insert reference to State law equivalent to section 10H of the Health Information Privacy Model Act].

Section 6. Request for External Review

A. (1) 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.

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C. If the requirement to exhaust the health carrier's internal grievance procedures is waived under subsection B(2), 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.

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(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) Within one (1) business day after 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)

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I. (1) Within forty-five (45) 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:

(a) The covered person;

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(4) (a) The commissioner may determine that a request is eligible for external review under section 8B of this Act 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 subparagraph (a) of this paragraph, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Act.

(5) Upon receipt of the notice that the request meets the reviewability requirements, the commissioner immediately shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 12 of

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(5) The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines deve

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Section 10.

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(iii) 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 subparagraph (d) of this paragraph;

(d) The covered person's treating physician:

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

(ii) 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;

(e) 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 required to exhaust the health carrier's internal grievance process pursuant to section 7 of this Act; and

(f) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under section 5B of this Act.

C. (1) Within one (1) business day after completion of the preliminary review

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(3) (a) The commissioner may specify the form for the health carrier's notice of initial determination under paragraph (2) and any supporting information to be included in the notice.

(b) The notice of initial determination provided under paragraph (2) shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determt a Td[(Th0.7 qo1gw 0.393

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(a) Select one or more clinical reviewers, as it determines is appropriate, pursuant to paragraph (4) to conduct the external review; and

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

(4) (a) In selecting clinical reviewers pursuant to paragraph (3)(a), 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 (3) years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

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

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

(6) In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health 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 five (5) business days after the date of receipt of the notice provided pursuant to subsection D(1), 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 designee utilization review organization has failed 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) of this paragraph, the independent review organization shall notify the covered person, the covered person's authorized representative, if applicable, the health carrier, and the commissioner.

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F. (1) Each clinical reviewer selected pursuaip (c)2.2 (t6.2 (s).98 7)0.81002 Tc 2 (1))]TJ0 Tc 0 T

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(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;

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(5) Whether:

(a) 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

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

J. (1) (a) Except as provided in subparagraph (b) of this paragraph, within twenty (20) days after the date it receives the opinion of each clinical reviewer pursuant to subsection I, the assigned independent review organization, in accordance with paragraph (2), shall make a decision and provide written notice of the decision to:

(i) The covered person;

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

(iii) The health carrier; and

(iv) The commissioner.

(b) (i) For an expedited external review, within forty-eight (48) hours after the date it receives the opinion of each clinical reviewer pursuant to subsection I, the assigned independent review organization, in accordance with paragraph (2), shall make a decision and provide notice of the decision orally or in writing to the persons listed in subparagraph (a) of this paragraph.

(ii) If the notice provided under item (i) was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the persons listed in subparagraph (a) of this paragraph and include the information set forth in paragraph (3).

(2) (a) If

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Section 11. Binding Nature of External Review Decision

A. 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.

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

C.

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

E. (1) An approval is effective for two (2) years, unless the commissioner determines before its expiration that the independent review organization is not satisfying the minimum qualifications established under section 13 of this Act.

(2) Whenever the commissioner 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 commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Act that is maintained by the commissioner pursuant to subsection F.

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

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

Section 13. Minimum Qualifications for Independent Review Organizations

A. 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 this Act that include, at a minimum:

(1) A quality assurance mechanism in place that:

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

(b) Ensures the selection of qualified and impartial clinical reviewers to conduct

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

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

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

(3) Hold a non-restricted license in a State of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

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

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B. (1) 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 commissioner pursuant to this Act.

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

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UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

The NAIC amended this model during the 2010 Spring National Meeting. These amendments were adopted as guidelines under the NAIC's model laws process. The 2010 1st Quarter Guideline Amendments are highlighted in grey.

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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,

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(1) Peer-

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GG. "Prospective review" means utilization review conducted prior to an admission or a course of treatment.

HH. "Protected health information" means health information:

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

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

II.

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Section 5. Notice of Right to External Review

A. (1) 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 set forth in subsection B at the same time the health carrier sends written notice of:

(a) An adverse determination upon completion of the health carrier's utilization review process set forth in [insert reference to State law equivalent to the Utilization Review and Benefit Determination Model Act]; and

Drafting Note: States that do not have a statutory utilization review process for health carriers similar to the NAIC Utilization Review and

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(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 the covered person's authorized representative may request an expedited external review to be conducted under section 10 of this Act.

(2) In addition to the information to be provided pursuant to paragraph (1), the health carrier shall include a copy of the description of both the standard and expedited external review

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(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:

(a) Has filed a grievance involving an adverse determination pursuant to [insert reference in State law equivalent to section 7 of the Health Carrier Grievance Procedure Model Act]; and

(b) Except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within thirty (30) days following the date the covered person or the covered person's authorized representative filed the grievance with the health carrier.

(3) Notwithstanding paragraph (2), 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 [insert reference in State law equivalent to the Utilization Review and Benefit Determination Model Act]2 (t)1r

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

D. (1) Whenever the commissioner receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection C, within one (1) business day after the date of receipt of the notice, the commissioner shall:

(a) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner 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

(b) 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.

(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 Model and Benefit Determination 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].

(4) The commissioner shall include in the notice provided to the covered person and, if2)

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(b) Within one (1) business day after 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 to the independent review organization by the covered person or the covered person's authorized representative pursuant to subsection D(3).

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subsection D(3), the assigned independent review organization shall within one (1) business day 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) Within one (1) business day after 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) of this paragraph.

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;

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(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 the commissioner of an approved independent review organization to conduct

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(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 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;

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

(iii) 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 subparagraph (d) of this paragraph;

(d) The covered person's treating physician:

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

(ii) 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;

(e) 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 required to exhaust the health carrier's internal grievance process pursuant to section 7 of this Act; and

(f) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under section 5B of this Act.

C. (1) Within one (1) business day after completion of the preliminary review, the health carrier shall notify the commissioner and the covered person and, if applicable, the covered person's authorized representative in writing whether:

(a) The request is complete; and

(b) The request is eligible for external review.

(2) If the request:

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

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(3) Within one (1) business day after the receipt of the notice of assignment to conduct the external review pursuant to paragraph (1), the assigned independent review organization shall:

(a) Select one or more clinical reviewers, as it determines is appropriate, pursuant to paragraph (4) to conduct the external review; and

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

(4) (a) In selecting clinical reviewers pursuant to paragraph (3)(a), 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 (3) years, are experts in the treatment of the covered person's condition and knowledgeable about the

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

F. (1) Each clinical reviewer selected pursuant to subsection D 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 pursuant to subsection D(2).

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subsection D(2), within one (1) business day after the receipt of the information, the assigned independent review organization 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 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 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, as provided in paragraph (3), the health carrier shall notify the covered person, the covered person's authorized representative if

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(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 3DD of this Act, considered in reaching the opinion;

(d) A description and analysis of any evidence-based standard, as that term is defined in section 3S of this Act; and

(e) Information on whether the reviewer's rationale for the opinion is based on

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(5) Whether:

(a) 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

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

J. (1) (a) Except as provided in subparagraph (b) of this paragraph, within twenty (20) days after the date it receives the opinion of each clinical reviewer pursuant to subsection I, the assigned independent review organization, in accordance with paragraph (2), shall make a decision and provide written notice of the decision to:

(i) The covered person;

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

(iii) The health carrier; and

(iv) The commissioner.

(b) (i) For an expedited external review, within forty-eight (48) hours after the date it receives the opinion of each clinical reviewer pursuant to subsection I, the assigned independent review organization, in accordance with paragraph (2), shall make a decision and provide notice of the decision orally or in writing to the persons listed in subparagraph (a) of this paragraph.

(ii) If the notice provided under item (i) was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the persons listed in subparagraph (a) of this paragraph and include the information set forth in paragraph (3).

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

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

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Section 11. Binding Nature of External Review Decision

A. 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.

B. An external review decision is binding on the covered person except to the extent the covered

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

E. (1) An approval is effective for two (2) years, unless the commissioner determines before its expiration that the independent review organization is not satisfying the minimum qualifications established under section 13 of this Act.

(2) Whenever the commissioner 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 commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Act that is maintained by the commissioner pursuant to subsection F.

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

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

Section 13. Minimum Qualifications for Independent Review Organizations

A. 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 this Act that include, at a minimum:

(1) A quality assurance mechanism in place that:

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

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

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

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

(2) A toll-free telephone service to receive information on a 24-hour-day, 7-day-a-week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

(3) Agree to maintain and provide to the commissioner the information set out in section 15 of this Act.

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Section 14. Hold Harmless for Independent Review Organizations

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

Section 15. External Review Reporting Requirements

A. (1) An independent review organization assigned pursuant to section 8, section 9 or section 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 commissioner, as required under paragraph (2).

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

(3) The report shall include in the aggregate by State, and 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;

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

(e) The number of external reviews pursuant to section 8G of this Act that were terminated as the result of a reconsideration by the e er3(h)-3 (an)2.4 (1 (f)-2 .1 (e)-5 4 (e)2

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

Drafting Note:

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Appendix B – Model External Review Request Form

This **EXTERNAL REVIEW REQUEST FORM** must be filed with [insert state insurance department] within **FOUR (4) MONTHS** after receipt from your insurer of a denial of payment on a claim or request for coverage of a health care service or treatment.

EXTERNAL REVIEW REQUEST FORM

APPLICANT NAME _____ ☐ Covered person/Patient ☐ Provider ☐ Authorized Representative

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: _____
Patient Name: _____

Address: _____
_____

Covered Person Phone #: Home (_____) _____
Work (_____) _____

INSURANCE INFORMATION

Insurer/HMO
Name: _____

Covered Person Insurance ID#:
_____

Insurance Claim/Reference #:
_____

Insurer/HMO Mailing Address:
_____
_____

Insurer Telephone #: (_____) _____

EMPLOYER INFORMATION

Employer's Name:
_____

Employer's Phone #: (_____) _____

Is the health coverage you have through your employer a self-funded plan? _____. If you are not certain please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

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HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider:
_____

Address:_____
_____
_____

Contact Person:_____Phone: ( )
_____

Medical Record #:_____

REASON FOR HEALTH CARRIER DENIAL (Please check one)

† The health care service or treatment is not medically necessary.

† The health care service or treatment is experimental or investigational.

SUMMARY OF EXTERNAL REVIEW REQUEST (Enter a brief description of the claim, the request for health care service or treatment that was denied, and/or attach a copy of the denial from your health carrier)*

_____
_____
_____

*You may also describe in your own words the health care service or treatment in dispute and why you are appealing this denial using the attached pages below.

EXPEDITED REVIEW

If you need a fast decision, you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Is this a request for an expedited appeal? Yes _____ _ No _____

SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I, _____, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize by insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the [insert state insurance department name]. I understand that the independent review organization and the [insert state insurance department name] will use this information to make a determination on my external appeal and that 5.3 (e].)-5.84 504 I ug0.065 Tw 1002zeion

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APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____ _____

Signature of Covered Person (or legal representative)* Date

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HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

DESCRIBE IN YOUR OWN WORDS THE DISAGREEMENT WITH YOUR HEALTH CARRIER. INDICATE CLEARLY THE SERVICE(S) BEING DENIED AND THE SPECIFIC DATE(S) BEING DENIED. EXPLAIN WHY YOU DISAGREE. ATTACH

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WHAT TO SEND AND WHERE TO SEND IT

PLEASE CHECK BELOW (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL FOUR (4) ITEMS BELOW ARE INCLUDED*)

1. † **YES**, I have included this completed application form signed and dated.

2. † **YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;

3. † **YES****, I have enclosed the letter from my health carrier or utilization review company that states:
   (a) Their decision is final and that I have exhausted all internal review procedures; or
   (b) They have waived the requirement to exhaust all of the health carrier's internal review procedures.

**You may make a request for external review without exhausting all internal review procedures under certain circumstances. You should contact the Office of the Insurance Commissioner [insert address and telephone number of the office of the insurance commissioner or other unit in the office that administers the external review p.6 (o)e/P504 13.4Td[(()-6 54 491.52 Tm[(p.6 (o)e/P504 f*A1.5 (c)1.2C ET/Art6 (c)-3.2 (e)01.5 (i)-0.3.4 (x)6 54 491.52 Tm[(p.6 (

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CERTIFICATION

I hereby certify that: I am a treating health care provider for _____

(hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard external review of the patient's appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that, for this reason, the patient's appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

_____

Treating Health Care Provider's Name (Please Print)

_____ _____

Signature Date

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Appendix C – Independent Review Organization External Review Annual Report Form

[Insert Name of State Insurance Department]

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Appendix D – Model Health Carrier External Review Annual Report Form

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