

## ARTICLE 19.

### HEALTH CARRIER EXTERNAL REVIEW ACT

#### **SECTION 38-71-1910.** Short title.

This article may be cited as the "Health Carrier External Review Act".

HISTORY: 2000 Act No. 380, Section 3A.

#### **SECTION 38-71-1920.** Definitions.

For purposes of this article:

(1) "Adverse determination" means a determination by a health carrier or its designee 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:

(a) does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; or

(b) is experimental or investigational and involves a condition that is life-threatening or seriously disabling, and the requested service or payment for the service is, therefore, denied, reduced, or terminated.

(2) "Authorized representative" means:

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

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

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

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

(4) "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(5) "Covered person" means an insured, subscriber, enrollee, or other individual entitled to covered benefits under a health benefit plan.

(6) "Director or his designee" means the Director of the South Carolina Department of Insurance or a person designated by the director.

(7) "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.

(8) "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee, at the completion of the health carrier's internal appeal process.

(9) "Health benefit plan" means a policy, contract, or certificate issued by a health carrier that provides benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

(a) coverage only for accident or disability income insurance or any combination of accident and disability income insurance;

- (b) coverage issued as a supplement to liability insurance;
- (c) liability insurance, including general liability insurance and automobile liability insurance;
- (d) workers' compensation or similar insurance;
- (e) automobile medical payment insurance;
- (f) credit-only insurance;
- (g) coverage for on-site medical clinics;
- (h) other similar insurance coverage specified in regulations under which benefits for medical care are secondary or incidental to other insurance benefits;
- (i) if offered separately:
  - (i) limited scope dental or vision benefits;
  - (ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;
  - (iii) other similar, limited benefits, as are specified in regulations;
- (j) if offered as independent, noncoordinated benefits:
  - (i) coverage only for a specified disease or illness;
  - (ii) hospital indemnity or other fixed indemnity insurance;
- (k) if offered as a separate insurance policy:
  - (i) Medicare supplemental health insurance, as defined under Section 1882( g)(1) of the Social Security Act;
  - (ii) coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code; and
  - (iii) similar supplemental coverage under a group health plan;
- (l) any health benefit plan offered or administered by the State Budget and Control Board.
- (10) "Health care professional" means a physician, dentist, or other person properly licensed, where required, to furnish health care services.
- (11) "Health care provider" or "provider" means a health care professional or a facility.
- (12) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.
- (13) "Health carrier" means an entity that provides health insurance coverage in this State and an insurance company, a health maintenance organization, and any other entity providing health insurance coverage which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.
- (14) "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.
- (15) "Life-threatening condition or disease" means a condition or disease which, according to the current diagnosis by the covered person's treating physician, has a high probability of causing the covered person's death within three years.
- (16) "Medical and scientific evidence" means:
  - (a) peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
  - (b) peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meets the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medica, Medline and Medlars database Health Services Technology Assessment Research;
  - (c) medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the federal Social Security Act;
  - (d) these standard reference compendia: the American Hospital Formulary Service--Drug Information; the American Medical Association Drug Evaluation; the American Dental Association Accepted Dental Therapeutics; and the United States Pharmacopoeia--Drug Information;

(e) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

(17) "Person" means a corporation, partnership, association, voluntary organization, individual, or any other entity, organization, or aggregation of individuals.

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

(19) "Serious medical condition" means a health condition or illness that requires immediate medical attention, where failure to provide immediate medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(20) "Seriously disabling" means a health condition or illness that involves a serious impairment to bodily functions or serious dysfunction of a bodily organ or part.

(21) "Utilization review" means a system for reviewing the necessary, appropriate, and efficient allocation of health care resources and services given or proposed to be given to a patient or a group of patients.

HISTORY: 2000 Act No. 380.

**SECTION 38-71-1930.** Application of this article.

(A) Except as provided in subsection (B), this article applies to all health carriers that provide or perform utilization review, including those plans subject to regulation under Chapter 33.

(B) This article does not apply to the administrative services performed on behalf of a self-funded plan subject to the Employee Retirement Income Security Act (ERISA) of 1974.

(C) For purposes of this article, notice to the subscriber or insured entitled to covered benefits under a health benefit plan shall constitute notice to the covered person. This subsection does not affect the health plan's obligations under a court order requiring a parent to provide health coverage pursuant to Section 63-17-2100, et seq.

HISTORY: 2000 Act No. 380, Section 3A.

**SECTION 38-71-1940.** Notice of right to request a review; notice of adverse determination.

(A) A health carrier shall notify the covered person in writing of the right to request an external review and include the appropriate statements and information set forth in subsection (B) at the time the health carrier sends written notice of either an adverse determination or a final adverse determination.

(B)(1) The health carrier shall include in the notice required under subsection (A) a clear and concise description of the right of the covered person to request a standard external review pursuant to Section 38-71-1970 or an expedited external review pursuant to Section 38-71-1980 upon receipt of an adverse determination or a final adverse determination and the circumstances under which the covered person is not required to exhaust the health carrier's internal appeal process or is considered to have exhausted the health carrier's internal appeal process pursuant to Section 38-71-1960.

(2) In addition to the information to be provided pursuant to subsection (B)(1), the health carrier shall include a brief description of both the standard and expedited external review procedures.

(3) As part of any forms provided under subsection (B)(2), the health carrier shall include an authorization form, or other document promulgated or approved by the director or his designee, by which

the covered person, for purposes of conducting an external review under this article, authorizes the health carrier to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review.

(C) A notice, statement, or form required by this section must achieve a score of no lower than 70 on the Flesch Reading Ease Test and must be printed in no smaller than 12 point type. No part of the notice, statement, or form may be printed in all capitals. A notice, statement, or form required by this section must include a statement of the right of the covered person to contact the director or his designee for assistance. The statement must include the telephone number and address of the director or his designee.

(D) A notice, statement, or form required by this section must be approved by the Department of Insurance. The director or his designee shall promulgate standard language, in a specified font size and type for any notice, statement, or form required by this section. Use of the standard language in the specified font size and type promulgated by the department pursuant to this section shall constitute compliance with the notice requirements of this section.

HISTORY: 2000 Act No. 380, Section 3A.

**SECTION 38-71-1950.** Requests for external review.

(A) All requests for external review must be made in writing to the health carrier.

(B) A covered person or his authorized representative may make a request for an external review of an adverse determination or final adverse determination only when the amount payable for covered benefits is at least five hundred dollars.

(C) A covered person is not entitled to an external review of a retrospective review determination unless the covered person has exhausted the health carrier's internal appeal process and may be held financially responsible for the covered benefits.

HISTORY: 2000 Act No. 380, Section 3A.

**SECTION 38-71-1960.** Exhaustion of internal appeal process.

(A)(1) Except in cases where the covered person's treating physician has certified in writing that the covered person has a serious medical condition, or where the denial of coverage is based on a determination that the health care service or treatment recommended or requested is experimental or investigational and the covered person's treating physician has provided the certifications required pursuant to Section 38-71-1980, a request for a standard or expedited external review may not be made until the covered person has exhausted the health carrier's internal appeal process.

(2) A covered person is considered to have exhausted the health carrier's internal appeal process for purposes of this section, if the covered person or his authorized representative:

(a) has filed an appeal involving an adverse determination pursuant to the health carrier's internal appeal process; and

(b) the health carrier has not issued a written decision within the time frames set forth in the health carrier's internal appeals process after receipt of all information necessary to complete the appeal and the covered person or his authorized representative has not agreed to a delay.

(B) A request for an external review of an adverse determination may be made before the covered person has exhausted the health carrier's internal appeal process whenever the health carrier agrees to waive the exhaustion requirement.

(C) If the requirement to exhaust the health carrier's internal appeal process is waived under subsection (B), the covered person or his authorized representative may file a request in writing for an external review.

HISTORY: 2000 Act No. 380, Section 3A.

**SECTION 38-71-1970.** Requests for external review.

(A)(1) Within sixty days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 38-71-1940, a covered person or his authorized representative may file a request for an external review with the health carrier.

(2) If the denial of coverage is based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the request for review must include a certification from the covered person's treating physician who must be a licensed physician qualified to practice in the area of medicine appropriate to treat the covered person's condition that:

(a) the covered person has a life-threatening disease or seriously disabling condition; and

(b) at least one of the following situations is applicable:

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

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

(iii) the recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by the health carrier; and

(c) medical and scientific evidence 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 more beneficial to the covered person than 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 the standard services or treatments.

(B)(1) Within five business days from the date the health carrier receives a request for an external review, the health carrier or its designee shall:

(a) assign an independent review organization from the list of approved independent review organizations compiled and maintained pursuant to Section 38-71-2000 to conduct an external review; and

(b) send the documents and any information considered in making the adverse determination or final adverse determination to the independent review organization; or

(c) inform the covered person or his authorized representative in writing that the request does not meet the criteria for external review pursuant to this article and include a statement explaining the reason for nonacceptance and the right of the covered person to contact the director or his designee for assistance. The statement shall include the telephone number and address of the director or his designee;

(2) Except as provided in subsection (B)(3), failure by the health carrier or its designee to send the documents and information within the time specified in subsection (B)(1) may not delay the conduct of the external review.

(3)(a) If the health carrier or its designee fails to send the documents and information within the time specified in subsection (B)(1), the 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 subsection (B)(3)(a), the independent review organization shall notify the covered person or his authorized representative and the health carrier.

(C)(1) Within five business days after receipt of the request for external review from the health carrier, the independent review organization shall determine whether all the information, certifications, and forms required to process an external review, including the release form provided under Section 38-71-1940B(3) have been provided. The independent review organization shall immediately notify the covered person or his authorized representative in writing if additional information is required.

(2) The independent review organization shall include in the notice provided pursuant to subsection (C)(1) a clear statement that the covered person or his authorized representative may submit in writing to the independent review organization within seven business days following the date of receipt of the notice

additional information and supporting documentation that the independent review organization shall consider when conducting the external review.

(3) If the request is not:

(a) complete, the independent review organization shall inform the covered person or his authorized representative what information or materials are needed to make the request complete; or

(b) accepted for external review, the independent review organization shall inform the covered person or his authorized representative and the health carrier in writing of the reasons for its nonacceptance.

(D)(1) If a request for external review is accepted for external review, the independent review organization shall notify the health carrier and the covered person or his authorized representative.

(2) In reaching a decision, the independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process, as set forth in Chapter 70, or the health carrier's internal appeal process.

(3) If the denial of coverage is based on a determination that the health care service or treatment recommended or requested is experimental or investigational, at the time a request is accepted for external review pursuant to subsection (C)(3),

(a) the independent review organization shall:

(i) immediately select a clinical peer review panel pursuant to subsection (D)(3)(b) to conduct the external review; and

(ii) based on the opinions of the clinical peer reviewers on the panel, make a decision to uphold or reverse the adverse determination or final adverse determination.

(b)(i) Notwithstanding the provisions of subsection (D)(3)(b)(ii), the panel shall consist of the number of physicians or other health care professionals considered appropriate by the independent review organization who meet the minimum qualifications described in Section 38-71-2010 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(ii) The health carrier may require that the panel consist of at least three physicians or other health care professionals who meet the minimum qualifications described in Section 38-71-2010 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(iii) Neither the covered person nor his 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 for the clinical peer review panel.

(c) Each member of the clinical peer review panel shall provide a written opinion to the independent review organization on whether to uphold or reverse the adverse determination or the final adverse determination. Each clinical peer reviewer's opinion shall include a description:

(i) of the covered person's medical condition, which is the subject of the adverse determination or final adverse determination;

(ii) 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 beneficial to the covered person than standard services or treatments and that the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatment; and

(iii) analysis of the medical and scientific evidence used in making the determination.

(E)(1) The independent review organization shall review all of the information and documents received from the health carrier and any other information submitted in writing to the independent review organization by the covered person or his authorized representative.

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

(F)(1) The health carrier may reconsider its adverse determination or final adverse determination at any time.

(2) Reconsideration by the health carrier may not delay or terminate the external review.

(3) The health carrier may terminate the external review only if the health carrier reverses its adverse determination or final adverse determination.

(4)(a) within five business days of making the decision to reverse its adverse determination or final adverse determination, as provided in subsection (F)(3), the health carrier shall send written notice to the covered person or his authorized representative and the independent review organization.

(b) the independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subsection (F)(4)(a).

(G) In addition to the documents and information provided or transmitted pursuant to this section, the 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 relevant medical records;

(2) the treating health care provider's recommendation;

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

(4) 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 or national or professional medical societies, boards, and associations;

(5) any applicable clinical review criteria developed and used by the health carrier or its designee; and

(6) If adverse determination or final adverse determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, whether:

(a) the recommended or requested health care service or treatment has been approved by the Federal Food and Drug Administration; or

(b) medical and scientific evidence demonstrates that the expected benefits of the recommended or requested health care service or treatment would be greater than the benefits of any available standard 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 standard services or treatments.

(H)(1) Within forty-five days after the date of receipt of the request for an external review by the health carrier, the independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the covered person or his authorized representative and the health carrier.

(2) If adverse determination or final adverse determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the independent review organization shall make a decision to uphold or reverse the health carrier's adverse determination or final adverse determination based upon the recommendation of a majority of the clinical peer review panel, if more than one physician or other health care professional serves on the panel.

(3) The independent review organization shall include in the notice sent pursuant to subsection (H)(1):

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

(b) the date the independent review organization received the assignment from the health carrier;

(c) the date the external review was conducted, if appropriate;

(d) the date of its decision;

(e) the principal reason or reasons for its decision;

(f) the rationale for its decision;

(g) references to the evidence or documentation, including the practice guidelines, considered in reaching its decision; and

(h) the written opinions of the clinical peer review panel, if any.

(4) Within five business days of receipt of a notice of a decision pursuant to subsection (H)(1) reversing the adverse determination or final adverse determination, the health carrier shall approve the covered benefit that was the subject of the adverse determination or final adverse determination, subject to applicable contract exclusions, limitations, or other provisions.

(I) The assignment by a health carrier of an approved independent review organization to conduct an external review in accordance with this section must be fair and impartial. The health carrier and the independent review organization shall comply with standards promulgated by the director or his designee by regulation or bulletin 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.

HISTORY: 2000 Act No. 380, Section 3A.

**SECTION 38-71-1980.** Expedited external review.

(A)(1) Within fifteen days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 38-71-1940, a covered person or his authorized representative may file a request for an expedited external review with the health carrier at the time the covered person receives:

(a) an adverse determination if the covered person's treating physician has certified that the covered person has a serious medical condition;

(b) a final adverse determination if:

(i) the covered person's treating physician has certified that the covered person has a serious medical condition; or

(ii) the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency medical care, as defined in Section 38-71-1520(2), but has not been discharged from a facility, if the covered person may be held financially responsible for the emergency medical care.

(2) If the denial of coverage is based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the request for review must include a certification from the covered person's treating physician who must be a licensed physician qualified to practice in the area of medicine appropriate to treat the covered person's condition that:

(a) the covered person has a life-threatening disease or seriously disabling condition; and

(b) at least one of the following situations is applicable:

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

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

(iii) the recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by the health carrier; and

(c) medical and scientific evidence 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 more beneficial to the covered person than 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 the standard services or treatments.

(B)(1) At the time the health carrier receives a request for an expedited external review, the health carrier or its designee as expeditiously as reasonably possible shall:

(a) assign an independent review organization from the list of approved independent review organizations compiled and maintained pursuant to Section 38-71-2000 to conduct the expedited external review; and

(b) send all the documents and any information considered in making the adverse determination or final adverse determination to the independent review organization by overnight delivery service or any other reasonably available expeditious method; or

(c) inform the covered person or his authorized representative that the request does not meet the criteria for external review pursuant to this article and include a statement of the right of the covered person to contact the director or his designee for assistance. The statement shall include the telephone number and address of the director or his designee.

(2) Except as provided in subsection (B)(3), failure by the health carrier or its designee to send the documents and information within the time specified in subsection (B)(1) may not delay the conduct of the external review.

(3)(a) If the health carrier or its designee fails to send the documents and information within the time specified in subsection (B)(1), the 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 subsection (B)(3)(a), the independent review organization shall notify the covered person or his authorized representative and the health carrier.

(C)(1) In reaching a decision, the independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process, as set forth in Chapter 70, or the health carrier's internal appeal process.

(2) If the denial of coverage is based on a determination that the health care service or treatment recommended or requested is experimental or investigational,

(a) the independent review organization shall:

(i) immediately select a clinical peer review panel pursuant to subsection (C)(2)(b) to conduct the external review; and

(ii) based on the opinions of the clinical peer reviewers on the panel, make a decision to uphold or reverse the adverse determination or final adverse determination.

(b)(i) notwithstanding the provisions of subsection (C)(2)(b)(ii), the panel shall consist of the number of physicians or other health care professionals, considered appropriate by the independent review organization, who meet the minimum qualifications described in Section 38-71-2010 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(ii) The health carrier may require that the panel consist of at least three physicians or other health care professionals who meet the minimum qualifications described in Section 38-71-2010 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(iii) Neither the covered person nor his 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 for the clinical peer review panel.

(c) Each member of the clinical peer review panel shall provide an opinion to the independent review organization on whether to uphold or reverse the adverse determination or the final adverse determination. Each clinical peer reviewer's opinion shall include a description:

(i) of the covered person's medical condition, which is the subject of the adverse determination or final adverse determination;

(ii) 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 beneficial to the covered person than standard services or treatments and that the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatment; and

(iii) analysis of the medical and scientific evidence used in making the determination.

(D) In addition to the documents and information provided or transmitted pursuant to this section, the 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 relevant medical records;
  - (2) the treating health care provider's recommendation;
  - (3) consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, his authorized representative, or the covered person's treating provider;
  - (4) 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 or national or professional medical societies, boards, and associations;
  - (5) any applicable clinical review criteria developed and used by the health carrier or its designee;
- and

(6) if adverse determination or final adverse determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, whether:

(a) the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration; or

(b) medical and scientific evidence demonstrates that the expected benefits of the recommended or requested health care service or treatment would be greater than the benefits of any available standard 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 standard services or treatments.

(E)(1) The health carrier may reconsider its adverse determination or final adverse determination at any time.

(2) Reconsideration by the health carrier may not delay or terminate the external review.

(3) The health carrier may terminate the external review only if the health carrier reverses its adverse determination or final adverse determination.

(4)(a) As expeditiously as reasonably possible upon making the decision to reverse its adverse determination or final adverse determination, as provided in subsection (E)(3), the health carrier shall send notice to the covered person or his authorized representative and the independent review organization.

(b) The independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subsection (E)(4)(a).

(F)(1) As expeditiously as reasonably possible, but in no event more than three business days after the date of receipt of the request for an expedited external review by the health carrier, the independent review organization shall provide notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the:

(a) covered person or his authorized representative; and

(b) health carrier.

(2) If adverse determination or final adverse determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the independent review organization shall make a decision to uphold or reverse the health carrier's adverse determination or final adverse determination based upon the recommendation of a majority of the clinical peer review panel, if more than one physician or other health care professional serves on the panel.

(3) If the notice provided pursuant to subsection (F)(1) was not in writing, within two days after the date of providing that notice, the independent review organization shall:

(a) provide written confirmation of the decision to the covered person or his authorized representative and the health carrier; and

(b) include the information set forth in Section 38-71-1970(H)(3).

(4) As expeditiously as reasonably possible after receipt of the notice of a decision pursuant to subsection (F)(1) reversing the adverse determination or final adverse determination, the health carrier shall approve the covered benefit that was the subject of the adverse determination or final adverse determination, subject to applicable contract exclusions, limitations, or other provisions.

(G) The assignment by a health carrier of an approved independent review organization to conduct an external review in accordance with this section must be fair and impartial. The health carrier and the independent review organization shall comply with standards promulgated by the director or his designee by regulation or bulletin 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.

HISTORY: 2000 Act No. 380, Section 3A; 2001 Act No. 82, Section 27, eff July 20, 2001.

**SECTION 38-71-1990.** External review decisions final; exceptions.

(A) An external review decision is binding on the health carrier.

(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. If such other remedies are available, the covered person or his authorized representative may not, in these proceedings, utilize, disclose, or introduce in evidence information generated during or findings reached by the independent review organization.

(C) A covered person or his authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination.

HISTORY: 2000 Act No. 380, Section 3A.

**SECTION 38-71-2000.** Approval of independent review organizations.

(A) The director or his designee shall approve independent review organizations eligible to be assigned to conduct external reviews to ensure that an independent review organization satisfies the minimum qualifications established under Section 38-71-2010.

(B) The director or his designee shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews and may establish an advisory committee with appropriate representation to review the applications. No member of the advisory committee may be liable to any person for any acts or omissions arising out of or related to the approval or reapproval of independent review organizations pursuant to this act.

(C)(1) An independent review organization wishing to be approved to conduct external reviews under this article shall submit the application form and include with the form all documentation and information necessary for the director or his designee to determine if the independent review organization satisfies the minimum qualifications established under Section 38-71-2010.

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

(D)(1) Except as provided in subsection (D)(2), an approval is effective for two years.

(2) The independent review organization must notify the director or his designee of any material changes in qualifications, including removal or loss of accreditation by a nationally recognized private accrediting entity, approved by the director or his designee pursuant to subsection (E). Whenever the director or his designee determines that an independent review organization no longer satisfies the minimum requirements established under Section 38-71-2010 or has violated a provision of this article, the director or his designee 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 article that is maintained by the director or his designee pursuant to subsection (F).

(E) An independent review organization accredited by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet the minimum qualifications established pursuant to Section 38-71-2010, which accrediting entity has been approved by the director or his designee, may be deemed to meet the minimum qualification requirements set forth in Section 38-71-2010.

(F) The director or his designee shall maintain and periodically update a list of approved independent review organizations and approved nationally recognized private accrediting entities.

(G) The director or his designee may promulgate regulations or bulletins to carry out the provisions of this section.

HISTORY: 2000 Act No. 380, Section 3A.

**SECTION 38-71-2010.** Standards for approval of independent review organizations.

(A) To be approved under Section 38-71-2000 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 Sections 38-71-1970 and 38-71-1980 that include, at a minimum:

(1) a quality assurance mechanism in place that ensures:

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

(b) the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases;

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

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

(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 director or his designee the information set out in Section 38-71-2030.

(B) All clinical peer reviewers assigned by an independent review organization to conduct external reviews must be physicians or other appropriate health care providers who:

(1) are 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; and

(2) hold a nonrestricted 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.

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

(D)(1) In addition to the requirements set forth in subsections (A), (B), and (C), to be approved pursuant to Section 38-71-2000 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent review organization to conduct the external review may have a material professional, familial, or financial conflict of interest with:

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

(b) the covered person whose treatment is the subject of the external review or his authorized representative;

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

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

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

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

HISTORY: 2000 Act No. 380, Section 3A.

**SECTION 38-71-2020.** Liability of independent review organizations and personnel.

No independent review organization, or employee, officer, or director of an independent review organization or health care professional who furnishes services to an independent review organization is liable to any person for any acts or omissions arising out of or related to an external review conducted pursuant to this article, except for cases of wilful and intentional misconduct.

HISTORY: 2000 Act No. 380, Section 3A.

**SECTION 38-71-2030.** External review; written records; reports.

(A)(1) An independent review organization assigned pursuant to Section 38-71-1970 or Section 38-71-1980 to conduct an external review shall maintain written records in the aggregate and by health carrier on all requests for external review for which it conducted an external review during a calendar year and submit a report to the director or his designee, as required under subsection (A)(2).

(2) Each independent review organization required to maintain written records on all requests for external review pursuant to subsection (A)(1) for which it was assigned to conduct an external review shall submit to the director or his designee, no later than March first of each year and upon request by the director or his designee, a report in the format specified by the director or his designee.

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

(a) the total number of requests for external review and the manner in which they were resolved;

(b) the average length of time for resolution;

(c) a summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the director or his designee; and

(d) any other information the director or his designee may request or require.

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

(B)(1) Each health carrier shall maintain written records in the aggregate and for each general type of health benefit plan offered by the health carrier on all requests for external review that are filed with the health carrier during a calendar year.

(2) Each health carrier required to maintain written records on all requests for external review pursuant to subsection (B)(1) shall submit to the director or his designee, no later than March first of each year and upon request by the director or his designee, a report in the format specified by the director or his designee.

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

(a) the total number of requests for external review and the manner in which they were resolved;

(b) the average length of time for resolution;

(c) a summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the director or his designee; and

(d) any other information the director or his designee may request or require.

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

(C) The director or his designee shall make the reports required in this section available to any person for inspection and copying upon request.

HISTORY: 2000 Act No. 380, Section 3A.

**SECTION 38-71-2040.** Health carrier to pay for external review.

The health carrier shall pay for the external review.

HISTORY: 2000 Act No. 380, Section 3A.

**SECTION 38-71-2050.** Health carrier to inform covered persons of rights related to external review.

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

(B) The description required under subsection (A) shall include a statement of the right of the covered person to contact the director or his designee for assistance. The statement shall include the telephone number and address of the director or his designee.

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

HISTORY: 2000 Act No. 380, Section 3A.

**SECTION 38-71-2060.** Regulations.

The director or his designee may, after notice, promulgate reasonable regulations or bulletins to carry out the provisions of this article.

HISTORY: 2000 Act No. 380, Section 3A.