

Regular Session, 2013

HOUSE BILL NO. 645

BY REPRESENTATIVE CROMER

Prefiled pursuant to Article III, Section 2(A)(4)(b)(i) of the Constitution of Louisiana.

1 AN ACT

2 To enact R.S. 22:821(B)(36) and (37) and Chapter 18 of Title 22 of the Louisiana Revised
3 Statutes of 1950, to be comprised of R.S. 22:2391 through 2453, and to repeal R.S.
4 22:821(B)(28) and Subpart F of Part III of Chapter 4 of Title 22 of the Louisiana
5 Revised Statutes of 1950, comprised of R.S. 22:1121 through 1144, relative to an
6 internal claim and appeals process and external review procedures for health
7 insurance issuers; to provide requirements for such process and procedures; to
8 provide for definitions; to provide with respect to utilization review organizations
9 and independent review organizations, including their licensure or certification by
10 the commissioner of insurance; to provide for fees; to provide for compliance,
11 penalties, and other regulatory matters; and to provide for related matters.

12 Be it enacted by the Legislature of Louisiana:

13 Section 1. R.S. 22:821(B)(36) and (37) and Chapter 18 of Title 22 of the Louisiana
14 Revised Statutes of 1950, comprised of R.S. 22:2391 through 2453, are hereby enacted to
15 read as follows:

16 §821. Fees

17 * * *

18 B. The following fees and licenses shall be collected in advance by the
19 commissioner of insurance:

20 * * *

- 21 (36) Utilization review organization other than a health insurance issuer
- 22 (a) Application fee.....\$ 1,500.00
- 23 (b) Annual report filing fee.....\$ 500.00
- 24 (37) Independent review organization

1 (a) Application fee.....\$ 500.00

2 (b) Annual filing fee.....\$ 500.00

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4 CHAPTER 18. INTERNAL CLAIMS AND APPEALS PROCESS

5 AND EXTERNAL REVIEW ACT

6 PART I. TITLE, DEFINITIONS, AND LICENSURE

7 §2391. Purpose; short title

8 A. This Chapter shall be known and may be cited as the "Internal Claims and
9 Appeals Process and External Review Act".

10 B. The purpose of this Chapter is the following:

11 (1) To establish standards and criteria for the structure and operation of
12 utilization review and benefit determination processes designed to facilitate ongoing
13 assessment and management of health care services.

14 (2) To provide standards for the establishment and maintenance of
15 procedures by health insurance issuers to assure that covered persons have the
16 opportunity for the appropriate resolution of internal and external appeals, as defined
17 in this Chapter.

18 (3) To provide uniform standards for the establishment and maintenance of
19 an internal claims and appeals process and external review procedures to assure that
20 covered persons have the opportunity for an independent review of an adverse
21 determination or final adverse determination, as defined in this Chapter.

22 §2392. Definitions

23 As used in this Chapter:

24 (1) "Adverse determination" means any of the following:

25 (a) A determination by a health insurance issuer or its designee utilization
26 review organization that, based upon the information provided, a request for a benefit
27 under the health insurance issuer's health benefit plan upon application of any
28 utilization review technique does not meet the health insurance issuer's requirements
29 for medical necessity, appropriateness, health care setting, level of care, or
30 effectiveness or is determined to be experimental or investigational and the requested

1 benefit is therefore denied, reduced, or terminated or payment is not provided or
2 made, in whole or in part, for the benefit.

3 (b) The denial, reduction, termination, or failure to provide or make
4 payment, in whole or in part, for a benefit based on a determination by a health
5 insurance issuer or its designee utilization review organization of a covered person's
6 eligibility to participate in the health insurance issuer's health benefit plan.

7 (c) Any prospective review or retrospective review determination that
8 denies, reduces, or terminates or fails to provide or make payment, in whole or in
9 part, for a benefit under a health benefit plan.

10 (d) A rescission of coverage determination.

11 (e) For purposes of this Chapter, Part III of this Chapter relative to external
12 reviews shall apply only to adverse determinations and final adverse determinations
13 that involve medical necessity, appropriateness, health care setting, level of care,
14 effectiveness, experimental or investigational treatment, or a rescission. Part II of
15 this Chapter shall apply to any other adverse determination or final adverse
16 determination.

17 (2) "Ambulatory review" means utilization review of health care services
18 performed or provided in an outpatient setting.

19 (3) "Authorized representative" means any of the following:

20 (a) A person to whom a covered person has given express written consent
21 to represent the covered person for purposes of this Chapter. It may also include the
22 covered person's treating provider if the covered person appoints the provider as his
23 authorized representative and the provider waives in writing any right to payment
24 from the covered person other than any applicable copayment or other coinsurance
25 amount. In the event that the service is determined not to be medically necessary, and
26 the covered person or his authorized representatives, except for the covered person's
27 treating health care professional, thereafter requests the services, nothing shall
28 prohibit the provider from charging usual and customary charges for all
29 non-medically necessary services provided.

1 **(b) A person authorized by law to provide substituted consent for a covered**
2 **person.**

3 **(c) An immediate family member of the covered person or the covered**
4 **person's treating health care professional when the covered person is unable to**
5 **provide consent.**

6 **(d) In the case of an urgent care request, a health care professional with**
7 **knowledge of the covered person's medical condition.**

8 **(4) "Best evidence" means evidence based on any of the following:**

9 **(a) Randomized clinical trials.**

10 **(b) If randomized clinical trials are not available, cohort studies, or**
11 **case-control studies.**

12 **(c) If Subparagraphs (a) and (b) of this Paragraph are not available,**
13 **case-series.**

14 **(d) If Subparagraphs (a), (b), and (c) of this Paragraph are not available,**
15 **expert opinion.**

16 **(5) "Business day" means a day of normal business operation other than**
17 **federally recognized holidays. Any day not specified as a business day shall be a**
18 **twenty-four-hour period, including weekends and holidays.**

19 **(6) "Case management" means a coordinated set of activities conducted for**
20 **individual patient management of serious, complicated, protracted, or other health**
21 **conditions.**

22 **(7) "Case-control study" means a retrospective evaluation of two groups of**
23 **patients with different outcomes to determine which specific interventions the**
24 **patients received.**

25 **(8) "Case-series" means an evaluation of a series of patients with a particular**
26 **outcome, without the use of a control group.**

27 **(9) "Certification" or "certify" means a determination by a health insurance**
28 **issuer or its designee utilization review organization that a request for a benefit under**
29 **the health insurance issuer's health benefit plan has been reviewed and, based on the**

1 information provided, satisfies the health insurance issuer's requirements for medical
2 necessity, appropriateness, health care setting, level of care, and effectiveness.

3 (10) "Clinical peer" means a physician or other health care professional who
4 holds a nonrestricted license in a state of the United States and in the same or similar
5 specialty as typically manages the medical condition, procedure, or treatment under
6 review.

7 (11) "Clinical review criteria" means the written screening procedures,
8 decision abstracts, clinical protocols, and practice guidelines used by the health
9 insurance issuer to determine the medical necessity and appropriateness of health
10 care services including those used in the determination of an item or health care
11 service as experimental.

12 (12) "Cohort study" means a prospective evaluation of two groups of patients
13 with only one group of patients receiving a specific intervention or interventions.

14 (13) "Commissioner" means the commissioner of insurance.

15 (14) "Concurrent review" means utilization review conducted during a
16 patient's stay or course of treatment in a facility, the office of a health care
17 professional, or other inpatient or outpatient health care setting.

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

20 (16) "Covered person" means a policyholder, subscriber, enrollee, or other
21 individual participating in a health benefit plan.

22 (17) "Discharge planning" means the formal process for determining, prior
23 to discharge from a facility, the coordination and management of the care that a
24 patient receives following discharge from a facility.

25 (18) "Disclose" means to release, transfer, or otherwise divulge protected
26 health information to any person other than the individual who is the subject of the
27 protected health information.

28 (19) "Emergency medical condition" means a medical condition manifesting
29 itself by symptoms of sufficient severity, including severe pain, such that a prudent
30 layperson, who possesses an average knowledge of health and medicine, could

1 reasonably expect that the absence of immediate medical attention would result in
 2 serious impairment to bodily functions, serious dysfunction of a bodily organ or part,
 3 or would place the person's health or, with respect to a pregnant woman, the health
 4 of the woman or her unborn child, in serious jeopardy.

5 (20) "Emergency services" means health care items and services furnished
 6 or required to evaluate and treat an emergency medical condition.

7 (21) "Evidence-based standard" means the conscientious, explicit, and
 8 judicious use of the current best evidence based on the overall systematic review of
 9 the research in making decisions about the care of individual patients.

10 (22) "Expert opinion" means a belief or an interpretation by specialists with
 11 experience in a specific area about the scientific evidence pertaining to a particular
 12 service, intervention, or therapy.

13 (23) "Facility" means an institution providing health care services or a health
 14 care setting, including but not limited to hospitals and other licensed inpatient
 15 centers, ambulatory surgical or treatment centers, skilled nursing centers, residential
 16 treatment centers, diagnostic, laboratory and imaging centers, rehabilitation and
 17 other therapeutic health settings, and inpatient hospice facilities.

18 (24) "Final adverse determination" means an adverse determination,
 19 including medical judgment, involving a covered benefit that has been upheld by a
 20 health insurance issuer, or its designee utilization review organization, at the
 21 completion of the health insurance issuer's internal claims and appeals process
 22 procedures provided pursuant to R.S. 22:2401.

23 (25) "Grievance" means, in a health insurance issuer's internal claims and
 24 appeals process, a written complaint or oral complaint, if the complaint involves an
 25 urgent care request submitted by or on behalf of a covered person regarding any of
 26 the following:

27 (a) Availability, delivery, or quality of health care services, including a
 28 complaint regarding an adverse determination made pursuant to utilization review.

29 (b) Claims payment, handling, or reimbursement for health care services.

1 (c) Matters pertaining to the contractual relationship between a covered
2 person and a health insurance issuer.

3 (26) "Health benefit plan" means a policy, contract, certificate, or agreement
4 entered into, offered, or issued by a health insurance issuer to provide, deliver,
5 arrange for, pay for, or reimburse any of the costs of health care services. "Health
6 benefit plan" shall not include a plan providing coverage for excepted benefits as
7 defined in R.S. 22:1061(3) and short-term policies that have a term of less than
8 twelve months.

9 (27) "Health care professional" means a physician or other health care
10 practitioner licensed, accredited, registered, or certified to perform specified health
11 care services consistent with state law.

12 (28) "Health care provider" or "provider" means a health care professional
13 or a facility.

14 (29) "Health care services" means services for the diagnosis, prevention,
15 treatment, cure, or relief of a health condition, illness, injury, or disease.

16 (30) "Health information" means information or data, whether oral or
17 recorded in any form or medium, and personal facts or information about events or
18 relationships that relate to any of the following:

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

21 (b) The provision of health care services to an individual.

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

23 (31) "Health insurance issuer" means an entity subject to the insurance laws
24 and regulations of this state, or subject to the jurisdiction of the commissioner, that
25 contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse
26 any of the costs of health care services, including through a health benefit plan as
27 defined in Paragraph (26) of this Section, and shall include a sickness and accident
28 insurance company, a health maintenance organization, a preferred provider
29 organization or any similar entity, or any other entity providing a plan of health
30 insurance or health benefits.

1 (32) "Immediately" means as expeditiously as the medical situation of the
2 covered person requires but in no event longer than one day for expedited reviews
3 or one business day for standard reviews.

4 (33) "Independent review organization" means an entity that conducts
5 independent external reviews of adverse determinations and final adverse
6 determinations.

7 (34) "Medical or scientific evidence" means evidence found in the following
8 sources:

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

13 (b) Peer-reviewed medical literature, including literature relating to therapies
14 reviewed and approved by a qualified institutional review board, biomedical
15 compendia and other medical literature that meet the criteria of the National
16 Institutes of Health's National Library of Medicine for indexing in Index Medicus
17 (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medica (EMBASE).

18 (c) Medical journals recognized by the secretary of the United States
19 Department of Health and Human Services under Section 1861(t)(2) of the federal
20 Social Security Act.

21 (d) The following standard reference compendia:

22 (i) The American Hospital Formulary Service-Drug Information.

23 (ii) Drug Facts and Comparisons.

24 (iii) The American Dental Association Guide to Dental Therapeutics.

25 (iv) The United States Pharmacopeia-Drug Information.

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

29 (i) The federal Agency for Healthcare Research and Quality.

30 (ii) The National Institutes of Health.

- 1 (iii) The National Cancer Institute.
- 2 (iv) The National Academy of Sciences.
- 3 (v) The federal Centers for Medicare and Medicaid Services.
- 4 (vi) The federal Food and Drug Administration.
- 5 (vii) Any national board recognized by the National Institutes of Health for
 6 the purpose of evaluating the medical value of health care services.
- 7 (f) Any other medical or scientific evidence that is comparable to the sources
 8 listed in Subparagraphs (a) through (e) of this Paragraph.
- 9 (35) "NAIC" means the National Association of Insurance Commissioners.
- 10 (36) "Person" or "entity" means an individual, a corporation, a partnership,
 11 an association, a joint venture, a joint stock company, a trust, an unincorporated
 12 organization, any similar entity, or any combination of the foregoing.
- 13 (37) "Prospective review" means utilization review conducted prior to an
 14 admission or the provision of a health care service or a course of treatment in
 15 accordance with a health insurance issuer's requirement that the health care service
 16 or course of treatment, in whole or in part, be approved prior to its provision.
- 17 (38) "Protected health information" means either of the following:
 18 (a) Health information that identifies an individual who is the subject of the
 19 information.
- 20 (b) Health information with respect to which there is a reasonable basis to
 21 believe that the information could be used to identify an individual.
- 22 (39) "Randomized clinical trial" means a controlled, prospective study of
 23 patients that have been randomized into an experimental group and a control group
 24 at the beginning of the study with only the experimental group of patients receiving
 25 a specific intervention, which includes study of the groups for variables and
 26 anticipated outcomes over time.
- 27 (40) "Rescission" means cancellation or discontinuance of coverage under
 28 a health benefit plan that has a retroactive effect. The term shall not include a
 29 cancellation or discontinuance of coverage under a health benefit plan if either:

1 (a) The cancellation or discontinuance of coverage has only a prospective
2 effect.

3 (b) The cancellation or discontinuance of coverage is effective retroactively
4 to the extent that it is attributable to a failure to timely pay required premiums or
5 contributions towards the cost of coverage.

6 (41) "Retrospective review" means a utilization review conducted after
7 services have been provided to a patient, but does not include the review of a claim
8 that is limited to an evaluation of reimbursement levels, veracity of documentation,
9 accuracy of coding, or adjudication for payment.

10 (42) "Second opinion" means an opportunity or requirement to obtain a
11 clinical evaluation by a provider other than the one originally making a
12 recommendation for a proposed health care service to assess the clinical or medical
13 necessity and appropriateness of the initial proposed health care service.

14 (43) "Urgent care request" means:

15 (a) A request for a health care service or course of treatment with respect to
16 which the time periods for making a non-urgent care request determination either:

17 (i) Could seriously jeopardize the life or health of the covered person or the
18 ability of the covered person to regain maximum function.

19 (ii) Would, in the opinion of a physician with knowledge of the covered
20 person's medical condition, subject the covered person to severe pain that cannot be
21 adequately managed without the health care service or treatment that is the subject
22 of the request.

23 (b)(i) Except as provided in Item (ii) of this Subparagraph, in determining
24 whether a request is to be treated as an urgent care request, an individual acting on
25 behalf of the health insurance issuer shall apply the judgment of a prudent layperson
26 who possesses an average knowledge of health and medicine.

27 (ii) Any request that a physician with knowledge of the covered person's
28 medical condition determines is an urgent care request within the meaning of
29 Subparagraph (a) of this Paragraph shall be treated as an urgent care request.

1 (44) "Utilization review" means a set of formal techniques designed to
 2 monitor the use of or evaluate the clinical or medical necessity, appropriateness,
 3 efficacy, or efficiency of health care services, procedures, or settings. Techniques
 4 may include ambulatory review, prospective review, second opinion, certification,
 5 concurrent review, case management, discharge planning, or retrospective review.

6 (45) "Utilization review organization" means a licensed entity that conducts
 7 utilization review in the internal claims and appeals process provided pursuant to
 8 R.S. 22:2401.

9 §2393. Applicability and scope

10 This Chapter shall apply to any health insurance issuer that offers a health
 11 benefit plan as defined in this Chapter.

12 §2394. Licensure as a utilization review organization

13 A. No health insurance issuer, or entity acting on behalf of, or agent of a
 14 health insurance issuer shall act as a utilization review organization unless authorized
 15 as such by the commissioner as provided in this Chapter.

16 B. Any other entity may apply for and be issued a license pursuant to this
 17 Chapter to act as a utilization review organization on behalf of a health insurance
 18 issuer.

19 C. An entity licensed as a utilization review organization shall notify the
 20 commissioner of any material change in fact or circumstance affecting its
 21 qualification for a license in this state within sixty days of the effective date of the
 22 change. The notice shall include any documentation that the commissioner may
 23 require. Changes in fact or circumstances shall include the following items:

- 24 (1) Changes in control as defined in R.S. 22:691.2.
- 25 (2) Amendments to the articles of incorporation.
- 26 (3) Changes in officers and directors.
- 27 (4) Merger or consolidation of the utilization or independent review
 28 organization with any other person or entity.
- 29 (5) Use of a trade name in this state.

1 §2395. Procedure for application to act as a utilization review organization

2 A. Any applicant for licensure as a utilization review organization, other than
3 a health insurance issuer, shall submit an application to the commissioner and pay
4 the application fee specified in R.S. 22:821(B)(36). The application shall be on a
5 form and accompanied by any supporting documentation required by the
6 commissioner and shall be signed and verified by the applicant. The information
7 required by the application shall include but not be limited to the following:

8 (1) The name of the entity operating as a utilization review organization and
9 any trade or business names used by that entity in connection with making utilization
10 review determinations.

11 (2) The names and addresses of every officer and director of the entity
12 operating as a utilization review organization, the name and address of the corporate
13 officer designated by the utilization review organization as the corporate
14 representative to oversee the utilization review, and such biographical information
15 as may be requested by the commissioner.

16 (3) The name and address of every person owning, directly or indirectly, ten
17 percent or more of the entity operating as a utilization review organization as well
18 as such biographical information as may be requested by the commissioner.

19 (4) The principal place of business of the utilization review organization.

20 (5) A general description of the operation of the utilization review
21 organization which includes a statement that the utilization review organization does
22 not engage in the practice of medicine or act to impinge upon or encumber the
23 independent medical judgment of treating physicians or health care providers.

24 (6) A copy of the utilization review organization's procedure manual which
25 meets the requirements of this Chapter for making utilization review.

26 (7) A sample copy of any contract, absent fees charged, for making
27 utilization review determinations that is entered into with a health insurance issuer,
28 nonfederal government health benefit plan, or other group health plan.

29 (8) The names, addresses, and qualifications of individuals being designated
30 to make utilization review determinations pursuant to this Chapter.

1 B. A health insurance issuer holding a valid certificate of authority to operate
 2 in this state may be authorized to act as a utilization review organization under the
 3 requirements of this Chapter following submission to the commissioner of
 4 appropriate documentation for review and approval that shall include but not be
 5 limited to the following:

6 (1) A general description of the operation of the utilization review
 7 organization which includes a statement that the utilization review organization does
 8 not engage in the practice of medicine or act to impinge upon or encumber the
 9 independent medical judgment of treating physicians or health care providers.

10 (2) A copy of the utilization review organization's program description or
 11 procedures manual which meets the requirements of this Chapter for making clinical
 12 or medical necessity determinations and resolving disputes in the internal claims and
 13 appeals process.

14 (3) A sample copy of any contract, absent fees charged, for making
 15 utilization review determinations that is entered into with another health insurance
 16 issuer.

17 PART II. INTERNAL CLAIMS AND APPEALS PROCESS

18 §2401. Requirements of federal laws and regulations; minimum requirements

19 Health insurance issuers shall implement effective processes for appeals of
 20 coverage determinations and claims pursuant to Section 2719 of the Public Health
 21 Service Act (42 USC §300gg-19) and any federal regulations promulgated pursuant
 22 thereto by the United States Department of Labor and the United States Department
 23 of Health and Human Services. Under such processes, a health insurance issuer
 24 shall, at a minimum:

25 (1) Have in effect an internal claims appeal process.

26 (2) Provide notice to covered persons, in a culturally and linguistically
 27 appropriate manner, of available internal and external appeals processes and the
 28 availability of the office of consumer advocacy of the Louisiana Department of
 29 Insurance to assist such persons with the appeals process.

1 (3) Allow covered persons, upon request and free of charge, to review and
 2 have copies of all documents relevant to the claim for benefits and to submit
 3 comments and documents relating to the claim, without regard to whether that
 4 information was submitted or considered in the initial benefit determination, and to
 5 receive continued coverage pending the outcome of the appeals process where
 6 required by applicable law or the plan document or policy.

7 PART III. HEALTH INSURANCE ISSUER EXTERNAL REVIEW ACT

8 §2431. Short title

9 This Part shall be known and may be cited as the "Health Insurance Issuer
 10 External Review Act".

11 §2432. Purpose and intent

12 The purpose of this Part is to provide uniform standards for the establishment
 13 and maintenance of external review procedures to assure that covered persons have
 14 the opportunity for an independent review of an adverse determination or final
 15 adverse determination, as defined in this Chapter.

16 §2433. Notice of right to external review

17 A.(1) For matters involving an issue of medical necessity, appropriateness,
 18 health care setting, level of care, effectiveness, or a rescission, a health insurance
 19 issuer shall notify the covered person in writing of the covered person's right to
 20 request an external review to be conducted pursuant to R.S. 22:2436 through 2438
 21 and include the appropriate statements and information set forth in Subsection B of
 22 this Section at the same time that the health insurance issuer sends written notice of:

23 (a) An adverse determination upon completion of the health insurance
 24 issuer's internal claims and appeals process provided pursuant to R.S. 22:2401.

25 (b) A final adverse determination.

26 (2) As part of the written notice required pursuant to Paragraph (1) of this
 27 Subsection, a health insurance issuer shall include the following, or substantially
 28 equivalent, language: "We have denied your request for the provision of or payment
 29 for a health care service or course of treatment. You may have the right to have our
 30 decision reviewed by health care professionals who have no association with us. In

1 order to request an external appeal, you should send your request in writing to our
2 office at the designated address included in this notice."

3 (3) The commissioner may prescribe by regulation the form and content of
4 the notice required pursuant to this Section.

5 B.(1) The health insurance issuer shall include in the notice required
6 pursuant to Subsection A of this Section:

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

9 (i) If the covered person has a medical condition for which the time frame
10 for completion of an expedited review of a grievance involving an adverse
11 determination as provided pursuant to R.S. 22:2401 would seriously jeopardize the
12 life or health of the covered person or would jeopardize the covered person's ability
13 to regain maximum function, the covered person or his authorized representative
14 may file a request for an expedited external review to be conducted pursuant to R.S.
15 22:2437. Further, the notice shall inform the covered person that an expedited
16 external review pursuant to R.S. 22:2438 is available if the adverse determination
17 involves a denial of coverage based on a determination that the recommended or
18 requested health care service or treatment is experimental or investigational and the
19 covered person's treating physician certifies in writing that any delay in appealing
20 the adverse determination may pose an imminent threat to the covered person's
21 health, including but not limited to severe pain, potential loss of life, limb, or major
22 bodily function, or the immediate deterioration of the health of the covered person.
23 The notice shall also inform the covered person or his authorized representative that
24 he may simultaneously file a request for an expedited review of a grievance
25 involving an adverse determination as provided pursuant to R.S. 22:2401, but that
26 the independent review organization assigned to conduct the expedited external
27 review will determine whether the covered person shall be required to complete the
28 expedited review of the grievance prior to conducting the expedited external review.

29 (ii) The covered person or his authorized representative may file a grievance
30 under the health insurance issuer's internal claims and appeals process as provided

1 pursuant to R.S. 22:2401, but if the health insurance issuer has not issued a written
2 decision to the covered person or his authorized representative within thirty days
3 following the date the covered person or his authorized representative files the
4 grievance with the health insurance issuer and the covered person or his authorized
5 representative has not requested or agreed to a delay, the covered person or his
6 authorized representative may file a request for external review pursuant to R.S.
7 22:2434 and shall be considered to have exhausted the health insurance issuer's
8 internal claims and appeals process for purposes of R.S. 22:2435.

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

11 (i) If the covered person has a medical condition for which the time frame
12 for completion of a standard external review pursuant to R.S. 22:2436 would
13 seriously jeopardize the life or health of the covered person or would jeopardize the
14 covered person's ability to regain maximum function, the covered person or his
15 authorized representative may file a request for an expedited external review
16 pursuant to R.S. 22:2437.

17 (ii) If the final adverse determination concerns either of the following:

18 (aa) An admission, availability of care, continued stay, or health care service
19 for which the covered person received emergency services, but has not been
20 discharged from a facility, the covered person or his authorized representative may
21 request an expedited external review pursuant to R.S. 22:2437.

22 (bb) A denial of coverage based on a determination that the recommended
23 or requested health care service or treatment is experimental or investigational, the
24 covered person or his authorized representative may file a request for a standard
25 external review to be conducted pursuant to R.S. 22:2438 or if the covered person's
26 treating physician certifies in writing that any delay in appealing the adverse
27 determination may pose an imminent threat to the covered person's health, including
28 but not limited to severe pain, potential loss of life, limb, or major bodily function,
29 or the immediate deterioration of the health of the covered person, the covered

1 person or his authorized representative may request an expedited external review to
2 be conducted under R.S. 22:2438.

3 (2) In addition to the information to be provided pursuant to Paragraph (1)
4 of this Subsection, the health insurance issuer shall include a copy of the description
5 of both the standard and expedited external review procedures the health insurance
6 issuer is required to provide pursuant to R.S. 22:2445, highlighting the provisions in
7 the external review procedures that give the covered person or his authorized
8 representative the opportunity to submit additional information and including any
9 forms used to process an external review.

10 (3) As part of any forms provided under Paragraph (2) of this Subsection, the
11 health insurance issuer shall include an authorization form, or other document
12 approved by the commissioner that complies with the requirements of 45 CFR
13 Section 164.508, by which the covered person, for purposes of conducting an
14 external review under this Part, authorizes the health insurance issuer and the
15 covered person's treating health care provider to disclose protected health
16 information, including medical records, concerning the covered person that are
17 pertinent to the external review, as further provided in this Paragraph. A health
18 insurance issuer shall not use or disclose protected health information for any
19 purpose other than in the performance of the health insurance issuer's functions,
20 except as otherwise permitted by state or federal law, including providing such
21 information to an independent review organization as required by this Part.

22 §2434. Request for external review

23 A.(1) Except for a request for an expedited external review, all requests for
24 external review shall be made in writing to the health insurance issuer.

25 (2) The commissioner may prescribe by regulation the form and content of
26 external review requests required to be submitted pursuant to this Section.

27 B. A covered person or his authorized representative may make a request for
28 an external review of an adverse determination or final adverse determination when
29 such determination involves an issue of medical necessity, appropriateness, health
30 care setting, level of care, effectiveness, or a rescission.

1 §2435. Exhaustion of internal claims and appeals process

2 A.(1) Except as provided in Subsection B of this Section, a request for an
3 external review pursuant to R.S. 22:2436 through 2438 shall not be made until the
4 covered person has exhausted the health insurance issuer's internal claims and
5 appeals process provided pursuant to R.S. 22:2401.

6 (2) In addition, a covered person shall be considered to have exhausted the
7 health insurance issuer's internal claims and appeals process for purposes of this
8 Section, if both of the following conditions are met:

9 (a) The covered person or his authorized representative, if applicable, has
10 filed a grievance involving an adverse determination as provided pursuant to R.S.
11 22:2401.

12 (b) Except to the extent the covered person or his authorized representative
13 has requested or agreed to a delay, the covered person or his authorized
14 representative has not received a written decision on the grievance from the health
15 insurance issuer within thirty days following the date that the covered person or his
16 authorized representative filed the grievance with the health insurance issuer.

17 (3) Notwithstanding Paragraph (2) of this Subsection, a covered person or
18 his authorized representative may not make a request for an external review of an
19 adverse determination involving a retrospective review determination made pursuant
20 to R.S. 22:2401 until the covered person has exhausted the health insurance issuer's
21 internal claims and appeals process.

22 B.(1)(a) At the same time that a covered person or his authorized
23 representative files a request for an expedited review of a grievance involving an
24 adverse determination as provided pursuant to R.S. 22:2401, the covered person or
25 his authorized representative may file a request for an expedited external review of
26 the adverse determination for either of the following:

27 (i) Pursuant to R.S. 22:2437, if the covered person has a medical condition
28 in which the time frame for completion of an expedited review of the grievance
29 involving an adverse determination made pursuant to R.S. 22:2401 would seriously

1 ~~jeopardize the life or health of the covered person or would jeopardize the covered~~
2 ~~person's ability to regain maximum function.~~

3 (ii) Pursuant to R.S. 22:2438, if the adverse determination involves a denial
4 of coverage based on a determination that the recommended or requested health care
5 service or treatment is experimental or investigational and the covered person's
6 treating physician certifies in writing that any delay in appealing the adverse
7 determination may pose an imminent threat to the covered person's health, including
8 but not limited to severe pain, potential loss of life, limb, or major bodily function,
9 or the immediate deterioration of the health of the covered person.

10 (b) Upon receipt of a request for an expedited external review under
11 Subparagraph (a) of this Paragraph, the independent review organization conducting
12 the external review in accordance with the provisions of R.S. 22:2437 or 2438 shall
13 determine whether the covered person shall be required to complete the expedited
14 grievance review process as provided pursuant to R.S. 22:2401 before it conducts the
15 expedited external review.

16 (c) Upon a determination made pursuant to Subparagraph (b) of this
17 Paragraph that the covered person must first complete the expedited grievance
18 review process as provided pursuant to R.S. 22:2401, the independent review
19 organization shall immediately notify the covered person and, if applicable, his
20 authorized representative of this determination and that the independent review
21 organization will not proceed with the expedited external review provided for by
22 R.S. 22:2437 or 2438 until completion of the expedited grievance review process if
23 the covered person's grievance at the completion of the expedited grievance review
24 process remains unresolved.

25 (2) A request for an external review of an adverse determination may be
26 made before the covered person has exhausted the health insurance issuer's internal
27 grievance procedures as provided pursuant to R.S. 22:2401 whenever the health
28 insurance issuer agrees to waive the exhaustion requirement.

29 (3) A request for an external review of an adverse determination may be
30 made before the covered person has exhausted the health insurance issuer's internal

1 grievance procedures as provided pursuant to R.S. 22:2401 whenever the health
 2 insurance issuer fails to adhere to requirements pursuant to R.S. 22:2401.
 3 Notwithstanding the provisions of this Paragraph, the internal claims and appeals
 4 process will not be deemed exhausted based on de minimus violations that do not
 5 cause, and are not likely to cause, prejudice or harm to the claimant so long as the
 6 health insurance issuer demonstrates that the violation was for good cause or due to
 7 matters beyond the control of the health insurance issuer and that the violation
 8 occurred in the context of an ongoing, good faith exchange of information between
 9 the health insurance issuer and the claimant. This exception shall not be available
 10 if the violation is part of a pattern or practice of violations by the health insurance
 11 issuer.

12 C. If the requirement to exhaust the health insurance issuer's internal
 13 grievance procedures is waived under Paragraph (B)(2) of this Section, the covered
 14 person or his authorized representative may file a request in writing for a standard
 15 external review as provided for by R.S. 22:2436 or 2438.

16 §2436. Standard external review

17 A. Within four months after the date of receipt of a notice of an adverse
 18 determination or final adverse determination pursuant to R.S. 22:2433, a covered
 19 person or his authorized representative may file a request for an external review with
 20 the health insurance issuer, regardless of the claim amount.

21 B. Within five business days following the date of receipt of the external
 22 review request from the covered person or his authorized representative pursuant to
 23 Subsection A of this Section, the health insurance issuer shall complete a preliminary
 24 review of the request to determine whether all of the following have been met:

25 (1) The individual is or was a covered person in the health benefit plan at the
 26 time the health care service was requested or, in the case of a retrospective review,
 27 was a covered person in the health benefit plan at the time the health care service was
 28 provided.

29 (2) The health care service is the subject of an adverse determination or a
 30 final adverse determination.

1 (3) The covered person has exhausted the health insurance issuer's internal
2 claims and appeals process as provided pursuant to R.S. 22:2401 unless the covered
3 person is not required to exhaust the health insurance issuer's internal claims and
4 appeals process pursuant to R.S. 22:2435.

5 (4) The covered person has provided all the information and forms required
6 to process an external review, including the authorization form provided for in R.S.
7 22:2433(B).

8 C.(1) Within the five business days allowed for the completion of the
9 preliminary review, the health insurance issuer shall notify the commissioner as
10 provided pursuant to Subsection D of this Section and notify the covered person and,
11 if applicable, his authorized representative of all the following, in writing, whether:

12 (a) The request is complete.

13 (b) The request is eligible for external review.

14 (2) If the request:

15 (a) Is not complete, the health insurance issuer shall inform the covered
16 person and, if applicable, his authorized representative in writing and include in the
17 notice what information or materials are needed to make the request complete.

18 (b) Is not eligible for external review, the health insurance issuer shall
19 inform the covered person and, if applicable, his authorized representative in writing
20 and include in the notice the reasons for its ineligibility.

21 (3)(a) The commissioner may specify the form and method for the health
22 insurance issuer's notice of initial determination pursuant to Paragraph (2) of this
23 Subsection and any supporting information to be included in the notice.

24 (b) The notice of initial determination pursuant to Paragraph (2) of this
25 Subsection shall include a statement informing the covered person and, if applicable,
26 his authorized representative that a health insurance issuer's initial determination that
27 the external review request is ineligible for review may be appealed to the
28 commissioner.

29 (4)(a) If the covered person or his authorized representative makes a written
30 request to the commissioner of insurance after the receipt of the denial of an external

1 review, the commissioner may determine that a request is eligible for external review
2 pursuant to Subsection B of this Section, notwithstanding a health insurance issuer's
3 initial determination that the request is ineligible, and require that it be referred for
4 external review.

5 (b) In making a determination under Subparagraph (a) of this Paragraph, the
6 commissioner's decision shall be made in accordance with all applicable provisions
7 of this Part.

8 (c) The commissioner shall notify the health insurance issuer and the covered
9 person or his authorized representative of his determination about the eligibility of
10 the request within five business days of the receipt of the request from the covered
11 person. Within one business day of receipt of the commissioner's determination that
12 a request is eligible for an external review, a health insurance issuer shall comply
13 with Subsection D of this Section.

14 D.(1) A health insurance issuer shall notify the commissioner that a request
15 is eligible for external review pursuant to Subsection C of this Section by submitting
16 a request for assignment of an independent review organization through the
17 Department of Insurance's website. Upon notification, the commissioner shall do the
18 following:

19 (a) Randomly assign an independent review organization from the list of
20 approved independent review organizations compiled and maintained by the
21 commissioner pursuant to R.S. 22:2440 to conduct the external review and notify the
22 health insurance issuer of the name of the assigned independent review organization.

23 (b) Within one business day, send written notice to the covered person and,
24 if applicable, his authorized representative, of the request's eligibility and acceptance
25 for external review and the identity and contact information of the assigned
26 independent review organization.

27 (2) In reaching a decision, the assigned independent review organization
28 shall not be bound by any decisions or conclusions reached during the health
29 insurance issuer's internal claims and appeals process as provided pursuant to R.S.
30 22:2401.

1 (3) The commissioner shall include in the notice provided to the covered
2 person and, if applicable, his authorized representative a statement that the covered
3 person or his authorized representative may submit in writing to the assigned
4 independent review organization, within five business days following the date of
5 receipt of the notice provided pursuant to Subparagraph (1)(b) of this Subsection,
6 additional information that the independent review organization shall consider when
7 conducting the external review. The independent review organization shall be
8 authorized but not required to accept and consider additional information submitted
9 after five business days.

10 E.(1) Within five business days after the date of receipt of the notice
11 provided pursuant to Subparagraph (D)(1)(b) of this Section, the health insurance
12 issuer or its utilization review organization shall provide to the assigned independent
13 review organization the documents and any information considered in making the
14 adverse determination or final adverse determination.

15 (2) Except as provided in Paragraph (3) of this Subsection, failure by the
16 health insurance issuer or its utilization review organization to provide the
17 documents and information within the time frame specified in Paragraph (1) of this
18 Subsection shall not delay the conduct of the external review.

19 (3)(a) If the health insurance issuer or its utilization review organization fails
20 to provide the documents and information within the time frame specified in
21 Paragraph (1) of this Subsection, the assigned independent review organization may
22 terminate the external review and make a decision to reverse the adverse
23 determination or final adverse determination.

24 (b) Within one business day after making the decision under Subparagraph
25 (a) of this Paragraph, the independent review organization shall notify the covered
26 person in writing, if applicable, his authorized representative, the health insurance
27 issuer, and the commissioner.

28 F.(1) The assigned independent review organization shall review all of the
29 information and documents received pursuant to Subsection E of this Section and
30 any other information timely submitted in writing to the independent review

1 organization by the covered person or his authorized representative pursuant to
2 Paragraph (D)(3) of this Section.

3 (2) Upon receipt of any information submitted by the covered person or his
4 authorized representative pursuant to Paragraph (D)(3) of this Section, the assigned
5 independent review organization shall, within one business day, forward the
6 information to the health insurance issuer.

7 G.(1) Upon receipt of the information, if any, required to be forwarded
8 pursuant to Paragraph (F)(2) of this Section, the health insurance issuer may
9 reconsider its adverse determination or final adverse determination that is the subject
10 of the external review.

11 (2) Reconsideration by the health insurance issuer of its adverse
12 determination or final adverse determination pursuant to Paragraph (1) of this
13 Subsection shall not delay or terminate the external review.

14 (3) The external review may be terminated only if the health insurance issuer
15 decides, upon completion of its reconsideration, to reverse its adverse determination
16 or final adverse determination and provide coverage or payment for the health care
17 service that is the subject of the adverse determination or final adverse
18 determination.

19 (4)(a) Within one business day after making the decision to reverse its
20 adverse determination or final adverse determination, as provided in Paragraph (3)
21 of this Subsection, the health insurance issuer shall notify the covered person, if
22 applicable, his authorized representative, the assigned independent review
23 organization, and the commissioner in writing of its decision.

24 (b) The assigned independent review organization shall terminate the
25 external review upon receipt of the notice from the health insurance issuer sent
26 pursuant to Subparagraph (a) of this Paragraph.

27 H. In addition to the documents and information provided pursuant to
28 Subsection E of this Section, the assigned independent review organization, to the
29 extent that the information or documents are available, shall consider the following
30 in reaching a decision:

1 (1) The covered person's medical records.

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

3 (3) Consulting reports from appropriate health care professionals and other
4 documents submitted by the health insurance issuer, covered person, his authorized
5 representative, or the covered person's treating provider.

6 (4) The terms of coverage under the covered person's health benefit plan
7 with the health insurance issuer to ensure that the independent review organization's
8 decision is not contrary to the terms of coverage under the covered person's health
9 benefit plan with the health insurance issuer.

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

14 (6) Any applicable clinical review criteria developed and used by the health
15 insurance issuer or its designee utilization review organization.

16 (7) The opinion of the independent review organization's clinical peer or
17 peers after considering Paragraphs (1) through (6) of this Subsection to the extent the
18 information or documents are available and the clinical peer or peers consider
19 appropriate.

20 I.(1) Within forty-five days after the date of receipt of the request for an
21 external review, the assigned independent review organization shall provide written
22 notice of its decision to uphold or reverse the adverse determination or the final
23 adverse determination to each of the following:

24 (a) The covered person.

25 (b) If applicable, the covered person's authorized representative.

26 (c) The health insurance issuer.

27 (d) The commissioner.

28 (2) The independent review organization shall include the following in the
29 notice sent pursuant to Paragraph (1) of this Subsection:

30 (a) A general description of the reason for the request for external review.

1 **(b) The date that the independent review organization received the**
2 **assignment from the commissioner to conduct the external review.**

3 **(c) The date that the external review was conducted.**

4 **(d) The date of its decision.**

5 **(e) The principal reason or reasons for its decision, including what applicable**
6 **evidence-based standards, if any, were a basis for its decision.**

7 **(f) The rationale for its decision.**

8 **(g) References to the evidence or documentation, including the**
9 **evidence-based standards, considered in reaching its decision.**

10 **(3) Upon receipt of a notice of a decision made pursuant to Paragraph (1) of**
11 **this Subsection reversing the adverse determination or final adverse determination,**
12 **the health insurance issuer shall immediately approve the coverage or payment that**
13 **was the subject of the adverse determination or final adverse determination.**

14 **J. The assignment by the commissioner of an approved independent review**
15 **organization to conduct an external review in accordance with this Section shall be**
16 **done on a random basis among those approved independent review organizations**
17 **qualified to conduct the particular external review based on the nature of the health**
18 **care service that is the subject of the adverse determination or final adverse**
19 **determination and other circumstances, including conflict of interest concerns**
20 **pursuant to R.S. 22:2441(D).**

21 **§2437. Expedited external review**

22 **A. Except as provided in Subsection F of this Section, a covered person or**
23 **his authorized representative may make a request regardless of the claim amount for**
24 **an expedited external review with the health insurance issuer at the time that the**
25 **covered person receives:**

26 **(1) An adverse determination if both of the following apply:**

27 **(a) The adverse determination involves a medical condition of the covered**
28 **person for which the time frame for completion of an expedited internal review of**
29 **a grievance involving an adverse determination made pursuant to R.S. 22:2401**

1 would seriously jeopardize the life or health of the covered person or would
 2 jeopardize the covered person's ability to regain maximum function.

3 (b) The covered person or his authorized representative has filed a request
 4 for an expedited review of a grievance involving an adverse determination made
 5 pursuant to R.S. 22:2401.

6 (2) A final adverse determination if either of the following applies:

7 (a) The covered person has a medical condition in which the time frame for
 8 completion of a standard external review pursuant to R.S. 22:2436 would seriously
 9 jeopardize the life or health of the covered person or would jeopardize the covered
 10 person's ability to regain maximum function.

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

14 B.(1) Immediately upon receipt of the request pursuant to Subsection A of
 15 this Section, the health insurance issuer shall determine whether the request meets
 16 the reviewability requirements specified in R.S. 22:2436(B). The health insurance
 17 issuer shall immediately notify the covered person and, if applicable, his authorized
 18 representative of its eligibility determination.

19 (2)(a) The commissioner may specify the form and method for the health
 20 insurance issuer's notice of initial determination pursuant to Paragraph (1) of this
 21 Subsection and any supporting information to be included in the notice.

22 (b) The notice of initial determination pursuant to Paragraph (1) of this
 23 Subsection shall include a statement informing the covered person and, if applicable,
 24 his authorized representative that a health insurance issuer's initial determination that
 25 an expedited external review request is ineligible for review may be appealed to the
 26 commissioner.

27 (3)(a) If the covered person or his authorized representative makes a written
 28 request to the commissioner of insurance after receipt of the notice of denial of an
 29 expedited external review, the commissioner may determine that a request is eligible
 30 for an expedited external review in accordance with the criteria found in R.S.

1 22:2436(B), notwithstanding a health insurance issuer's initial determination that the
2 request is ineligible, and require that it be referred for external review.

3 (b) In making a determination under Subparagraph (a) of this Paragraph, the
4 commissioner's decision shall be made in accordance with all applicable provisions
5 of this Part.

6 (c) The commissioner shall immediately notify the health insurance issuer
7 and the covered person or his authorized representative of its determination about the
8 eligibility of the request. Following receipt of the commissioner's determination that
9 a request is eligible for an expedited external review, a health insurance issuer shall
10 immediately comply with Paragraph (4) of this Subsection.

11 (4) Immediately upon the health insurance issuer's determination that a
12 request is eligible for an expedited external review or upon the determination by the
13 commissioner that a request is eligible for an expedited external review, the health
14 insurance issuer shall submit a request for assignment of an independent review
15 organization through the Department of Insurance's website. Upon receipt of the
16 notice that the request meets the reviewability requirements, the commissioner shall
17 immediately assign an independent review organization to conduct the expedited
18 external review from the list of approved independent review organizations compiled
19 and maintained by the commissioner pursuant to R.S. 22:2440. The commissioner
20 shall immediately notify the health insurance issuer and the covered person or his
21 authorized representative of the name and contact information of the assigned
22 independent review organization.

23 (5) In reaching a decision in accordance with Subsection E of this Section,
24 the assigned independent review organization is not bound by any decisions or
25 conclusions reached during the health insurance issuer's utilization review process
26 or the health insurance issuer's internal claims and appeals process provided pursuant
27 to R.S. 22:2401.

28 C. Upon receipt of the notice from the commissioner of the name of the
29 independent review organization assigned to conduct the expedited external review
30 pursuant to Paragraph (B)(4) of this Section, the health insurance issuer or its

1 designee utilization review organization shall provide or transmit all necessary
2 documents and information considered in making the adverse determination or final
3 adverse determination to the assigned independent review organization
4 electronically, by telephone or facsimile, or by any other available expeditious
5 method.

6 D. In addition to the documents and information provided or transmitted
7 pursuant to Subsection C of this Section, the assigned independent review
8 organization, to the extent the information or documents are available, shall consider
9 the following in reaching a decision:

10 (1) The covered person's pertinent medical records.

11 (2) The attending health care professional's recommendation.

12 (3) Consulting reports from appropriate health care professionals and other
13 documents submitted by the health insurance issuer, the covered person, his
14 authorized representative, or the covered person's treating provider.

15 (4) The terms of coverage under the covered person's health benefit plan
16 with the health insurance issuer to ensure that the independent review organization's
17 decision is not contrary to the terms of coverage under the covered person's health
18 benefit plan with the health insurance issuer.

19 (5) The most appropriate practice guidelines, which shall include
20 evidence-based standards, and may include any other practice guidelines developed
21 by the federal government or national or professional medical societies, boards, and
22 associations.

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

26 (7) The opinion of the independent review organization's clinical peer or
27 peers after considering the information specified by Paragraphs (1) through (6) of
28 this Subsection to the extent the information and documents are available and the
29 clinical peer or peers consider appropriate.

1 E.(1) As expeditiously as the covered person's medical condition or
2 circumstances requires, but in no event more than seventy-two hours after the date
3 that the health insurance issuer receives the request for an expedited external review,
4 the assigned independent review organization shall do both of the following:

5 (a) Make a decision to uphold or reverse the adverse determination or final
6 adverse determination.

7 (b) Notify the covered person, his authorized representative, if applicable,
8 the health insurance issuer, and the commissioner of the decision.

9 (2) If the notice provided pursuant to Paragraph (1) of this Subsection was
10 not in writing, within forty-eight hours after the date of providing that notice, the
11 assigned independent review organization shall do both of the following:

12 (a) Provide written confirmation of the decision to the covered person, his
13 authorized representative, if applicable, the health insurance issuer, and the
14 commissioner.

15 (b) Include the information specified in R.S. 22:2436(I)(2).

16 (3) Upon receipt of the notice of a decision pursuant to Paragraph (1) of this
17 Subsection reversing the adverse determination or final adverse determination, the
18 health insurance issuer shall immediately approve the coverage that was the subject
19 of the adverse determination or final adverse determination.

20 F. An expedited external review shall not be provided for retrospective
21 adverse determinations or retrospective final adverse determinations.

22 G. The assignment by the commissioner of an approved independent review
23 organization to conduct an expedited external review in accordance with this Section
24 shall be done on a random basis among those approved independent review
25 organizations qualified to conduct the particular expedited external review based on
26 the nature of the health care service that is the subject of the adverse determination
27 or final adverse determination and other circumstances, including conflict of interest
28 concerns pursuant to R.S. 22:2441(D).

1 §2438. External review of experimental or investigational treatment adverse
2 determinations

3 A.(1) Within four months after the date of receipt of a notice of an adverse
4 determination or final adverse determination pursuant to R.S. 22:2433 that involves
5 a denial of coverage based on a determination that the health care service or
6 treatment recommended or requested is experimental or investigational, a covered
7 person or his authorized representative may file a request for a standard and an
8 expedited external review with the health insurance issuer, regardless of the claim
9 amount.

10 (2)(a) A covered person or his authorized representative may make an oral
11 request to the health insurance issuer for an expedited external review of the adverse
12 determination or final adverse determination pursuant to Paragraph (1) of this
13 Subsection if the covered person's treating physician certifies, in writing, that any
14 delay in appealing the adverse determination may pose an imminent and serious
15 threat to the covered person's health, including but not limited to severe pain,
16 potential loss of life, limb, or major bodily function, or the immediate and serious
17 deterioration of the health of the covered person.

18 (b)(i) Upon notice of the request for an expedited external review, the health
19 insurance issuer shall immediately determine whether the request meets the
20 reviewability requirements of Subsection B of this Section. The health insurance
21 issuer shall immediately notify the covered person and, if applicable, his authorized
22 representative of its eligibility determination.

23 (ii) The commissioner may specify the form and method for the health
24 insurance issuer's notice of initial determination pursuant to Item (i) of this
25 Subparagraph and any supporting information to be included in the notice.

26 (iii) The notice of initial determination under Item (i) of this Subparagraph
27 shall include a statement informing the covered person and, if applicable, his
28 authorized representative that a health insurance issuer's initial determination that the
29 expedited external review request is ineligible for review may be appealed to the
30 commissioner.

1 (c)(i) If the covered person or his authorized representative makes a written
2 request to the commissioner of insurance after receipt of the denial of an expedited
3 external review, the commissioner may determine that a request is eligible for an
4 expedited external review pursuant to Subsection B of this Section, notwithstanding
5 a health insurance issuer's initial determination the request is ineligible, and require
6 that it be referred for an expedited external review.

7 (ii) In making a determination pursuant to Item (i) of this Subparagraph, the
8 commissioner's decision shall be made in accordance with all applicable provisions
9 of this Part.

10 (iii) The commissioner shall immediately notify the health insurance issuer
11 and the covered person or his authorized representative of its determination
12 concerning the eligibility of the request. Following receipt of the commissioner's
13 determination that a request is eligible for an expedited external review, a health
14 insurance issuer shall immediately comply with Subparagraph (d) of this Paragraph.

15 (d) Immediately upon the health insurance issuer's determination that a
16 request is eligible for an expedited external review or upon the determination by the
17 commissioner that a request is eligible for an expedited external review, the health
18 insurance issuer shall submit a request for assignment of an independent review
19 organization through the Department of Insurance's website. Upon receipt of the
20 notice that the expedited external review request meets the reviewability
21 requirements of Subsection B of this Section, the commissioner shall immediately
22 randomly assign an independent review organization to review the expedited request
23 from the list of approved independent review organizations compiled and maintained
24 by him pursuant to R.S. 22:2440 and notify the health insurance issuer and the
25 covered person or his authorized representative of the name and contact information
26 of the assigned independent review organization.

27 (e) At the time that the health insurance issuer receives the notice of the
28 assigned independent review organization pursuant to Subparagraph (d) of this
29 Paragraph, the health insurance issuer or its designee utilization review organization
30 shall provide or transmit all necessary documents and information considered in

1 making the adverse determination or final adverse determination to the assigned
2 independent review organization electronically, by telephone or facsimile, or any
3 other available expeditious method.

4 B. Within five business days following the date of receipt of the standard
5 external review request, the health insurance issuer shall conduct and complete a
6 preliminary review of the request to determine whether each of the following
7 conditions have been met:

8 (1) The individual is or was a covered person in the health benefit plan at the
9 time the health care service or treatment was recommended or requested or, in the
10 case of a retrospective review, was a covered person in the health benefit plan at the
11 time the health care service or treatment was provided.

12 (2) The recommended or requested health care service or treatment that is
13 the subject of the adverse determination or final adverse determination is not
14 explicitly listed as an excluded benefit under the covered person's health benefit plan
15 with the health insurance issuer.

16 (3) The covered person's treating physician has certified that one of the
17 following situations exists:

18 (a) Standard health care services or treatments have not been effective in
19 improving the condition of the covered person.

20 (b) Standard health care services or treatments are not medically appropriate
21 for the covered person.

22 (c) There is no available standard health care service or treatment covered
23 by the health insurance issuer that is more beneficial than the recommended or
24 requested health care service or treatment.

25 (4) The covered person's treating physician either:

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

29 (b) Is a licensed, board-certified, or board-eligible physician qualified to
30 practice in the area of medicine appropriate to treat the covered person's condition

1 and has certified, in writing, that scientifically valid studies using accepted protocols
 2 demonstrate that the health care service or treatment requested by the covered person
 3 that is the subject of the adverse determination or final adverse determination is
 4 likely to be more beneficial to the covered person than any available standard health
 5 care services or treatments.

6 (5) The covered person has exhausted the health insurance issuer's internal
 7 claims and appeals process provided pursuant to R.S. 22:2401, unless the covered
 8 person is not required to exhaust the health insurance issuer's internal claims and
 9 appeals process pursuant to R.S. 22:2435.

10 (6) The covered person has provided all the information and forms required
 11 by the commissioner that are necessary to process a standard external review,
 12 including the authorization form provided pursuant to R.S. 22:2433(B).

13 C.(1) Within five business days after the completion of the preliminary
 14 review, the health insurance issuer shall notify the covered person and, if applicable,
 15 his authorized representative in writing whether each of the following conditions
 16 have been met:

17 (a) The request is complete.

18 (b) The request is eligible for a standard external review.

19 (2) If the request:

20 (a) Is not complete, the health insurance issuer shall inform the covered
 21 person and, if applicable, his authorized representative in writing and specify in the
 22 notice what information or materials are needed to make the request complete.

23 (b) Is not eligible for a standard external review, the health insurance issuer
 24 shall inform the covered person and his authorized representative, if applicable, in
 25 writing and include in the notice the reasons for its ineligibility.

26 (3)(a) The commissioner may specify the form and method for the health
 27 insurance issuer's notice of initial determination pursuant to Paragraph (2) of this
 28 Subsection and any supporting information to be included in the notice.

29 (b) The notice of initial determination provided pursuant to Paragraph (2) of
 30 this Subsection shall include a statement informing the covered person and, if

1 applicable, his authorized representative that a health insurance issuer's initial
2 determination that the standard external review request is ineligible for review may
3 be appealed to the commissioner.

4 (4)(a) If the covered person or his authorized representative makes a written
5 request to the commissioner of insurance after receipt of the denial of a standard
6 external review, the commissioner may determine that a request is eligible for a
7 standard external review under Subsection B of this Section, notwithstanding a
8 health insurance issuer's initial determination that the request is ineligible, and
9 require that it be referred for a standard external review.

10 (b) In making a determination pursuant to Subparagraph (a) of this
11 Paragraph, the commissioner's decision shall be made in accordance with all
12 applicable provisions of this Part.

13 (c) The commissioner shall notify the health insurance issuer and the covered
14 person or his authorized representative of his determination concerning the eligibility
15 of the request within five business days. Following receipt of the commissioner's
16 determination that a request is eligible for a standard external review, the health
17 insurance issuer shall comply with Subsection D of this Section.

18 D.(1) A health insurance issuer shall notify the commissioner that a request
19 is eligible for a standard external review pursuant to Subsection C of this Section by
20 submitting a request for assignment of an independent review organization through
21 the Department of Insurance's website. Upon notification, the commissioner shall
22 do both of the following:

23 (a) Randomly assign an independent review organization to conduct the
24 standard external review from the list of approved independent review organizations
25 compiled and maintained by the commissioner pursuant to R.S. 22:2440 and notify
26 the health insurance issuer of the name of the assigned independent review
27 organization.

28 (b) Within one business day, notify in writing the covered person and, if
29 applicable, his authorized representative of the request's eligibility and acceptance

1 for a standard external review and the identity of and contact information for the
2 assigned independent review organization.

3 (2) The commissioner shall include a statement in the notice provided to the
4 covered person and, if applicable, his authorized representative that the covered
5 person or his authorized representative may submit in writing to the assigned
6 independent review organization, within five business days following the date of
7 receipt of the notice provided pursuant to Paragraph (1) of this Subsection, additional
8 information that the independent review organization shall consider when conducting
9 the standard external review. The independent review organization shall be
10 authorized but not required to accept and consider additional information submitted
11 after five business days. Within one business day after the receipt of the notice of
12 assignment to conduct the standard external review pursuant to Paragraph (1) of this
13 Subsection, the assigned independent review organization shall follow the clinical
14 peer process provided for in Paragraph (3) of this Subsection.

15 (3) For both a standard and an expedited external review, the assigned
16 independent review organization shall do both of the following:

17 (a) Select one or more clinical peers, as it determines is appropriate, pursuant
18 to Paragraph (4) of this Subsection, to conduct the standard or expedited external
19 review.

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

24 (4)(a) In selecting clinical peers pursuant to Subparagraph (3)(a) of this
25 Subsection, the assigned independent review organization shall select physicians or
26 other health care professionals who meet the minimum qualifications of R.S.
27 22:2441 and, through clinical experience in the past three years, are experts in the
28 treatment of the covered person's condition and knowledgeable about the
29 recommended or requested health care service or treatment.

1 (b) The covered person, his authorized representative, if applicable, or the
2 health insurance issuer shall not choose or control the choice of the physicians or
3 other health care professionals to be selected to conduct the standard external review
4 or the expedited external review.

5 (5) In accordance with Subsection H of this Section, each clinical peer shall
6 provide a written opinion to the assigned independent review organization on
7 whether the recommended or requested health care service or treatment should be
8 covered.

9 (6) In reaching an opinion, clinical peers shall not be bound by any decisions
10 or conclusions reached during the health insurance issuer's utilization review process
11 or the health insurance issuer's internal claims and appeals process provided pursuant
12 to R.S. 22:2401.

13 E.(1) Within five business days after the date of receipt of the notice
14 provided pursuant to Paragraph (D)(1) of this Section, the health insurance issuer or
15 its designee utilization review organization shall provide the documents and any
16 information considered in making the adverse determination or the final adverse
17 determination to the assigned independent review organization.

18 (2) Except as provided in Paragraph (3) of this Subsection, failure by the
19 health insurance issuer or its designee utilization review organization to provide the
20 documents and information within the time frame specified in Paragraph (1) of this
21 Subsection shall not delay the conduct of the standard external review or the
22 expedited external review.

23 (3)(a) If the health insurance issuer or its designee utilization review
24 organization has failed to provide the documents and information within the time
25 frame specified in Paragraph (1) of this Subsection, the assigned independent review
26 organization may terminate the standard external review or the expedited external
27 review and make a decision to reverse the adverse determination or final adverse
28 determination.

29 (b) Immediately upon making the decision under Subparagraph (a) of this
30 Paragraph, the independent review organization shall notify the covered person, his

1 authorized representative, if applicable, the health insurance issuer, and the
2 commissioner.

3 F.(1) For a standard or an expedited external review, each clinical peer
4 selected pursuant to Subsection D of this Section shall review all of the information
5 and documents received pursuant to Subsection E of this Section and any other
6 information submitted in writing by the covered person or his authorized
7 representative pursuant to Paragraph (D)(2) of this Section.

8 (2) Within one business day after receipt of any information submitted by
9 the covered person or his authorized representative pursuant to Paragraph (D)(2) of
10 this Section, the assigned independent review organization shall forward the
11 information to the health insurance issuer.

12 G.(1) Upon receipt of the information required to be forwarded pursuant to
13 Paragraph (F)(2) of this Section, the health insurance issuer may reconsider its
14 adverse determination or final adverse determination that is the subject of the
15 standard or the expedited external review.

16 (2) Reconsideration by the health insurance issuer of its adverse
17 determination or final adverse determination pursuant to Paragraph (1) of this
18 Subsection shall not delay or terminate the standard or the expedited external review.

19 (3) The standard or the expedited external review may terminate only if the
20 health insurance issuer decides, upon completion of its reconsideration, to reverse
21 its adverse determination or final adverse determination and provide coverage or
22 payment for the recommended or requested health care service or treatment that is
23 the subject of the adverse determination or final adverse determination.

24 (4)(a) For a standard or an expedited review, immediately upon making the
25 decision to reverse its adverse determination or final adverse determination, as
26 provided in Paragraph (3) of this Subsection, the health insurance issuer shall notify
27 the covered person, his authorized representative, if applicable, the assigned
28 independent review organization, and the commissioner in writing of its decision.

1 **(b) The assigned independent review organization shall terminate the**
2 **standard or the expedited external review upon receipt of the notice from the health**
3 **insurance issuer sent pursuant to Subparagraph (a) of this Paragraph.**

4 **H.(1) Except as provided in Paragraph (3) of this Subsection, within twenty**
5 **days after being selected in accordance with Subsection D of this Section to conduct**
6 **the standard external review, each clinical peer shall provide an opinion to the**
7 **assigned independent review organization pursuant to Subsection I of this Section**
8 **regarding whether the recommended or requested health care service or treatment**
9 **should be covered.**

10 **(2) Except for an opinion provided pursuant to Paragraph (3) of this**
11 **Subsection, each clinical peer's opinion for a standard review shall be in writing and**
12 **include the following information:**

13 **(a) A description of the covered person's medical condition.**

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

21 **(c) A description and analysis of any medical or scientific evidence**
22 **considered in reaching the opinion.**

23 **(d) A description and analysis of any evidence-based standard.**

24 **(e) Information on whether the peer's rationale for the opinion is based on**
25 **the provisions of Subparagraph (I)(5)(a) or (b) of this Section.**

26 **(3)(a) For an expedited external review, each clinical peer shall provide an**
27 **opinion orally or in writing containing the information outlined in Paragraph (2) of**
28 **this Subsection to the assigned independent review organization as expeditiously as**
29 **the covered person's medical condition or circumstances requires, but in no event**

1 more than five days after being selected in accordance with Subsection D of this
 2 Section.

3 (b) If the opinion provided pursuant to Subparagraph (a) of this Paragraph
 4 was not in writing, within forty-eight hours following the date that the opinion was
 5 provided, the clinical peer shall provide written confirmation of the opinion to the
 6 assigned independent review organization and include the information required
 7 under Paragraph (2) of this Subsection.

8 I. In addition to the documents and information provided pursuant to
 9 Paragraph (A)(2) of this Section or Subsection E of this Section, each clinical peer
 10 selected to conduct a standard or an expedited review pursuant to Subsection D of
 11 this Section, to the extent the information or documents are available and the peer
 12 considers appropriate, shall consider the following in reaching an opinion pursuant
 13 to Subsection H of this Section:

14 (1) The covered person's pertinent medical records.

15 (2) The attending physician's or health care professional's recommendation.

16 (3) Consulting reports from appropriate health care professionals and other
 17 documents submitted by the health insurance issuer, covered person, his authorized
 18 representative, or his treating physician or health care professional.

19 (4) The terms of coverage under the covered person's health benefit plan
 20 with the health insurance issuer to ensure that, but for the health insurance issuer's
 21 determination that the recommended or requested health care service or treatment
 22 that is the subject of the opinion is experimental or investigational, the peer's opinion
 23 is not contrary to the terms of coverage under the covered person's health benefit
 24 plan with the health insurance issuer.

25 (5) Either of the following:

26 (a) Whether the recommended or requested health care service or treatment
 27 has been approved by the federal Food and Drug Administration, if applicable, for
 28 the condition.

29 (b) Whether medical or scientific evidence or evidence-based standards
 30 demonstrate that the expected benefits of the recommended or requested health care

1 service or treatment is more likely than not to be more beneficial to the covered
 2 person than any available standard health care service or treatment and whether the
 3 adverse risks of the recommended or requested health care service or treatment
 4 would not be substantially increased over those of available standard health care
 5 services or treatments.

6 J.(1)(a) Except as provided in Subparagraph (b) of this Paragraph, within
 7 twenty days after the date it receives the opinion of each clinical peer made pursuant
 8 to Subsection I of this Section, the assigned independent review organization in a
 9 standard external review, in accordance with Paragraph (2) of this Subsection, shall
 10 make a decision and provide written notice of the decision to:

11 (i) The covered person.

12 (ii) If applicable, his authorized representative.

13 (iii) The health insurance issuer.

14 (iv) The commissioner.

15 (b)(i) For an expedited external review, within forty-eight hours after the
 16 date it receives the opinion of each clinical peer pursuant to Subsection I of this
 17 Section, the assigned independent review organization, in accordance with Paragraph
 18 (2) of this Subsection, shall make a decision and provide notice of the decision orally
 19 or in writing to the persons specified in Subparagraph (a) of this Paragraph.

20 (ii) If the notice provided under Item (i) of this Subparagraph was not in
 21 writing, within forty-eight hours after the date of providing that notice, the assigned
 22 independent review organization shall provide written confirmation of the decision
 23 to the persons specified in Subparagraph (a) of this Paragraph and include the
 24 information provided for in Paragraph (3) of this Subsection.

25 (2)(a) For a standard or an expedited review, if a majority of the clinical
 26 peers recommend that the recommended or requested health care service or treatment
 27 should be covered, the independent review organization shall make a decision to
 28 reverse the health insurance issuer's adverse determination or final adverse
 29 determination.

1 **(b) For a standard or an expedited external review, if a majority of the**
2 **clinical peers recommend that the recommended or requested health care service or**
3 **treatment should not be covered, the independent review organization shall make a**
4 **decision to uphold the health insurance issuer's adverse determination or final**
5 **adverse determination.**

6 **(c)(i) For a standard or an expedited external review, if the clinical peers are**
7 **evenly split as to whether the recommended or requested health care service or**
8 **treatment should be covered, the independent review organization shall obtain the**
9 **opinion of an additional clinical peer in order for the independent review**
10 **organization to make a decision based on the opinions of a majority of the clinical**
11 **peers made pursuant to Subparagraph (a) or (b) of this Paragraph.**

12 **(ii) The additional clinical peer selected under Item (i) of this Subparagraph**
13 **shall use the same information to reach an opinion as the clinical peers who have**
14 **already submitted their opinions pursuant to Subsection I of this Section.**

15 **(iii) The selection of the additional clinical peer under Item (i) of this**
16 **Subparagraph shall not extend the time within which the assigned independent**
17 **review organization is required to make a decision based on the opinions of the**
18 **clinical peers selected under Subsection D of this Section pursuant to Paragraph (1)**
19 **of this Subsection.**

20 **(3) For a standard or an expedited appeal, the independent review**
21 **organization shall include in the notice provided pursuant to Paragraph (1) of this**
22 **Subsection:**

23 **(a) A general description of the reason for the request for external review.**

24 **(b) The written opinion of each clinical peer, including the recommendation**
25 **of each clinical peer as to whether the recommended or requested health care service**
26 **or treatment should be covered and the rationale for the peer's recommendation.**

27 **(c) The date that the independent review organization was assigned by the**
28 **commissioner to conduct the external review.**

29 **(d) The date that the external review was conducted.**

30 **(e) The date of its decision.**

1 (f) The principal reason or reasons for its decision.

2 (g) The rationale for its decision.

3 (4) For a standard or an expedited external review, upon receipt of a notice
4 of a decision pursuant to Paragraph (1) of this Subsection reversing the adverse
5 determination or final adverse determination, the health insurance issuer shall
6 immediately approve coverage and payment of the recommended or requested health
7 care service or treatment that was the subject of the adverse determination or final
8 adverse determination.

9 K. The assignment by the commissioner of an approved independent review
10 organization to conduct an external review in accordance with this Section shall be
11 done on a random basis among those approved independent review organizations
12 qualified to conduct the particular external review based on the nature of the health
13 care service that is the subject of the adverse determination or final adverse
14 determination and other circumstances, including conflict of interest concerns
15 pursuant to R.S. 22:2441(D).

16 §2439. Binding nature of external review decision

17 A. A standard or an expedited external review decision shall be binding on
18 the health insurance issuer except to the extent the health insurance issuer has other
19 remedies available under applicable federal or state law.

20 B. A standard or an expedited external review decision shall be binding on
21 the covered person except to the extent the covered person has other remedies
22 available under applicable federal or state law.

23 C. A covered person or his authorized representative may not file a
24 subsequent request for a standard or expedited external review involving the same
25 adverse determination or final adverse determination for which the covered person
26 has already received a standard or expedited external review decision pursuant to this
27 Part.

28 §2440. Approval of independent review organizations

29 A. The commissioner shall approve independent review organizations
30 eligible to be assigned to conduct external reviews under this Part.

1 B. In order to be eligible for approval by the commissioner under this
2 Section to conduct external reviews under this Part, an independent review
3 organization shall:

4 (1) Except as otherwise provided in this Section, be accredited by a
5 nationally recognized private accrediting entity that the commissioner has
6 determined has independent review organization accreditation standards that are
7 equivalent to or exceed the minimum qualifications for independent review
8 organizations provided for pursuant to R.S. 22:2441.

9 (2) Submit an application for approval in accordance with Subsection D of
10 this Section along with the application fee specified in R.S. 22:821(37). Such
11 application shall also include a specified e-mail address to which external review
12 information may be submitted.

13 C. The commissioner shall develop an application form for initially
14 approving and for re-approving independent review organizations to conduct
15 external reviews.

16 D.(1) Any independent review organization wishing to be approved to
17 conduct external reviews under this Part shall submit the application form and
18 include with the form all documentation and information necessary for the
19 commissioner to determine if the independent review organization satisfies the
20 minimum qualifications provided for by R.S. 22:2441.

21 (2)(a) Subject to Subparagraph (b) of this Paragraph, an independent review
22 organization shall be eligible for approval under this Section only if it is accredited
23 by a nationally recognized private accrediting entity that the commissioner has
24 determined has independent review organization accreditation standards that are
25 equivalent to or exceed the minimum qualifications for independent review
26 organizations provided for by R.S. 22:2441.

27 (b) The commissioner may approve independent review organizations that
28 are not accredited by a nationally recognized private accrediting entity if there are
29 no acceptable nationally recognized private accrediting entities providing
30 independent review organization accreditation.

1 (3) The commissioner shall charge an application fee as specified in R.S.
2 22:821(37) that independent review organizations shall submit to the commissioner
3 with an application for approval or re-approval.

4 E.(1) An approval shall be effective for two years, unless the commissioner
5 determines before its expiration that the independent review organization is not
6 satisfying the minimum qualifications provided for by R.S. 22:2441. An application
7 for renewal shall be submitted not less than sixty days prior to the expiration of such
8 approval, shall be made on a form provided by the commissioner, and shall be
9 accompanied by the fee required by R.S. 22:821(37).

10 (2) Whenever the commissioner determines that an independent review
11 organization has lost its accreditation or no longer satisfies the minimum
12 requirements established under R.S. 22:2441, the commissioner shall terminate the
13 approval of the independent review organization and remove the independent review
14 organization from the list of independent review organizations approved to conduct
15 external reviews under this Part that is maintained by the commissioner pursuant to
16 Subsection F of this Section.

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

19 §2441. Minimum qualifications for independent review organizations

20 A. To be approved under R.S. 22:2440 to conduct external reviews, an
21 independent review organization shall not be a health insurance issuer and shall have
22 and maintain written policies and procedures that govern all aspects of both the
23 standard external review process and the expedited external review process provided
24 for in this Part. At a minimum, these shall include the following:

25 (1) A quality assurance mechanism in place that:

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

28 (b) Ensures the selection of qualified and impartial clinical peers to conduct
29 external reviews on behalf of the independent review organization and suitable
30 matching of peers to specific cases and ensures that the independent review

1 ~~organization employs or contracts with an adequate number of clinical peers to meet~~
 2 ~~this objective.~~

3 (c) Ensures the confidentiality of medical and treatment records and clinical
 4 review criteria.

5 (d) Ensures that any person employed by or under contract with the
 6 independent review organization adheres to the requirements of this Part.

7 (2) A toll-free telephone service to receive information on a
 8 twenty-four-hour-a-day, seven-day-a-week basis related to external reviews that is
 9 capable of accepting, recording, or providing appropriate instructions to incoming
 10 telephone callers during other than normal business hours.

11 (3) An agreement to maintain and provide to the commissioner the
 12 information required pursuant to R.S. 22:2443.

13 B. Any clinical peer assigned by an independent review organization to
 14 conduct external reviews shall be a physician or other appropriate health care
 15 provider who meets the following minimum qualifications:

16 (1) Is an expert in the treatment of the covered person's medical condition
 17 that is the subject of the external review.

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

21 (3) Has a nonrestrictive medical license in a state of the United States and,
 22 for physicians, a current certification by a recognized American medical specialty
 23 board in the area or areas appropriate to the subject of the external review.

24 (4) Does not have a history of disciplinary actions or sanctions, including
 25 loss of staff privileges or participation restrictions, that have been taken or are
 26 pending by any hospital, governmental agency or unit, or regulatory body that raise
 27 a substantial question as to the clinical peer's physical, mental, or professional
 28 competence or moral character.

29 C. In addition to the requirements specified in Subsection A of this Section,
 30 an independent review organization shall not own or control, be a subsidiary of, or

1 in any way be owned or controlled by, or exercise control with, a health benefit plan,
2 a national, state, or local trade association of health benefit plans, or a national, state,
3 or local trade association of health care providers.

4 D.(1) In addition to the requirements specified in Subsections A, B, and C
5 of this Section, in order to be approved pursuant to R.S. 22:2440 to conduct an
6 external review of a specified case, neither the independent review organization
7 selected to conduct the external review nor any clinical peer assigned by the
8 independent organization to conduct the external review may have a material
9 professional, familial, or financial conflict of interest with any of the following:

10 (a) The health insurance issuer that is the subject of the external review.

11 (b) The covered person whose treatment is the subject of the external review
12 or his authorized representative.

13 (c) Any officer, director, or management employee of the health insurance
14 issuer that is the subject of the external review.

15 (d) The health care provider, his medical group, or his independent practice
16 association recommending the health care service or treatment that is the subject of
17 the external review.

18 (e) The facility at which the recommended health care service or treatment
19 would be provided.

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

23 (2) In determining whether an independent review organization or a clinical
24 peer of the independent review organization has a material professional, familial, or
25 financial conflict of interest for purposes of Paragraph (1) of this Subsection, the
26 commissioner shall take into consideration situations in which the independent
27 review organization or clinical peer to be assigned by the independent review
28 organization to conduct an external review of a specified case may have such a
29 relationship or connection with a person specified in Paragraph (1) of this
30 Subsection, but that the characteristics of such relationship or connection are not a

1 material conflict of interest that would result in the disapproval of the independent
2 review organization or the clinical peer from conducting the external review.

3 E.(1) An independent review organization that is accredited by a nationally
4 recognized private accrediting entity that has independent review accreditation
5 standards that the commissioner has determined are equivalent to or exceed the
6 minimum qualifications of this Section shall be presumed in compliance with this
7 Section and be eligible for approval pursuant to R.S. 22:2440.

8 (2) The commissioner shall initially review and periodically review the
9 independent review organization accreditation standards of a nationally recognized
10 private accrediting entity to determine whether the entity's standards are, and
11 continue to be, equivalent to or exceed the minimum qualifications provided for in
12 this Section.

13 (3) Upon request, a nationally recognized private accrediting entity shall
14 make its current independent review organization accreditation standards available
15 to the commissioner in order for the commissioner to determine if the entity's
16 standards are equivalent to or exceed the minimum qualifications provided for in this
17 Section.

18 F. An independent review organization shall be unbiased. An independent
19 review organization shall establish and maintain written procedures to ensure that it
20 is unbiased in addition to any other procedures required by this Section.

21 §2442. Hold harmless for external review procedures

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

1 §2443. External review reporting requirements

2 A.(1) An independent review organization assigned pursuant to R.S. 22:2436
3 through 2438 to conduct an external review shall maintain written records in the
4 aggregate, by state, and by health insurance issuer on all requests for external review
5 for which it conducted an external review during a calendar year and, upon request,
6 submit a report to the commissioner, as required by Paragraph (2) of this Subsection.

7 (2) Each independent review organization required to maintain written
8 records on all requests for external review pursuant to Paragraph (1) of this
9 Subsection for which it was assigned to conduct an external review shall submit to
10 the commissioner an annual report. The annual report shall include each of the
11 following:

12 (a) The total number of requests for external review.

13 (b) The number of requests for external review resolved and their resolution.

14 (c) A synopsis of actions being taken to correct problems identified.

15 (3) The report shall include in the aggregate, by state, and for each health
16 insurance issuer:

17 (a) The total number of requests for external review.

18 (b) The number of requests for external review resolved and, of those
19 resolved, the number resolved upholding the adverse determination or final adverse
20 determination and the number resolved reversing the adverse determination or final
21 adverse determination.

22 (c) The average length of time for resolution.

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

25 (e) The number of external reviews conducted pursuant to R.S. 22:2436(G)
26 that were terminated as the result of a reconsideration by the health insurance issuer
27 of its adverse determination or final adverse determination after the receipt of
28 additional information from the covered person or his authorized representative.

29 (f) A general description for each request for external review including the
30 following:

- 1 (i) A general description of the reason for the request for external review.
- 2 (ii) The date received.
- 3 (iii) The date of each review.
- 4 (iv) The resolution.
- 5 (v) The date of the resolution.
- 6 (vi) The name of the covered person for whom the request for external
- 7 review was filed.
- 8 (g) Any other information that the commissioner may request or require.

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

11 B.(1) Each health insurance issuer shall maintain written records in the
 12 aggregate, by state, and for each type of health benefit plan offered by the health
 13 insurance issuer, for all requests for external review that the health insurance issuer
 14 receives notice of from the commissioner pursuant to this Part.

15 (2) Each health insurance issuer required to maintain written records on all
 16 requests for external review pursuant to Paragraph (1) of this Subsection shall submit
 17 to the commissioner, upon request, a report in the format specified by the
 18 commissioner.

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

- 21 (a) The total number of requests for external review.
- 22 (b) From the total number of requests for external review reported under
- 23 Subparagraph (a) of this Paragraph, the number of requests determined eligible for
- 24 an external review.
- 25 (c) Any other information the commissioner may request or require.

26 (4) The health insurance issuer shall retain the written records required
 27 pursuant to this Subsection for at least three years.

28 §2444. Funding of external review

29 The health insurance issuer against which a request for a standard external
 30 review or an expedited external review is filed shall pay the cost of the independent

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1 review organization for conducting the external review, and no fee or other charge
 2 may be levied upon a covered person for any costs of an external review.

3 §2445. Disclosure requirements

4 A.(1) Each health insurance issuer shall include a description of the external
 5 review procedures in or attached to the policy, certificate, membership booklet,
 6 outline of coverage, or other evidence of coverage that it provides to covered
 7 persons.

8 (2) The description required by Paragraph (1) of this Subsection shall be in
 9 a format prescribed by the commissioner.

10 B. The description required by Subsection A of this Section shall include a
 11 statement that informs covered persons of their right to file a request for an external
 12 review of an adverse determination or final adverse determination with the health
 13 insurance issuer. The statement may explain that an external review is available
 14 when the adverse determination or final adverse determination involves an issue of
 15 medical necessity, appropriateness, health care setting, level of care, or effectiveness.
 16 The statement shall include the telephone number and address of the commissioner.

17 C. In addition to the requirements of Subsection B of this Section, the
 18 statement shall inform covered persons that, when filing a request for an external
 19 review, they will be required to authorize the release of any of their medical records
 20 that may be required to be reviewed for the purpose of reaching a decision on the
 21 external review.

22 PART IV. COMPLIANCE, PENALTIES, AND OTHER

23 REGULATORY MATTERS

24 §2451. Confidentiality requirements

25 A health insurance issuer shall annually certify in writing to the
 26 commissioner that the utilization review program of the health carrier or its designee
 27 complies with all applicable state and federal law establishing confidentiality and
 28 reporting requirements.

1 §2452. Regulations; preemption

2 A. The commissioner may promulgate such rules and regulations as may be
 3 necessary or proper to carry out the provisions of this Chapter. Such rules and
 4 regulations shall be promulgated and adopted in accordance with the Administrative
 5 Procedure Act, R.S. 49:950 et seq.

6 B. If at any time a provision of this Chapter is in conflict with federal law or
 7 regulations promulgated pursuant to federal law, such a provision shall be preempted
 8 only to the extent necessary to avoid direct conflict with such federal law or
 9 regulations. The commissioner shall, pursuant to rule or regulation promulgated and
 10 adopted in accordance with the Administrative Procedure Act, subsequently
 11 administer and enforce this Chapter in a manner that conforms to such federal law
 12 or regulations.

13 §2453. Penalties; fines; cease and desist orders; grounds for suspension or
 14 revocation of licensure or certificate of authority

15 A. Whenever the commissioner has reason to believe that any health
 16 insurance issuer, utilization review organization, or independent review organization
 17 is not in full compliance with the provisions of this Chapter, he shall notify such
 18 person in accordance and compliance with the Administrative Procedure Act, R.S.
 19 49:950 et seq., and the commissioner shall, in accordance and compliance with such
 20 Act, issue and cause to be served an order requiring the health insurance issuer,
 21 utilization review organization, or independent review organization to cease and
 22 desist from any violation and order any one or more of the following:

23 (1) Payment of a monetary penalty of not more than five hundred dollars for
 24 each day that a determination was not made within the time frames established by
 25 this Chapter.

26 (2) Payment of a monetary penalty of not more than one thousand dollars for
 27 each and every act or violation, but not to exceed an aggregate penalty of one
 28 hundred thousand dollars; however, if the health insurance issuer, utilization review
 29 organization, or independent review organization knew or reasonably should have
 30 known that it was in violation of this Chapter, the penalty shall be not more than

1 twenty-five thousand dollars for each and every act or violation, but not to exceed
2 an aggregate penalty of two hundred fifty thousand dollars in any six-month period.

3 (3) Suspension or revocation of the license of the health insurance issuer's
4 certificate of authority to operate in this state or the license of a utilization review
5 organization, or withdrawal of the approval of the certification of an independent
6 review organization if the health insurance issuer, utilization review organization,
7 or independent review organization knew or reasonably should have known that it
8 was in violation of this Chapter.

9 B. Any health insurance issuer, licensed utilization review organization, or
10 certified independent review organization that violates a cease and desist order
11 issued by the commissioner pursuant to this Chapter while such order is in effect
12 shall be subject at the discretion of the commissioner to any one or more of the
13 following:

14 (1) A monetary penalty of not more than twenty-five thousand dollars for
15 each and every act or violation, not to exceed an aggregate of two hundred fifty
16 thousand dollars.

17 (2) Suspension or revocation of the health insurance issuer's certificate of
18 authority to operate in this state or the license of the utilization review organization
19 or withdrawal of the approval of the certification of the independent review
20 organization to operate in this state.

21 C. The commissioner may withdraw his approval of the certification of an
22 independent review organization, or the commissioner may suspend or revoke the
23 license of an utilization review organization or the authorization of a health
24 insurance issuer to act as an utilization review organization. In lieu of such
25 withdrawal of approval of its certification as an independent review organization,
26 the suspension or revocation of a license of an utilization review organization, or
27 revocation of a health insurance issuer's authority to act as an utilization review
28 organization, a fine may be imposed for each separate violation, not to exceed five
29 thousand dollars per violation, or twenty-five thousand dollars in the aggregate, if
30 the commissioner finds that the utilization review organization or the health

1 insurance issuer acting as an utilization review organization or the independent
 2 review organization has either:

3 (1) Used such method or practice that constitute an unfair trade practice,
 4 pursuant to Part IV of Chapter 7 of this Title, R.S. 22:1961 et seq., or that such
 5 conduct of its business renders determinations in this state made pursuant to this
 6 Chapter hazardous or injurious to covered persons or the public.

7 (2) Failed to comply with any provision of this Chapter.

8 D. An aggrieved party affected by the commissioner's decision, act, or order
 9 may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et
 10 seq.

11 E. Whenever the commissioner believes, from evidence satisfactory to him,
 12 that any utilization review organization, health insurance issuer acting as a utilization
 13 review organization, or independent review organization is violating or is about to
 14 violate any provision of this Chapter or any order or requirement of the
 15 commissioner issued or promulgated pursuant to authority granted to the
 16 commissioner by any provision of this Code or by law, he may bring an action in the
 17 District Court for the Nineteenth Judicial District, Baton Rouge, Louisiana, against
 18 such utilization review organization, health insurance issuer acting as a utilization
 19 review organization, or independent review organization to enjoin such utilization
 20 review organization, health insurance issuer acting as a utilization review
 21 organization, or independent review organization from continuing such violation or
 22 engaging therein or doing any act in furtherance thereof. In any such action, an order
 23 or judgment may be entered awarding such preliminary or final injunction as is
 24 proper.

25 Section 2. R.S. 22:821(B)(28) and Subpart F of Part III of Chapter 4 of Title 22 of
 26 the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1121 through 1144, are
 27 hereby repealed in their entirety.

1 Section 3. This Act shall become effective on January 1, 2015.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____