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.

INSURANCE/HEALTH: Provides relative to an internal claims and appeals process and external review procedures for health insurance issuers

AN ACT

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

Be it enacted by the Legislature of Louisiana:

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

§821. Fees

* * *

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

* * *

(36) Utilization review organization other than a health insurance issuer

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

(b) Annual report filing fee..... $ 500.00

(37) Independent review organization

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

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

* * *

CHAPTER 18. INTERNAL CLAIMS AND APPEALS PROCESS AND EXTERNAL REVIEW ACT

PART I. TITLE, DEFINITIONS, AND LICENSURE

§2391. Purpose; short title

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

B. The purpose of this Chapter is the following:

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

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

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

§2392. Definitions

As used in this Chapter:

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

(a) A determination by a health insurance issuer or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health insurance issuer's health benefit plan upon application of any utilization review technique does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.

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

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

(d) A rescission of coverage determination.

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

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

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

(a) A person to whom a covered person has given express written consent to represent the covered person for purposes of this Chapter. It may also include the covered person's treating provider if the covered person appoints the provider as his authorized representative and the provider waives in writing any right to payment from the covered person other than any applicable copayment or other coinsurance

amount. In the event that the service is determined not to be medically necessary, and the covered person or his authorized representatives, except for the covered person's treating health care professional, thereafter requests the services, nothing shall prohibit the provider from charging usual and customary charges for all non-medically necessary services provided.

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

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

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

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

(a) Randomized clinical trials.

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

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

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

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

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

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

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

(9) "Certification" or "certify" means a determination by a health insurance issuer or its designee utilization review organization that a request for a benefit under the health insurance issuer's health benefit plan has been reviewed and, based on the information provided, satisfies the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

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

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

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

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

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

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

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

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

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

(19) "Emergency medical condition" means a medical condition manifesting itself by symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) The following standard reference compendia:

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

(ii) Drug Facts and Comparisons.

(iii) The American Dental Association Accepted Dental Therapeutics.

(iv) The United States Pharmacopeia-Drug Information.

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

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

(ii) The National Institutes of Health.

(iii) The National Cancer Institute.

(iv) The National Academy of Sciences.

(v) The federal Centers for Medicare and Medicaid Services.

(vi) The federal Food and Drug Administration.

(vii) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services.

(f) Any other medical or scientific evidence that is comparable to the sources listed in Subparagraphs (a) through (e) of this Paragraph.

(35) "NAIC" means the National Association of Insurance Commissioners.

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

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

(38) "Protected health information" means either of the following:

(a) Health information that identifies an individual who is the subject of the information.

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

(39) "Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

(40) "Rescission" means cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. The term shall not include a cancellation or discontinuance of coverage under a health benefit plan if either:

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

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

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

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

(43) "Urgent care request" means:

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

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

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

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

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

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

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

§2393. Applicability and scope

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

§2394. Licensure as a utilization review organization

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

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

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

(1) Changes in control as defined in R.S. 22:691.2.

(2) Amendments to the articles of incorporation.

(3) Changes in officers and directors.

(4) Merger or consolidation of the utilization or independent review organization with any other person or entity.

(5) Use of a trade name in this state.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART II. INTERNAL CLAIMS AND APPEALS PROCESS

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

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

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

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

PART III. HEALTH INSURANCE ISSUER EXTERNAL REVIEW ACT

§2431. Short title

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

§2432. Purpose and intent

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

§2433. Notice of right to external review

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

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

(b) A final adverse determination.

(2) As part of the written notice required pursuant to Paragraph (1) of this Subsection, a health insurance issuer shall include the following, or substantially equivalent, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us. In order to request an external appeal, you should send your request in writing to our office at the designated address included in this notice."

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

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

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

(i) If the covered person has a medical condition for which the time frame for completion of an expedited review of a grievance involving an adverse determination as provided pursuant to R.S. 22:2401 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or his authorized representative may file a request for an expedited external review to be conducted pursuant to R.S. 22:2437. Further, the notice shall inform the covered person that an expedited external review pursuant to R.S. 22:2438 is available if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that any delay in appealing the adverse determination may pose an imminent and serious threat to the covered person's health, including but not limited to severe pain, potential loss of life, limb,

or major bodily function, or the immediate and serious deterioration of the health of the covered person. The notice shall also inform the covered person or his authorized representative that he may simultaneously file a request for an expedited review of a grievance involving an adverse determination as provided pursuant to R.S. 22:2401, but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review.

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

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

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

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

(aa) An admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been

discharged from a facility, the covered person or his authorized representative may request an expedited external review pursuant to R.S. 22:2437.

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

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

(3) As part of any forms provided under Paragraph (2) of this Subsection, the health insurance issuer shall include an authorization form, or other document approved by the commissioner that complies with the requirements of 45 CFR Section 164.508, by which the covered person, for purposes of conducting an external review under this Part, authorizes the health insurance issuer and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review, as further provided in this Paragraph. A health insurance issuer shall not use or disclose protected health information for any purpose other than in the performance of the health insurance issuer's functions,

except as otherwise permitted by state or federal law, including providing such information to an independent review organization as required by this Part.

§2434. Request for external review

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

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

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

§2435. Exhaustion of internal claims and appeals process

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

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

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

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

(3) Notwithstanding Paragraph (2) of this Subsection, a covered person or his authorized representative may not make a request for an external review of an

adverse determination involving a retrospective review determination made pursuant to R.S. 22:2401 until the covered person has exhausted the health insurance issuer's internal claims and appeals process.

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

(i) Pursuant to R.S. 22:2437, if the covered person has a medical condition in which the time frame for completion of an expedited review of the grievance involving an adverse determination made pursuant to R.S. 22:2401 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

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

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

(c) Upon a determination made pursuant to Subparagraph (b) of this Paragraph that the covered person must first complete the expedited grievance

review process as provided pursuant to R.S. 22:2401, the independent review organization shall immediately notify the covered person and his authorized representative of this determination and that the independent review organization will not proceed with the expedited external review provided for by R.S. 22:2437 until completion of the expedited grievance review process if the covered person's grievance at the completion of the expedited grievance review process remains unresolved.

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

(3) A request for an external review of an adverse determination may be made before the covered person has exhausted the health insurance issuer's internal grievance procedures as provided pursuant to R.S. 22:2401 whenever the health insurance issuer fails to adhere to requirements pursuant to R.S. 22:2401. Notwithstanding the provisions of this Subparagraph, the internal claims and appeals process will not be deemed exhausted based on de minimus violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the health insurance issuer demonstrates that the violation was for good cause or due to matters beyond the control of the health insurance issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the health insurance issuer and the claimant. This exception shall not be available if the violation is part of a pattern or practice of violations by the health insurance issuer.

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

§2436. Standard external review

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

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

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

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

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

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

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

(a) The request is complete.

(b) The request is eligible for external review.

(2) If the request:

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

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

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

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

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

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

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

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

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

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

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

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

E.(1) Within five business days after the date of receipt of the notice provided pursuant to Paragraph (D)(1) of this Section, the health insurance issuer or its utilization review organization shall provide to the assigned independent review

organization the documents and any information considered in making the adverse determination or final adverse determination.

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

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

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

F.(1) The assigned independent review organization shall review all of the information and documents received pursuant to Subsection E of this Section and any other information timely submitted in writing to the independent review organization by the covered person or his authorized representative pursuant to Paragraph (D)(3) of this Section.

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

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

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

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

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

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

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

(1) The covered person's medical records.

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

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

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

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

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

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

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

(a) The covered person.

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

(c) The health insurance issuer.

(d) The commissioner.

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

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

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

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

(d) The date of its decision.

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

(f) The rationale for its decision.

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

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

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

§2437. Expedited external review

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

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

(a) The adverse determination involves a medical condition of the covered person for which the time frame for completion of an expedited internal review of a grievance involving an adverse determination made pursuant to R.S. 22:2401 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

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

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

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

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

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

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

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

(3)(a) If the covered person or his authorized representative makes a written request to the commissioner of insurance after receipt of the notice of denial of an expedited external review, the commissioner may determine that a request is eligible for an expedited external review in accordance with the criteria found in R.S. 22:2436(B), notwithstanding a health insurance issuer's initial determination that the request is ineligible, and require that it be referred for external review.

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

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

(4) Immediately upon the health insurance issuer's determination that a request is eligible for an expedited external review or upon the determination by the commissioner that a request is eligible for an expedited external review, the health insurance issuer shall input a request for assignment of an independent review organization. Upon receipt of the notice that the request meets the reviewability requirements, the commissioner immediately shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to R.S. 22:2440. The commissioner shall immediately notify the health insurance issuer and the covered person or his authorized representative of the name and contact information of the assigned independent review organization.

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

C. Upon receipt of the notice from the commissioner of the name of the independent review organization assigned to conduct the expedited external review pursuant to Paragraph (B)(5) of this Section, the health insurance issuer or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically, by telephone or facsimile, or by any other available expeditious method.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A.(1) Within four months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to R.S. 22:2433 that involves a denial of coverage based on a determination that the health care service or

treatment recommended or requested is experimental or investigational, a covered person or his authorized representative may file a request for a standard and an expedited external review with the health insurance issuer, regardless of the claim amount.

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

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

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

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

(c)(i) If the covered person or his authorized representative makes a written request to the commissioner of insurance after receipt of the denial of an expedited external review, the commissioner may determine that a request is eligible for an expedited external review pursuant to Paragraph (B)(2) of this Section,

notwithstanding a health insurance issuer's initial determination the request is ineligible, and require that it be referred for an expedited external review.

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

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

(d) Immediately upon the health insurance issuer's determination that a request is eligible for an expedited external review or upon the determination by the commissioner that a request is eligible for an expedited external review, the health insurance issuer shall input a request for assignment of an independent review organization. Upon receipt of the notice that the expedited external review request meets the reviewability requirements of Paragraph (B)(2) of this Section, the commissioner shall immediately randomly assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by him pursuant to R.S. 22:2440 and notify the covered person or his authorized representative of the name and contact information of the assigned independent review organization.

(e) At the time that the health insurance issuer receives the notice of the assigned independent review organization pursuant to Subparagraph (e) of this Paragraph, the health insurance issuer or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically, by telephone or facsimile, or any other available expeditious method.

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

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

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

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

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

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

(c) There is no available standard health care service or treatment covered by the health insurance issuer that is more beneficial than the recommended or requested health care service or treatment specified in Subparagraph (d) of this Paragraph.

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

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

(b) Is a licensed, board-certified, or board-eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols

demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments.

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

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

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

(a) The request is complete.

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

(2) If the request:

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

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

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

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

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

(4)(a) If the covered person or his authorized representative makes a written request to the commissioner of insurance after receipt of the denial of a standard external review, the commissioner may determine that a request is eligible for a standard external review under Paragraph (B)(2) of this Section, notwithstanding a health insurance issuer's initial determination that the request is ineligible, and require that it be referred for a standard external review.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Immediately upon making the decision under Subparagraph (a) of this Paragraph, the independent review organization shall notify the covered person, his authorized representative, if applicable, the health insurance issuer, and the commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3)(a) For an expedited external review, each clinical peer shall provide an opinion orally or in writing containing the information outlined in Paragraph (2) of this Subsection to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances requires, but in no event more than five days after being selected in accordance with Subsection D of this Section.

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

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

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

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

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

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

(5) Either of the following:

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

(b) Whether medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person

than any available standard health care service or treatment and whether the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

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

(i) The covered person.

(ii) If applicable, his authorized representative.

(iii) The health insurance issuer.

(iv) The commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

(e) The date of its decision.

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

(g) The rationale for its decision.

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

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

§2439. Binding nature of external review decision

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

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

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

§2440. Approval of independent review organizations

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

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

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

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

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

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

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

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

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

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

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

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

§2441. Minimum qualifications for independent review organizations

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

(1) A quality assurance mechanism in place that:

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

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

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

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

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

(3) An agreement to maintain and provide to the commissioner the information provided for by R.S. 22:2443.

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

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

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

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

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

C. In addition to the requirements specified in Subsection A of this Section, an independent review organization shall not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with, a health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.

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

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

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

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

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

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

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

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

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

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

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

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

§2442. Hold harmless for external review procedures

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

§2443. External review reporting requirements

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

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

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

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

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

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

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

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

determination and the number resolved reversing the adverse determination or final adverse determination.

(c) The average length of time for resolution.

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

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

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

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

(ii) The date received.

(iii) The date of each review.

(iv) The resolution.

(v) The date of the resolution.

(vi) The name of the covered person for whom the request for external review was filed.

(g) Any other information that the commissioner may request or require.

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

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

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

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

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

(b) From the total number of requests for external review reported under Subparagraph (a) of this Paragraph, the number of requests determined eligible for an external review.

(c) Any other information the commissioner may request or require.

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

§2444. Funding of external review

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

§2445. Disclosure requirements

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

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

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

C. In addition to the requirements of Subsection B of this Section, the statement shall inform covered persons that, when filing a request for an external

review, they will be required to authorize the release of any of their medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

PART IV. COMPLIANCE, PENALTIES, AND OTHER REGULATORY MATTERS

§2451. Confidentiality requirements

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

§2452. Regulations; preemption

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

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

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

A. Whenever the commissioner has reason to believe that any health insurance issuer, utilization review organization, or independent review organization is not in full compliance with the provisions of this Chapter, he shall notify such person in accordance and compliance with the Administrative Procedure Act, R.S. 49:950 et seq., and the commissioner shall, in accordance and compliance with such Act, issue and cause to be served an order requiring the health insurance issuer,

utilization review organization, or independent review organization to cease and desist from any violation and order any one or more of the following:

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

(2) Payment of a monetary penalty of not more than one thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of one hundred thousand dollars; however, if the health insurance issuer, utilization review organization, or independent review organization knew or reasonably should have known that it was in violation of this Chapter, the penalty shall be not more than twenty-five thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of two hundred fifty thousand dollars in any six-month period.

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

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

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

(2) Suspension or revocation of the health insurance issuer's certificate of authority to operate in this state or the license of the utilization review organization

or withdrawal of the approval of the certification of the independent review organization to operate in this state.

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

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

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

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

E. Whenever the commissioner believes, from evidence satisfactory to him, that any utilization review organization, health insurance issuer acting as a utilization review organization, or independent review organization is violating or is about to violate any provision of this Chapter or any order or requirement of the commissioner issued or promulgated pursuant to authority granted to the commissioner by any provision of this Code or by law, he may bring an action in the District Court for the Nineteenth Judicial District, Baton Rouge, Louisiana, against

such utilization review organization, health insurance issuer acting as a utilization review organization, or independent review organization to enjoin such utilization review organization, health insurance issuer acting as a utilization review organization, or independent review organization from continuing such violation or engaging therein or doing any act in furtherance thereof. In any such action, an order or judgment may be entered awarding such preliminary or final injunction as is proper.

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

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

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

Cromer HB No. 645

Abstract: Deletes the existing medical necessity appeals process and external review process and replaces it with a utilization appeals process, grievance appeals process, internal review process, and external review procedures.

Present law generally establishes minimum standards required for entities that determine what medical services or procedures will be covered under a health benefit plan based on medical necessity. Designates such entities as medical necessity organizations (MNROs) and independent review organizations (IROs).

Proposed law revises these standards and additionally provides for grievances and review of adverse determinations not limited to those solely based on medical necessity, as follows:

(1) Present law requires the licensing of MNROs and requires IROs to be certified by the department.

Proposed law requires the licensing of any entity that conducts an utilization review (URO) unless it is a health insurance issuer, which must then be approved by the commissioner of insurance to conduct utilization review. Requires the approval by the commissioner of IROs. Additionally provides standards and criteria for an IRO.

(2) Present law requires a licensing fee of $1,500 and an annual report filing fee of $500 for MNROs other than health insurance issuers.

Proposed law instead requires an application fee of $1,500 licensing fee and an annual report filing fee of $500 for utilization review organizations (URO) other than health insurance issuers. Also provides for an application fee of $500 for a two-year approval of an IRO with an annual filing fee of $500.

(3) Proposed law deletes the existing medical necessity appeals process and external review process provided for in present law and replaces it with a utilization appeals process, grievance appeals process, and external review process. Establishes utilization and benefit determination procedures, standards, and criteria for the structure and operation of utilization review and benefit determination processes designed to facilitate ongoing assessment and management of health services. Also provides standards for the establishment and maintenance of procedures by health insurance issuers to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination. Provides uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination. Clarifies that proposed law relative to external reviews shall apply only to adverse determinations and final adverse determinations that involve medical necessity, appropriateness, health care setting, level of care, effectiveness, or a rescission.

(4) Present law, relative to internal reviews, establishes minimum standards for informal consideration and first level and second level appeals required for entities that determine what medical services or procedures will be covered under a health benefit plan based on medical necessity. Provides for informal reconsideration and a two-level internal appeals process all for review of adverse determinations based on a lack of medical necessity.

Proposed law requires that health insurance issuers shall implement effective processes for appeal of coverage determinations and claims pursuant to provisions of applicable federal law, the Public Health Services Act, as amended by the Patient Protection and Affordable Care Act (PPACA), and regulations promulgated pursuant to that law by the U. S. Department of Labor and the U. S. Department of Health and Human Services. Such federal law requires only one level of appeal in the internal grievance process, under new time frames consistent with federal law for making benefit determinations, which is now considered a utilization review. Expands such utilization review to include rescission, denial, or reduction in payment and eligibility issues. Provides for timely notification to health care providers and covered persons of health insurance issuers' determinations. Additionally establishes new procedures for a first level review of grievances involving an adverse determination, a standard review of grievances not involving an adverse determination, and a voluntary internal second level of review of grievances at the discretion of the covered person, which may include an adverse determination or a grievance not involving an adverse determination.

Proposed law further specifies that such appeal processes shall, at a minimum, have in effect an internal claims appeal process and provide notice to covered persons, in a culturally and linguistically appropriate manner, of available internal and external appeals processes and the availability of the office of consumer advocacy of the state's Department of Insurance to assist such persons with the appeals process

(5) Present law provides for an expedited internal appeal for emergency services.

Proposed law, pursuant to applicable federal law and regulations, adds an expedited internal appeal for urgent care requests.

(6) Present law requires that a request for internal review be filed by the covered person within 60 days of receipt of an adverse determination.

Proposed law, pursuant to applicable federal law and regulations, allows for at least 180 days to file a request for internal review after the receipt of notice of an adverse benefit determination. Also allows four months to file a request for an external appeal of a final adverse benefit determination.

(7) Present law provides for an expedited external appeal for emergency services or investigational or experimental services.

Proposed law additionally provides for an expedited external appeal for urgent care requests.

(8) Present law restricts requests for an internal or external review of experimental or investigational appeals to a minimum claim of $500 before being eligible for external review.

Proposed law provides that a covered person may make a request, regardless of the claim amount, for any type of external review.

(9) Present law provides that unless the covered person has an emergency medical condition or the MNRO agrees to waive the requirements for the first level appeal, the second level appeal, or both, then the MNRO shall not be required to grant a request for an external review until the second level appeal process has been exhausted.

Proposed law, pursuant to applicable federal law and regulations, states that if exhaustion of internal appeals is required prior to external review, exhaustion shall be unnecessary if: (a) the health insurance issuer waives the exhaustion requirement; (b) the issuer is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process except those failures that are based on de minimus violations that do not cause, and are not likely to cause, prejudice, or harm to the covered person; or (c) the covered person simultaneously requests an expedited internal appeal and an expedited external review when the covered person has a medical condition when any delay in appealing the adverse determination may pose an imminent and serious threat to the covered person's health, including but not limited severe pain, potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the covered person.

(10) Present law is silent on the issue of which person or entity shall be responsible for the cost of an external review.

Proposed law provides that the cost of an IRO for conducting an external review shall be paid by the health insurance issuer against which a request for such review is filed.

(11) Present law requires that a request for an external review be filed by the covered person within 60 days of receipt of the second level appeal adverse determination.

Proposed law, pursuant to applicable federal law and regulations, allows four months to file a request for external review after the receipt of notice of an adverse benefit determination or final internal adverse benefit determination.

(12) Present law requires an MNRO to provide covered persons with a notice explaining their rights to an external review.

Proposed law requires that health insurance issuers include a description of the external review procedures in their materials provided to covered persons, including a statement that informs such persons' of their rights to an external review.

(13) Present law requires a health insurance issuer to provide for an independent review process to examine its coverage decisions based on medical necessity and requires the MNRO to forward documents and any information used in making the second level appeal adverse determination to its designated IRO.

Proposed law requires that an IRO be assigned to an external review by the commissioner on a random basis. Provides for the impartiality of the IRO and clinical peers conducting the external review. Further provides with respect to the information submitted to the IRO.

(14) Present law requires that an IRO hold a nonrestricted license in a state of the U.S. and, in the case of a physician, hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review. Does not require an IRO to be accredited by a nationally recognized private accrediting organization.

Proposed law requires that the process for assigning the IRO provide for the maintenance of a list by the commissioner of approved IROs (only those that are accredited by a nationally recognized private accrediting organization) qualified to conduct the external review, based on the nature of the health care service that is the subject of the review. Further requires that any clinical peer assigned to an external review by an IRO hold an unrestricted license in a state of the United States. Provides for the avoidance of conflicts of interest by an IRO or a clinical peer assigned by an IRO to conduct an external review.

(15) Present law requires an IRO to review all information and documents received and any other information submitted in writing by a covered person or the covered person's health care provider.

Proposed law provides that a covered person must be allowed to submit information to the IRO which the IRO must consider, if timely submitted, when conducting the external review, and the covered person must be notified of the right to submit additional information to the IRO. Additionally requires that the IRO allow the covered person at least five business days to submit any additional information and any additional information submitted by the covered person must be forwarded to the health insurance issuer within one business day of receipt by the IRO.

(16) Present law provides that a covered person's health care provider may request an expedited external review at the time that he receives an adverse determination involving an emergency medical condition. Within 72 hours after receiving appropriate medical information, requires the IRO to make a decision to uphold or reverse the adverse determination and notify the covered person, the MNRO, and the covered person's health care provider of the decision.

Proposed law requires that the process provide for an expedited external review in certain circumstances and, in such cases, provide notice of the decision as expeditiously as possible, but not later than 72 hours after receipt of the request for external review. Provides that if notice of the IRO's decision is not in writing, the IRO must provide written confirmation of its decision within 48 hours after the date of the notice of the decision.

(17) Proposed law provides that no IRO, clinical peer working on its behalf, or its employee, agent, or contractor shall be liable in damages to any person for opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under proposed law during or upon completion of an external review, unless the opinion was rendered or act or omission was performed in bad faith or involved negligence or gross negligence.

(18) Present law provides that an MNRO shall maintain written records in the aggregate and by health insurance issuer and health benefit plan on all requests for external review for which an external review was conducted during a calendar year, referred to as the "register".

Proposed law requires an IRO to maintain written records in the aggregate, by state, and by health insurance issuer on all requests for external review for which it conducted an external review during a calendar year and, upon request, to submit a report to the commissioner. Also requires submission of an annual report to the commissioner.

(19) Proposed law requires health insurance issuers to provide a description of the external review process in or attached to the summary plan descriptions, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons.

(20) Proposed law makes all external review decisions binding on the health insurance issuer and the covered person except to the extent that either has other remedies available under applicable federal or state law.

(21) Proposed law provides that if at any time any of its provisions is in conflict with federal law or applicable regulations, such a provision shall be preempted only to the extent necessary to avoid direct conflict with such federal law or regulations. Further provides that the commissioner shall, pursuant to rule or regulation promulgated and adopted in accordance with the Administrative Procedure Act, subsequently administer and enforce proposed law in a manner that conforms to such federal law or regulations.

(22) Present law provides for penalties to be imposed by the commissioner for violations of present law, including fines and suspension or revocation of licensure.

Proposed law provides for penalties to be imposed by the commissioner for violations of proposed law, including fines or suspension or revocation of licensure or approval, as well as granting him cease and desist authority and the authority to bring a cause of action in the 19th Judicial District Court.

Effective January 1, 2015.

(Adds R.S. 22:821(B)(36) and (37) and 2391- 2453; Repeals R.S. 22:821(B)(28) and 1121-1144)

Summary of Amendments Adopted by House

Committee Amendments Proposed by House Committee on Insurance to the original bill.

1. Defined" immediately" for purposes of proposed law as expeditiously as the medical situation of the covered person requires but in no event longer than one day for expedited reviews or one business day for standard reviews.

2. Clarified that proposed law relative to external reviews shall apply only to adverse determinations and final adverse determinations that involve medical necessity, appropriateness, health care setting, level of care, effectiveness, or a recission and not to those involving contractual disputes between a health insurance issuer and an insured.

3. Provided more specific language for situations in which a covered person may request an expedited external review, limiting it to those situations in which the treating physician certifies in writing that any delay in appealing the adverse determination may pose an imminent and serious threat to the covered person's health, including but not limited to severe pain, potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the covered person.

4. Specified minimum requirements which health insurance issuers' appeals processes must meet, including providing notice to covered persons of available internal and external appeals processes and the availability of the office of consumer advocacy of the state's Department of Insurance to assist such persons with the appeals process.

5. Clarified that an URO or a health insurance issuer acting as an URO may transmit protected health information to an IRO without breaching confidentiality laws.

6. Removed the requirement for notice by health insurance issuers to the commissioner of insurance in certain appeals situations when no subsequent action is required of the commissioner.

7. Provided that any appeal of eligibility for an external review heard by the commissioner shall be limited to applicable provisions of proposed law, including the standards by which a health insurance issuer determines eligibility, but not including the terms of the covered person's benefit plan.

8. Clarified that if a covered person submits information to an IRO for consideration during an external review, the IRO is only required to consider such information that is timely filed.

9. Deleted language which gave a covered person or his health care providers a cause of action for benefits or damages against an URO, health insurance issuer, health benefit plan, or IRO for any action involving a decision made pursuant to proposed law if the determination or opinion was rendered in bad faith or involved negligence, gross negligence, or intentional misrepresentation of factual information about the covered person's medical condition.

10. Added language relative to preemption of any provision of proposed law and the enforcement authority of the commissioner.

11. Changed the effective date from January 1, 2014, to January 1, 2015.