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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2018

A N A C T

RELATING TO INSURANCE -- BENEFIT DETERMINATION AND UTILIZATION REVIEW ACT

Introduced By: Representatives Ajello, Jacquard, Shekarchi, Kazarian, and Vella-Wilkinson
Date Introduced: April 04, 2018

Referred To: House Health, Education & Welfare

It is enacted by the General Assembly as follows:

SECTION 1. Sections 27-18.9-7 and 27-18.9-8 of the General Laws in Chapter 27-18.9 entitled "Benefit Determination and Utilization Review Act [Effective January 1, 2018.]" are hereby amended to read as follows:

27-18.9-7. Internal appeal procedural requirements. [Effective January 1, 2018.].

(a) Administrative and non-administrative appeals. The review agent shall conform to the following for the internal appeal of administrative or non-administrative, adverse benefit determinations:

(1) The review agent shall maintain and make available a written description of its appeal procedures by which either the beneficiary or the provider of record may seek review of determinations not to authorize health care services.

(2) The process established by each review agent may include a reasonable period within which an appeal must be filed to be considered and that period shall not be less than one hundred eighty (180) calendar days after receipt of the adverse benefit determination notice.

(3) During the appeal, a review agent may utilize a reconsideration process in assessing an adverse benefit determination. If utilized, the review agent shall develop a reasonable reconsideration and appeal process, in accordance with this section. For non-administrative, adverse benefit determinations, the period for the reconsideration may not exceed fifteen (15) days from the date the request for reconsideration or appeal is received. The review agent shall

notify the beneficiary and/or provider of the reconsideration determination with the form and content described in § 27-18.9-6(b), as appropriate. Following the decision on reconsideration, the beneficiary and/or provider shall have a period of forty-five (45) calendar days during which the beneficiary and/or provider may request an appeal of the reconsideration decision and/or submit additional information.

(4) Prior to a final internal appeal decision, the review agent must allow the claimant to review the entire adverse determination and appeal file and allow the claimant to present evidence and/or additional testimony as part of the internal appeal process.

(5) A review agent is only entitled to request and review information or data relevant to the benefit determination and utilization review processes.

(6) The review agent shall maintain records of written adverse benefit determinations, reconsiderations, appeals and their resolution, and shall provide reports as requested by the office.

(7) (i) The review agent shall notify, in writing, the beneficiary and/or provider of record of its decision on the administrative appeal in no case later than thirty (30) calendar days after receipt of the request for the review of an adverse benefit determination for pre-service claims, and sixty (60) days for post-service claims, commensurate with 29 C.F.R. § 2560.503-1(i)(2)(ii) and (iii).

(ii) The review agent shall notify, in writing, the beneficiary and provider of record of its decision on the non-administrative appeal as soon as practical considering medical circumstances, but in no case later than thirty (30) calendar days after receipt of the request for the review of an adverse benefit determination, inclusive of the period to conduct the reconsideration, if any. The timeline for decision on appeal is paused from the date on which the determination on reconsideration is sent to the beneficiary and/or provider and restarted when the beneficiary and/or provider submits additional information and/or a request for appeal of the reconsideration decision.

(8) The review agent shall also provide for an expedited appeal process for urgent and emergent situations taking into consideration medical exigencies. Notwithstanding any other provision of this chapter, each review agent shall complete the adjudication of expedited appeals, including notification of the beneficiary and provider of record of its decision on the appeal, not later than seventy-two (72) hours after receipt of the claimant's request for the appeal of an adverse benefit determination.

(9) Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The review agent or health care entity is required to continue coverage pending the outcome of an appeal.

(10) A review agent may not disclose or publish individual medical records or any confidential information obtained in the performance of benefit determination or utilization review activities. A review agent shall be considered a third-party health insurer for the purposes of § 5-37.3-6(b)(6) and shall be required to maintain the security procedures mandated in § 5-37.3-4(c).

(b) Non-administrative appeals. In addition to subsection (a) of this section the utilization review agent shall conform to the following for its internal appeals adverse benefit determinations:

(1) A claimant is deemed to have exhausted the internal claims appeal process when the utilization review agent or health care entity fails to strictly adhere to all benefit determination and appeal processes with respect to a claim. In this case the claimant may initiate an external appeal or remedies under section 502(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq., or other state and federal law, as applicable.

(2) No reviewer under this section, who has been involved in prior reviews or in the adverse benefit determination under appeal or who has participated in the direct care of the beneficiary, may participate in reviewing the case under appeal.

(3) All internal-level appeals of utilization review determinations not to authorize a health care service that had been ordered by a physician, dentist, or other provider shall be made according to the following:

(i) The reconsideration decision of a non-administrative, adverse benefit determination shall not be made until the utilization review agent's professional provider with the same licensure status as typically manages the condition, procedure, treatment, or requested service under discussion, and which professional is a physician or dentist who is licensed, certified, or otherwise formally recognized as a specialist in the field of health care services or problem being reviewed, has spoken to, or otherwise provided for, an equivalent two-way, direct communication with the beneficiary's attending physician, dentist, other professional provider, or other qualified professional provider responsible for treatment of the beneficiary concerning the services under review.

(ii) A review agent who does not utilize a reconsideration process must comply with the peer-review obligation described in subsection (b)(3)(i) of this section as part of the appeal process.

(iii) When the appeal of any adverse benefit determination, including an appeal of a reconsideration decision, is based in whole or in part on medical judgment, including determinations with regard to whether a particular service, treatment, drug, or other item is

experimental, investigational or not medically necessary or appropriate, the reviewer making the appeal decision must be ~~appropriately trained having the same licensure status as the ordering provider or be~~ a physician or dentist and be in the same or similar specialty as typically manages the condition, and be licensed, certified, or otherwise formally recognized as a specialist in the field of health care services or problem being reviewed. These qualifications must be provided to the claimant upon request.

(iv) The utilization review agency reviewer must document and sign their decisions.

(4) The review agent must ensure that an appropriately licensed practitioner or licensed physician is reasonably available to review the case as required under this subsection (b) and shall conform to the following:

(i) Each agency peer reviewer shall have access to and review all necessary information as requested by the agency and/or submitted by the provider(s) and/or beneficiaries;

(ii) Each agency shall provide accurate peer review contact information to the provider at the time of service, if requested, and/or prior to such service, if requested. This contact information must provide a mechanism for direct communication with the agency's peer reviewer; and

(iii) Agency peer reviewers shall respond to the provider's request for a two-way, direct communication defined in this subsection (b) as follows:

(A) For a prospective review of non-urgent and non-emergent health care services, a response within one business day of the request for a peer discussion;

(B) For concurrent and prospective reviews of urgent and emergent health care services, a response within a reasonable period of time of the request for a peer discussion; and

(C) For retrospective reviews, prior to the internal-level appeal decision.

(5) The review agency will have met the requirements of a two-way, direct communication, when requested and/or as required prior to the internal level of appeal, when it has made two (2) reasonable attempts to contact the attending provider directly. Repeated violations of this section shall be deemed to be substantial violations pursuant to § 27-18.9-9 and shall be cause for the imposition of penalties under that section.

(6) For the appeal of an adverse benefit determination decision that a drug is not covered, the review agent shall complete the internal-appeal determination and notify the claimant of its determination:

(i) No later than seventy-two (72) hours following receipt of the appeal request; or

(ii) No later than twenty-four (24) hours following the receipt of the appeal request in cases where the beneficiary is suffering from a health condition that may seriously jeopardize the

beneficiary's life, health, or ability to regain maximum function or when an beneficiary is undergoing a current course of treatment using a non-formulary drug.

(iii) And if approved on appeal, coverage of the non-formulary drug must be provided for the duration of the prescription, including refills unless expedited then for the duration of the exigency.

(7) The review agents using clinical criteria and medical judgment in making utilization review decisions shall comply with the following:

(i) The requirement that each review agent shall provide its clinical criteria to OHIC upon request;

(ii) Provide and use written clinical criteria and review procedures established according to nationally accepted standards, evidence-based medicine and protocols that are periodically evaluated and updated or other reasonable standards required by the commissioner;

(iii) Establish and employ a process to incorporate and consider local variations to national standards and criteria identified herein including without limitation, a process to incorporate input from local participating providers; and

(iv) Updated description of clinical decision criteria to be available to beneficiaries, providers, and the office upon request and readily available accessible on the health care entity or the review agent's website.

(8) The review agent shall maintain records of written, adverse benefit determination reconsiderations and appeals to include their resolution, and shall provide reports and other information as requested by the office.

27-18.9-8. External appeal procedural requirements. [Effective January 1, 2018.].

(a) General requirements.

(1) In cases where the non-administrative, adverse benefit determination or the final internal level of appeal to reverse a non-administrative, adverse benefit determination is unsuccessful, the health care entity or review agent shall provide for an external appeal by an independent review organization (IRO) approved by the commissioner and ensure that the external appeal complies with all applicable laws and regulations. Provided, the independent review must be conducted by a licensed physician or dentist who is licensed , certified, or otherwise formally recognized as a specialist in the field of the health care services or the problem being reviewed

(2) In order to seek an external appeal, claimant must have exhausted the internal claims and appeal process unless the utilization review agent or health care entity has waived the internal appeal process by failing to comply with the internal appeal process or the claimant has applied

for expedited external review at the same time as applying for expedited internal review.

(3) A claimant shall have at least four (4) months after receipt of a notice of the decision on a final internal appeal to request an external appeal by an IRO.

(4) Health care entities and review agents must use a rotational IRO registry system specified by the commissioner, and must select an IRO in the rotational manner described in the IRO registry system.

(5) A claimant requesting an external appeal may be charged no more than a twenty-five dollar ($25.00) external appeal fee by the review agent. The external appeal fee, if charged, must be refunded to the claimant if the adverse benefit determination is reversed through external review. The external appeal fee must be waived if payment of the fee would impose an undue financial hardship on the beneficiary. In addition, the annual limit on external appeal fees for any beneficiary within a single plan year (in the individual market, within a policy year) must not exceed seventy-five dollars ($75.00). Notwithstanding the aforementioned, this subsection shall not apply to excepted benefits as defined in 42 U.S.C. § 300gg-91(c).

(6) IRO and/or the review agent and/or the health care entity may not impose a minimum dollar amount of a claim for a claim to be eligible for external review by an IRO.

(7) The decision of the external appeal by the IRO shall be binding on the health care entity and/or review agent; however, any person who is aggrieved by a final decision of the external appeal agency is entitled to judicial review in a court of competent jurisdiction.

(8) The health care entity must provide benefits (including making payment on the claim) pursuant to an external review decision without delay regardless whether the health care entity or review agent intends to seek judicial review of the IRO decision.

(9) The commissioner shall promulgate rules and regulations including, but not limited to, criteria for designation, operation, policy, oversight, and termination of designation as an IRO. The IRO shall not be required to be certified under this chapter for activities conducted pursuant to its designation.

(b) The external appeal process shall include, but not be limited to, the following characteristics:

(1) The claimant must be noticed that he/she shall have at least five (5) business days from receipt of the external appeal notice to submit additional information to the IRO.

(2) The IRO must notice the claimant of its external appeal decision to uphold or overturn the review agency decision:

(i) No more than ten (10) calendar days from receipt of all the information necessary to complete the external review and not greater than forty-five (45) calendar days after the receipt of

the request for external review; and

(ii) In the event of an expedited external appeal by the IRO for urgent or emergent care, as expeditiously as possible and no more than seventy-two (72) hours after the receipt of the request for the external appeal by the IRO. Notwithstanding provisions in this section to the contrary, this notice may be made orally but must be followed by a written decision within forty-eight (48) hours after oral notice is given.

(3) For an external appeal of an internal appeal decision that a drug is not covered, the IRO shall complete the external appeal determination and notify the claimant of its determination:

(i) No later than seventy-two (72) hours following receipt of the external appeal request; or

(ii) No later than twenty-four (24) hours following the receipt of the external appeal request if the original request was an expedited request; and

(iii) If approved on external appeal, coverage of the non-formulary drug must be provided for the duration of the prescription, including refills, unless expedited then for the duration of the exigencies.

(c) External appeal decision notifications. The health care entity and review agent must ensure that the IRO adheres to the following relative to decision notifications:

(1) May be written or electronic with reasonable assurance of receipt by claimant unless urgent or emergent. If urgent or emergent, oral notification is acceptable followed by written or electronic notification within three (3) calendar days;

(2) Must be culturally and linguistically appropriate;

(3) The details of claim that is being denied to include the date of service, provider name, amount of claim, diagnostic code, and treatment costs with corresponding meanings;

(4) Must include the specific reason or reasons for the external appeal decision;

(5) Must include information for claimant as to procedure to obtain copies of any and all information relevant to the external appeal which copies must be provided to the claimant free of charge; and

(6) Must not be written in a manner that could reasonably be expected to negatively impact the beneficiary.

SECTION 2. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- BENEFIT DETERMINATION AND UTILIZATION REVIEW ACT

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This act would provide that both internal and external reviews of health insurance benefit determinations as to insurance coverage would be conducted by a licensed physician or dentist who is licensed, certified, or otherwise formally recognized as a specialist in the field of the health care services or the problems being reviewed.

This act would take effect upon passage.

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