

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 131

BY BUSINESS COMMITTEE

AN ACT

1 RELATING TO THE IDAHO HEALTH CARRIER EXTERNAL REVIEW ACT; AMENDING SECTION
2 41-5903, IDAHO CODE, TO REVISE DEFINITIONS; AMENDING SECTION 41-5904,
3 IDAHO CODE, TO REMOVE LANGUAGE RELATING TO CERTAIN FINAL ADVERSE BENE-
4 FIT DETERMINATIONS AND TO MAKE A TECHNICAL CORRECTION; AMENDING SECTION
5 41-5905, IDAHO CODE, TO REVISE PROVISIONS RELATING TO NOTICE OF THE
6 RIGHT TO AN EXTERNAL REVIEW; AMENDING SECTION 41-5906, IDAHO CODE, TO
7 REMOVE PROVISIONS RELATING TO THE DUTY OF THE DIRECTOR TO PRESCRIBE
8 A CERTAIN RULE AND TO CORRECT A CODIFIER'S ERROR; AMENDING SECTION
9 41-5907, IDAHO CODE, TO REVISE PROVISIONS RELATING TO THE EXHAUSTION OF
10 THE INTERNAL GRIEVANCE PROCESS; AMENDING SECTION 41-5908, IDAHO CODE,
11 TO REVISE AND TO PROVIDE ADDITIONAL PROVISIONS RELATING TO A STANDARD
12 EXTERNAL REVIEW AND TO PROVIDE CORRECT TERMINOLOGY; AMENDING SECTION
13 41-5909, IDAHO CODE, TO REVISE PROVISIONS RELATING TO AN EXPEDITED
14 EXTERNAL REVIEW; AMENDING SECTION 41-5915, IDAHO CODE, TO REMOVE PRO-
15 VISIONS RELATING TO THE AUTHORITY OF THE DIRECTOR TO PROVIDE BY RULE
16 FOR A CERTAIN FEE; AND AMENDING SECTION 41-5916, IDAHO CODE, TO PROVIDE
17 ADDITIONAL DISCLOSURE REQUIREMENTS.
18

19 Be It Enacted by the Legislature of the State of Idaho:

20 SECTION 1. That Section 41-5903, Idaho Code, be, and the same is hereby
21 amended to read as follows:

22 41-5903. DEFINITIONS. For purposes of this chapter:

23 (1) "Administrative record" means all nonprivileged documents,
24 records or other health information which was submitted, considered, gener-
25 ated or relied upon by the health carrier in the course of making the adverse
26 benefit determination, including, but not limited to, documents, records
27 or other information that constitutes the plan's policy statements or guid-
28 ance concerning the denied treatment or benefit, all records provided by the
29 covered person or the covered person's medical care provider related to the
30 denied treatment or benefit, all records provided to an independent review
31 organization as part of the independent review of the denied treatment or
32 benefit and the opinion issued by the independent review organization.

33 (2) "Adverse benefit determination" means a determination by a health
34 carrier or its designee utilization review organization that an admission,
35 availability of care, continued stay or other health care service that is a
36 covered benefit has been reviewed and, based upon the information provided,
37 does not meet the health carrier's requirements for medical necessity, ap-
38 propriateness, health care setting, level of care, effectiveness or has been
39 determined to be an investigational service, and the requested service or
40 payment for the service is therefore terminated, denied or reduced.

41 (3) "Ambulatory review" means utilization review of health care ser-
42 vices performed or provided in an outpatient setting.

- 1 (4) "Authorized representative" means:
2 (a) A person to whom a covered person has given express written consent
3 to represent the covered person in an external review;
4 (b) A person authorized by law to provide substituted consent for a cov-
5 ered person; or
6 (c) A family member of the covered person or the covered person's treat-
7 ing health care professional only when the covered person is unable to
8 provide consent.
9 (5) "Best evidence" means evidence based on randomized clinical tri-
10 als.
11 (a) If randomized clinical trials are not available, then cohort stud-
12 ies or case-control studies;
13 (b) If studies in paragraph (a) of this subsection (5) are not avail-
14 able, then case-series.
15 (6) "Case-control study" means a retrospective evaluation of two (2)
16 groups of patients with different outcomes to determine which specific in-
17 terventions the patients received.
18 (7) "Case management" means a coordinated set of activities conducted
19 for individual patient management of serious, complicated, protracted or
20 other health conditions.
21 (8) "Case-series" means an evaluation of a series of patients with a
22 particular outcome, without the use of a control group.
23 (9) "Certification" means a determination by a health carrier or its
24 designee utilization review organization that an admission, availability
25 of care, continued stay or other health care service has been reviewed and,
26 based on the information provided, satisfies the health carrier's require-
27 ments for medical necessity, appropriateness, health care setting, level of
28 care and effectiveness.
29 (10) "Clinical review criteria" means the written screening proce-
30 dures, decision abstracts, clinical protocols and practice guidelines used
31 by a health carrier to determine the necessity and appropriateness of health
32 care services.
33 (11) "Cohort study" means a prospective evaluation of two (2) groups of
34 patients with only one (1) group of patients receiving a specific interven-
35 tion(s).
36 (12) "Concurrent review" means utilization review conducted during a
37 patient's hospital stay or course of treatment.
38 (13) "Covered benefits" or "benefits" means those health care services
39 to which a covered person is entitled under the terms and conditions of a
40 health benefit plan.
41 (14) "Covered person" means a policyholder, subscriber, enrollee or
42 other individual participating in a health benefit plan. A covered person
43 includes the authorized representative of the covered person.
44 (15) "Director" means the director of the Idaho department of insur-
45 ance.
46 (16) "Discharge planning" means the formal process for determining,
47 prior to discharge from a facility, the coordination and management of the
48 care that a patient receives following discharge from a facility.

1 (17) "Disclose" means to release, transfer or otherwise divulge pro-
2 tected health information to any person other than the individual who is the
3 subject of the protected health information.

4 (18) "Evidence-based standard" means the conscientious, explicit and
5 judicious use of the current best evidence based on the overall systematic
6 review of the research in making decisions about the care of individual pa-
7 tients.

8 (19) "Expedited external review" is the procedure available for urgent
9 care requests for external review.

10 (20) "Expert" means a specialist with experience in a specific area
11 about the scientific evidence pertaining to a particular service, interven-
12 tion or therapy.

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

18 (22) "Final adverse benefit determination" means an adverse benefit
19 determination, as defined in section 41-5903(2), Idaho Code, involving a
20 covered benefit that has been upheld by a health carrier, or its designee
21 utilization review organization, at the completion of the health carrier's
22 internal grievance process procedures as set forth in the covered person's
23 health benefit plan.

24 (23) "Health benefit plan" means a policy, contract, certificate or
25 agreement offered or issued by a health carrier to provide, deliver, arrange
26 for, pay for or reimburse any of the costs of health care services.

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

30 (25) "Health care provider" or "provider" means a health care profes-
31 sional or a facility.

32 (26) "Health care services" means services for the diagnosis, preven-
33 tion, treatment, cure or relief of a health condition, illness, injury or
34 disease.

35 (27) "Health carrier" means an entity subject to the insurance laws and
36 regulations of this state, or subject to the jurisdiction of the director,
37 that contracts or offers to contract to provide, deliver, arrange for, pay
38 for or reimburse any of the costs of health care services, including a dis-
39 ability insurance company, a health maintenance organization, a nonprofit
40 hospital and health service corporation, or any other entity providing a
41 plan of health insurance, health benefits or health care services.

42 (28) "Health information" means information or data, whether oral or
43 recorded in any form or medium, and personal facts or information about
44 events or relationships that relates to:

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

47 (b) The provision of health care services to an individual; or

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

49 (29) "Independent review organization" means an entity that conducts
50 independent external reviews of final adverse benefit determinations.

1 (30) "Investigational" means the definition provided in the covered
2 person's health benefit plan; if the health benefit plan does not provide
3 a definition of "investigational," it shall be defined as follows: Any
4 treatment, procedure, facility, equipment, drug, device or commodity, re-
5 gardless of its medical necessity, which is experimental, or in the early
6 developmental stage of medical technology, for which there are no randomized
7 clinical trials or, absent such trials, for which there are no cohort studies
8 or case-control studies or, absent such studies, then for which there is no
9 case-series. The determination by the health carrier will be based on ob-
10 jective data and information obtained by the health carrier and reviewed, by
11 competent medical personnel, according to the following:

12 (a) The technology has final approval from the appropriate government
13 regulatory bodies;

14 (b) Medical or scientific evidence regarding the technology is suf-
15 ficiently comprehensive to permit well substantiated conclusions
16 concerning the safety and effectiveness of the technology;

17 (c) The technology's overall beneficial effects on health outweigh the
18 overall harmful effects on health; and

19 (d) The technology is as beneficial as any established alternative.

20 When used under the usual conditions of medical practice, the technology
21 should be reasonably expected to satisfy the criteria of paragraphs (c) and
22 (d) of this subsection (30).

23 (31) "Medically necessary" or "~~M~~medical necessity" means the defini-
24 tion provided in the covered person's health benefit plan; if the covered
25 person's health benefit plan does not define "medically necessary" or "med-
26 ical necessity," these terms shall mean health care services and supplies
27 that a physician or other health care provider, exercising prudent clinical
28 judgment, would provide to a covered person for the purpose of preventing,
29 evaluating, diagnosing or treating an illness, injury, disease or its symp-
30 toms, and that are:

31 (a) In accordance with generally accepted standards of medical prac-
32 tice;

33 (b) Clinically appropriate, in terms of type, frequency, extent, site
34 and duration, and considered effective for the covered person's ill-
35 ness, injury or disease;

36 (c) Not primarily for the convenience of the covered person, physician
37 or other health care provider; and

38 (d) Not more costly than an alternative service or sequence of services
39 or supply, and at least as likely to produce equivalent therapeutic or
40 diagnostic results as to the diagnosis or treatment of the covered per-
41 son's illness, injury or disease.

42 For these purposes, "generally accepted standards of medical practice"
43 means standards that are based on credible medical or scientific evidence.

44 (32) "Medical or scientific evidence" means evidence found in the fol-
45 lowing sources:

46 (a) Peer-reviewed scientific studies published in or accepted for
47 publication by medical journals that meet nationally recognized re-
48 quirements for scientific manuscripts and that submit most of their
49 published articles for review by experts who are not part of the edito-
50 rial staff;

1 (b) Peer-reviewed medical literature, including literature relating
2 to therapies reviewed and approved by a qualified institutional review
3 board, biomedical compendia and other medical literature that meet the
4 criteria of the national institutes of health's library of medicine for
5 indexing in index medicus (MEDLINE) and elsevier science ltd. for in-
6 dexing in excerpta medicus (EMBASE);

7 (c) Medical journals recognized by the U.S. secretary of health and
8 human services under section 1861(t) (2) of the federal social security
9 act;

10 (d) The following standard reference compendia:

- 11 (i) The American hospital formulary service -- drug information;
12 (ii) Drug facts and comparisons;
13 (iii) The United States pharmacopoeia -- drug information; and
14 (iv) The American dental association accepted dental therapeu-
15 tics.

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

- 19 (i) The federal agency for healthcare research and quality;
20 (ii) The national institutes of health;
21 (iii) The national cancer institute;
22 (iv) The national academy of sciences;
23 (v) The centers for medicare and medicaid services;
24 (vi) The federal food and drug administration; and
25 (vii) Any national board recognized by the national institutes of
26 health for the purpose of evaluating the medical value of health
27 care services; or

28 (f) Any other medical or scientific evidence that is comparable to the
29 sources listed in paragraphs (a) through (e) of this subsection (32).

30 (33) "Person" means an individual, a corporation, a partnership, an as-
31 sociation, a joint venture, a joint stock company, a trust, an unincorpor-
32 ated organization, any similar entity or any combination of the foregoing.

33 (34) "Post service review" means a review of medical necessity con-
34 ducted after services have been provided to a patient, but does not include
35 the review of a claim that is limited to an evaluation of reimbursement
36 levels, veracity of documentation, accuracy of coding or adjudication for
37 payment.

38 (35) "Pre-service review" means utilization review conducted prior to
39 an admission or a course of treatment.

40 (36) "Protected health information" means health information:

41 (a) That identifies an individual who is the subject of the informa-
42 tion; or

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

45 (37) "Randomized clinical trial" means a controlled, prospective study
46 of patients who have been randomized into an experimental group and a control
47 group at the beginning of the study with only the experimental group of pa-
48 tients receiving a specific intervention, which includes study of the groups
49 for variables and anticipated outcomes over time.

1 (38) "Second opinion" means an opportunity or requirement to obtain a
 2 clinical evaluation by a provider other than the one originally making a rec-
 3 ommendation for a proposed health care service to assess the clinical neces-
 4 sity and appropriateness of the initial proposed health care service.

5 (39) "Urgent care request" means a claim relating to an admission,
 6 availability of care, continued stay or health care service for which the
 7 covered person received emergency services but has not been discharged from
 8 a facility, or any pre-service or concurrent care claim for medical care or
 9 treatment for which application of the time periods for making a regular
 10 external review determination:

11 (a) Could seriously jeopardize the life or health of the covered person
 12 or the ability of the covered person to regain maximum function;

13 (b) In the opinion of the treating health care professional with knowl-
 14 edge of the covered person's medical condition, would subject the cov-
 15 ered person to severe pain that cannot be adequately managed without the
 16 disputed care or treatment; or

17 (c) The treatment would be significantly less effective if not promptly
 18 initiated.

19 The opinion of the covered person's treating health care professional with
 20 knowledge of the covered person's medical condition that a request is an ur-
 21 gent care request should be treated with deference.

22 (40) "Utilization review" means a set of formal techniques designed to
 23 monitor the use of, or evaluate the clinical necessity, appropriateness, ef-
 24 ficacy or efficiency of health care services, procedures or settings. Tech-
 25 niques may include ambulatory review, pre-service review, second opinion,
 26 certification, concurrent review, case management, discharge planning or
 27 post service review.

28 (41) "Utilization review organization" means an entity that conducts
 29 utilization review, other than a health carrier performing a review for its
 30 own health benefit plans.

31 SECTION 2. That Section 41-5904, Idaho Code, be, and the same is hereby
 32 amended to read as follows:

33 41-5904. APPLICABILITY AND SCOPE. (1) Except as provided in subsec-
 34 tion (2) of this section, this chapter shall apply to all health carriers-
 35 ~~final adverse benefit determinations which involve an issue of medical ne-~~
 36 ~~cessity or investigational service or supply.~~

37 (2) The provisions of this chapter shall not apply to a plan, policy
 38 or certificate that provides coverage only for a specified disease, speci-
 39 fied accident or accident-only coverage; nor shall this chapter apply to a
 40 credit, dental, disability income, hospital indemnity, long-term care in-
 41 surance, vision care, limited benefit health plans or any other limited sup-
 42 plemental benefit; nor shall this chapter apply to a medicare advantage plan
 43 or medicare supplemental policy of insurance, as defined by the director by
 44 rule, coverage under a plan through medicare, medicaid, or the federal em-
 45 ployees health benefits program, any coverage issued under chapter 55, ti-
 46 tle 10, of the United States Code and any coverage issued as supplemental to
 47 that coverage; nor shall this chapter apply to any coverage issued as supple-
 48 mental to liability insurance, worker's compensation or similar insurance,
 49 automobile medical payment insurance or any insurance under which benefits

1 are payable with or without regard to fault, whether written on a group blan-
 2 ket or individual basis; nor shall this chapter apply to a single employer
 3 self-funded employee benefit plan subject to and operated in compliance with
 4 the employee retirement income security act of 1974 (ERISA).

5 (3) The availability or use of external review pursuant to this chapter
 6 shall not alter the standard of review used by a court of competent jurisdic-
 7 tion when adjudicating the health carrier's final adverse benefit determi-
 8 nation.

9 SECTION 3. That Section 41-5905, Idaho Code, be, and the same is hereby
 10 amended to read as follows:

11 41-5905. NOTICE OF RIGHT TO EXTERNAL REVIEW. (1) ~~If at the conclusion~~
 12 ~~of the health carrier's internal grievance process the decision is adverse~~
 13 ~~to the covered person, based upon a determination that the service or supply~~
 14 ~~to be provided or which was provided did not meet medical necessity criteria~~
 15 ~~or is investigational~~ When a final adverse benefit determination is made,
 16 the health carrier shall notify the covered person in writing of the covered
 17 person's right to request an external review to be conducted pursuant to sec-
 18 tion 41-5908, 41-5909 or 41-5910, Idaho Code, and include the appropriate
 19 statements and information set forth in subsection (2) of this section at the
 20 same time the health carrier sends written notice of the final adverse bene-
 21 fit determination.

22 (2) The director may prescribe by rule the form and content of the no-
 23 tice required under this section, which shall include:

24 (a) The following, or substantially equivalent, language:

25 "We have denied your request for the provision of or payment for a
 26 health care service or course of treatment. You may have the right
 27 to have our decision reviewed by health care professionals who have
 28 no association with us if our decision involved making a judgment
 29 as to the medical necessity, appropriateness, health care setting,
 30 level of care or effectiveness of your health care service or sup-
 31 ply, or your health care service or supply was denied based upon a
 32 determination that it was investigational. You may request an ex-
 33 ternal review by submitting a written request to the department of
 34 insurance."

35 The notice shall include contact information for the department of insur-
 36 ance, including the website, address and telephone number.

37 (b) If the adverse benefit determination is for a pre-service or con-
 38 current service and was denied based upon a failure to meet medical
 39 necessity criteria or because the service was determined to be inves-
 40 tigational, the health carrier shall notify the covered person of the
 41 right to an expedited external review if the request is an urgent care
 42 request. The notification shall include the definition of urgent care
 43 request.

44 (c) The health carrier shall include a copy of the description of both
 45 the standard and expedited external review procedures the health car-
 46 rier is required to provide pursuant to section 41-5916, Idaho Code,
 47 highlighting the provisions in the external review procedures that give
 48 the covered person the opportunity to submit additional information,
 49 and include any forms used to process an external review.

1 (d) The health carrier shall include an authorization form, or other
 2 document approved by the director, that complies with the requirements
 3 of 45 CFR section 164.508, by which the covered person, for purposes of
 4 conducting an external review pursuant to this chapter, authorizes the
 5 health carrier and the covered person's treating health care providers
 6 to disclose protected health information, including medical records,
 7 concerning the covered person that are pertinent to the external re-
 8 view. Until the director receives this form from the covered person,
 9 duly executed, the external review process is stayed and the health car-
 10 rier has no obligations under this chapter.

11 SECTION 4. That Section 41-5906, Idaho Code, be, and the same is hereby
 12 amended to read as follows:

13 41-5906. ~~REQUEST TO FOR~~ EXTERNAL REVIEW. A covered person may make a
 14 request for an external review of a final adverse benefit determination. Ex-
 15 cept for a request for an expedited external review as set forth in section
 16 41-5909, Idaho Code, all requests for external review shall be made in writ-
 17 ing to the director. The director may prescribe by rule the form and con-
 18 tent of external review requests required to be submitted under this sec-
 19 tion. ~~The director shall prescribe by rule the amount of the administrative~~
 20 ~~filing fee, if any, to be paid by the covered person when the external review~~
 21 ~~request is submitted.~~

22 SECTION 5. That Section 41-5907, Idaho Code, be, and the same is hereby
 23 amended to read as follows:

24 41-5907. EXHAUSTION OF INTERNAL GRIEVANCE PROCESS. (1) Except as pro-
 25 vided in subsection (2) of this section, a request for an external review
 26 pursuant to section 41-5908, 41-5909 or 41-5910, Idaho Code, shall not be
 27 made until the covered person has exhausted the health carrier's internal
 28 grievance process.

29 ~~(a)~~ A covered person shall be considered to have exhausted the health
 30 carrier's internal grievance process for purposes of this section, if
 31 the covered person:

32 ~~(i)~~a) Has filed and completed a grievance, involving an adverse
 33 benefit determination, according to the terms and conditions of
 34 the covered person's health benefit plan; or

35 ~~(ii)~~b) Except to the extent the covered person requested or agreed
 36 to a delay, has not received a written decision on the grievance
 37 from the health carrier within thirty-five (35) days following the
 38 date the covered person filed the grievance with the health car-
 39 rier, or the covered person filed a grievance on an urgent care re-
 40 quest on a pre-service or concurrent care adverse benefit deter-
 41 mination and has not received a determination from the health car-
 42 rier within three (3) business days after filing.

43 ~~(b)~~2) A request for an external review of an adverse benefit determi-
 44 nation may be made before the covered person has exhausted the health
 45 carrier's internal grievance procedures as set forth in the health car-
 46 rier's grievance appeal process whenever:

47 (a) ~~The~~ health carrier agrees to waive the exhaustion requirement;

1 (b) The health carrier has failed to strictly follow its duties in af-
 2 fording a timely, full and fair opportunity for the covered person to
 3 take advantage of the internal grievance procedures; or

4 (c) The urgent care request involves a medical condition for which the
 5 time frame for completion of the carrier's internal grievance process
 6 pursuant to this section would seriously jeopardize the life or health
 7 of the covered person or would jeopardize the covered person's ability
 8 to regain maximum function, and the covered person has applied for exped-
 9 ited external review at the same time as applying for an expedited in-
 10 ternal review.

11 ~~(2) If the requirement to exhaust the health carrier's internal~~
 12 ~~grievance procedures is waived under subsection (1) (b) of this section, the~~
 13 ~~covered person may file a request in writing for a standard external review,~~
 14 ~~or where appropriate, an expedited external review.~~

15 SECTION 6. That Section 41-5908, Idaho Code, be, and the same is hereby
 16 amended to read as follows:

17 41-5908. STANDARD EXTERNAL REVIEW. (1) Within four (4) months after
 18 the date of issuance of a notice of a final adverse benefit determination
 19 pursuant to section 41-5905, Idaho Code, a covered person may file a request
 20 for an external review with the director. The request shall be made on such
 21 form as may be designated by the director.

22 (2) Within seven (7) days after the date of receipt of a request for ex-
 23 ternal review pursuant to subsection (1) of this section, the director shall
 24 send a copy of the request to the health carrier.

25 (3) Within fourteen (14) days following the date of receipt of the copy
 26 of the external review request from the director pursuant to subsection (2)
 27 of this section, the health carrier shall complete a preliminary review of
 28 the request to determine whether:

29 (a) The individual is or was a covered person in the health benefit plan
 30 at the time the health care service was requested or, in the case of a
 31 post service review, was a covered person in the health benefit plan at
 32 the time the health care service was provided;

33 (b) The health care service that is the subject of the final adverse
 34 benefit determination is a covered service under the covered person's
 35 health benefit plan, but for a determination by the health carrier that
 36 the health care service is not covered because it does not meet the
 37 health carrier's requirements for medical necessity, appropriateness,
 38 health care setting, level of care, effectiveness or the service or sup-
 39 ply is investigational;

40 (c) The covered person has exhausted the health carrier's internal
 41 grievance process as set forth in the covered person's health benefit
 42 plan, unless the covered person is not required to exhaust the health
 43 carrier's internal grievance process pursuant to section 41-5907,
 44 Idaho Code; and

45 (d) The covered person has provided all the information and forms re-
 46 quired to process an external review, including the release form pro-
 47 vided under section 41-5905(2) (d), Idaho Code.

48 (4) Within five (5) business days after completion of the preliminary
 49 review, the health carrier shall notify the director and covered person in

1 writing whether the request is complete and whether the request is eligible
2 for external review.

3 (5) If the request is not complete, the health carrier shall inform the
4 covered person and the director in writing and include in the notice what in-
5 formation or materials are needed to make the request complete.

6 (6) If the request is not eligible for external review, the health car-
7 rier shall inform the covered person and the director in writing and include
8 in the notice the reasons for its ineligibility.

9 (7) The director may prescribe by rule the form for the health carrier's
10 notice of initial determination under this section and any supporting in-
11 formation to be included in the notice. The notice of initial determination
12 shall include a statement informing the covered person that a health car-
13 rier's initial determination that the external review request is ineligible
14 for review, may be appealed to the director.

15 (8) The director may determine that a request is eligible for external
16 review notwithstanding a health carrier's initial determination that the
17 request is ineligible and require that it be referred for external review.
18 The director's decision shall be made in accordance with the applicable
19 procedural requirements of this chapter and the terms and conditions of the
20 covered person's health benefit plan.

21 (9) Whenever the director receives a notice that a request is eligible
22 for external review following the preliminary review conducted pursuant to
23 subsection (3) of this section, within seven (7) days after the date of re-
24 ceipt of the notice, the director shall:

25 (a) Assign an independent review organization from the list of approved
26 independent review organizations compiled and maintained by the direc-
27 tor pursuant to section 41-5911, Idaho Code, to conduct the external re-
28 view and notify the health carrier of the name of the assigned indepen-
29 dent review organization; and

30 (b) Notify, in writing, the covered person of the request's eligibility
31 and acceptance for external review.

32 (c) The director shall include in the notice provided to the covered
33 person a statement that the covered person may submit, in writing, to
34 the assigned independent review organization within seven (7) days fol-
35 lowing the date of receipt of the notice provided pursuant to subsection
36 (9) (b) of this section, additional information that the independent re-
37 view organization shall consider when conducting the external review.

38 (10) In reaching a decision, the assigned independent review organiza-
39 tion is not bound by the exercise of discretion or any decisions or conclu-
40 sions reached during the health carrier's utilization review process or the
41 health carrier's internal grievance process.

42 (11) Within fourteen (14) days after the date of receipt of the notice
43 provided pursuant to subsection (9) (a) of this section, the health carrier
44 or its designee utilization review organization shall provide to the as-
45 signed independent review organization the documents and any information
46 considered in making the adverse benefit determination or final adverse ben-
47 efit determination.

48 (12) Except as provided in subsection (13) of this section, failure by
49 the health carrier or its utilization review organization to provide the

1 documents and information within the time specified in subsection (11) of
2 this section, shall not delay the conduct of the external review.

3 (13) If the health carrier or its utilization review organization fails
4 to provide the documents and information within the time specified in sub-
5 section (11) of this section, the assigned independent review organization
6 may terminate the external review and make a decision to reverse the adverse
7 benefit determination or final adverse benefit determination.

8 (14) Within one (1) business day after making the decision to terminate
9 the external review pursuant to subsection (13) of this section, the inde-
10 pendent review organization shall notify the covered person, the health car-
11 rier and the director.

12 (15) The assigned independent review organization shall review all of
13 the information and documents received pursuant to subsection (11) of this
14 section, and any other information submitted in writing to the independent
15 review organization by the covered person pursuant to subsection (9) (c) of
16 this section; provided however, that if the covered person does submit new
17 information in writing to the ~~internal independent~~ review organization pur-
18 suant to subsection (9) (c) of this section, then the health carrier is enti-
19 tled to seven (7) days following its receipt thereof to submit additional re-
20 sponsive information to the internal review organization.

21 (16) Upon receipt of any information submitted by the covered person
22 pursuant to subsection (9) (c) of this section, the assigned independent re-
23 view organization shall within one (1) business day forward the information
24 to the health carrier.

25 (17) Upon receipt of the information, if any, required to be forwarded
26 pursuant to subsection (16) of this section, the health carrier may recon-
27 sider its adverse determination or final adverse benefit determination that
28 is the subject of the external review. Reconsideration by the health carrier
29 of its adverse determination or final adverse determination shall not delay
30 or terminate the external review. The assigned independent review organiza-
31 tion shall review all of the information and documents received pursuant to
32 subsection (15) of this section.

33 (18) The external review may be terminated if the health carrier decides
34 to reverse its final adverse benefit determination and provide coverage or
35 payment for the health care service that is the subject of the final adverse
36 benefit determination. Within two (2) business days after making the deci-
37 sion to reverse its final adverse benefit determination, the health carrier
38 shall notify the covered person, the assigned independent review organiza-
39 tion and the director in writing of its decision.

40 (19) In addition to the documents and information provided pursuant to
41 subsection (11) of this section, the assigned independent review organiza-
42 tion, to the extent the information or documents are available, shall con-
43 sider the following in reaching a decision:

- 44 (a) The covered person's medical records;
- 45 (b) The attending health care professional's recommendation;
- 46 (c) Consulting reports from appropriate health care professionals and
47 other documents submitted by the health carrier, covered person or the
48 covered person's treating provider;
- 49 (d) The terms and conditions of coverage under the covered person's
50 health benefit plan with the health carrier to ensure that the inde-

1 pendent review organization's decision is controlled by the terms and
2 conditions of coverage under the covered person's health benefit plan
3 with the health carrier to the extent the health plan's terms and condi-
4 tions are not in conflict with this chapter;

5 (e) The most appropriate practice guidelines, which shall include the
6 applicable evidence-based standards and may include any other practice
7 guidelines developed by the federal government, national or profes-
8 sional medical societies, boards and associations, health carrier's
9 internal guidelines and medical policies;

10 (f) Any applicable clinical review criteria developed and used by the
11 health carrier or its designee utilization review organization;

12 (g) Medical or scientific evidence, as defined in section 41-5903(32),
13 Idaho Code;

14 (h) The opinion of the independent review organization's clinical re-
15 viewer or reviewers after considering paragraphs (a) through (g) of
16 this subsection (19) to the extent the information or documents are
17 available.

18 (20) Within forty-two (42) days after the date of receipt of the request
19 for an external review, the assigned independent review organization shall
20 provide written notice of its decision to uphold or reverse the final adverse
21 benefit determination to the covered person, the health carrier and the di-
22 rector. The independent review organization shall include in the notice:

23 (a) A general description of the reason for the request for external re-
24 view;

25 (b) The date the independent review organization received the assign-
26 ment from the director to conduct the external review;

27 (c) The date the external review was conducted;

28 (d) The date of its decision;

29 (e) The principal reason or reasons for its decision, including an ex-
30 planation of the scientific or clinical judgment applied to reach its
31 decision;

32 (f) References to the evidence or documentation, including the evi-
33 dence-based standards, considered in reaching its decision; and

34 (g) References to the terms and conditions of the health benefit plan at
35 issue, including an explanation of how its decision is consistent with
36 them.

37 (21) The assignment by the director of an approved independent review
38 organization to conduct an external review in accordance with this section
39 shall be done on a random basis among those approved independent review or-
40 ganizations qualified to conduct the particular external review based on the
41 nature of the health care service that is the subject of the final adverse
42 benefit determination and other circumstances, including conflict of inter-
43 est concerns pursuant to section 41-5912, Idaho Code.

44 (22) Upon receipt of a notice of a decision pursuant to subsection (20)
45 of this section reversing the adverse benefit determination or final adverse
46 benefit determination, the health carrier shall approve as soon as reason-
47 ably practicable but not later than one (1) business day after receipt of the
48 notice the coverage that was the subject of the adverse benefit determina-
49 tion or final adverse benefit determination.

1 SECTION 7. That Section 41-5909, Idaho Code, be, and the same is hereby
2 amended to read as follows:

3 41-5909. EXPEDITED EXTERNAL REVIEW. (1) ~~After having exhausted the~~
4 ~~health carrier's internal grievance process as provided in section 41-5907,~~
5 ~~Idaho Code, a~~ covered person may make a request for an expedited external
6 review of a pre-service or concurrent service adverse benefit determination
7 ~~based on medical necessity or investigational,~~ where the requested service
8 meets the definition of an urgent care request and the covered person has
9 exhausted the health carrier's internal grievance process or is entitled
10 to request external review before exhausting the health carrier's internal
11 grievance process as provided in section 41-5907, Idaho Code.

12 (2) Upon receipt of a request for an expedited external review, the di-
13 rector shall send a copy of the request to the health carrier.

14 (3) Upon receipt of the request pursuant to subsection (2) of this sec-
15 tion, the health carrier shall determine, as soon as possible but not later
16 than the second full business day thereafter, whether the carrier agrees
17 that the request meets the reviewability requirements set forth in section
18 41-5908(3), Idaho Code. The health carrier shall notify the director and
19 the covered person of its eligibility determination as soon as reasonably
20 practicable but not later than one (1) business day after making the deter-
21 mination.

22 (a) The director may prescribe by rule the form for the health carrier's
23 notice of initial determination under this subsection and any support-
24 ing information to be included in the notice.

25 (b) The notice of initial determination shall include a statement in-
26 forming the covered person that a health carrier's initial determina-
27 tion that an external review request is ineligible for review, may be
28 appealed to the director.

29 (4) The director may determine that a request is eligible for external
30 review pursuant to section 41-5908(3), Idaho Code, notwithstanding a health
31 carrier's initial determination that the request is ineligible, and require
32 that it be referred for external review. In making a determination under
33 this subsection (4), the director's decision shall be made in accordance
34 with the applicable procedural requirements of this chapter and the terms
35 and conditions of the covered person's health benefit plan.

36 (5) Upon receipt of the notice that the request meets the reviewability
37 requirements, the director shall assign an independent review organization
38 to conduct the expedited external review from the list of approved indepen-
39 dent review organizations compiled and maintained by the director pursuant
40 to section 41-5911, Idaho Code. The director shall notify the health carrier
41 and the covered person of the name of the assigned independent review organi-
42 zation.

43 (6) In reaching a decision in accordance with subsection (9) of this
44 section, the assigned independent review organization is not bound by the
45 exercise of discretion or any decisions or conclusions reached during the
46 health carrier's internal grievance process.

47 (7) Upon receipt of the notice from the director of the name of the inde-
48 pendent review organization assigned to conduct the expedited external re-
49 view pursuant to subsection (5) of this section, the health carrier or its

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

6 (8) In addition to the documents and information provided or transmit-
7 ted pursuant to subsection (7) of this section, the assigned independent re-
8 view organization, to the extent the information or documents are available
9 and the independent review organization considers them appropriate, shall
10 consider the following in reaching a decision:

11 (a) The covered person's pertinent medical records;

12 (b) The attending health care professional's recommendation;

13 (c) Consulting reports from appropriate health care professionals and
14 other documents submitted by the health carrier, covered person or the
15 covered person's treating provider;

16 (d) The terms and conditions of coverage under the covered person's
17 health benefit plan with the health carrier to ensure that the inde-
18 pendent review organization's decision is controlled by the terms and
19 conditions of coverage under the covered person's health benefit plan
20 with the health carrier to the extent the health plan's terms and condi-
21 tions are not in conflict with this chapter;

22 (e) The most appropriate practice guidelines, which shall include ev-
23 idence-based standards, and may include any other practice guidelines
24 developed by the federal government, national or professional medi-
25 cal societies, boards and associations, the health carrier's internal
26 guidelines and medical policies;

27 (f) Any applicable clinical review criteria developed and used by the
28 health carrier or its designated utilization review organization in
29 making the adverse benefit determination;

30 (g) Medical or scientific evidence, as defined in section 41-5903(32),
31 Idaho Code;

32 (h) The opinion of the independent review organization's clinical re-
33 viewer or reviewers after considering paragraphs (a) through (g) of
34 this subsection (8) to the extent the information and documents are
35 available.

36 (9) As expeditiously as the covered person's medical condition or cir-
37 cumstances require, but in no event more than seventy-two (72) hours after
38 the date of receipt of the request for an expedited external review that
39 meets the reviewability requirements set forth in section 41-5908(3), Idaho
40 Code, the assigned independent review organization shall:

41 (a) Make a decision to uphold or reverse the final adverse benefit de-
42 termination; and

43 (b) Notify the covered person, the health carrier and the director of
44 the decision.

45 (10) If the notice provided pursuant to subsection (9) (b) of this sec-
46 tion was not in writing, within forty-eight (48) hours after the date of pro-
47 viding that notice, the assigned independent review organization shall:

48 (a) Provide written confirmation of the decision to the covered person,
49 the health carrier and the director, which shall include an explanation
50 of the scientific or clinical judgment for the determination ~~addressing~~

1 ~~the medical necessity criteria as defined in this chapter or, where the~~
2 ~~appeal is based upon a denial of a service as investigational, address-~~
3 ~~ing the criteria for determination of investigational status as defined~~
4 ~~in this chapter; and~~

5 (b) Include the information set forth in section 41-5908(20), Idaho
6 Code.

7 (11) Upon receipt of the notice of a decision pursuant to subsection
8 (10) of this section reversing the final adverse benefit determination,
9 the health carrier shall notify the director and the covered person of its
10 eligibility determination intent to pay the covered benefit as soon as rea-
11 sonably practicable but not later than one (1) business day after ~~making the~~
12 determination receiving the notice of decision.

13 (12) An expedited external review shall not be provided for post service
14 final adverse benefit determinations.

15 (13) The assignment by the director of an approved independent review
16 organization to conduct an external review in accordance with this section
17 shall be done on a random basis among those approved independent review or-
18 ganizations qualified to conduct the particular external review based on the
19 nature of the health care service that is the subject of the final adverse
20 benefit determination and other circumstances, including conflict of inter-
21 est concerns pursuant to section 41-5912, Idaho Code.

22 SECTION 8. That Section 41-5915, Idaho Code, be, and the same is hereby
23 amended to read as follows:

24 41-5915. FUNDING OF EXTERNAL REVIEW. The health carrier against which
25 a request for a standard external review or an expedited external review is
26 filed shall pay the reasonable cost of the independent review organization
27 for conducting the external review. ~~The director may provide by rule for an~~
28 ~~administrative fee to offset the department's costs associated with exter-~~
29 ~~nal review to be paid by the covered person at the time he makes a request for~~
30 ~~external review.~~

31 SECTION 9. That Section 41-5916, Idaho Code, be, and the same is hereby
32 amended to read as follows:

33 41-5916. DISCLOSURE REQUIREMENTS. (1) Each health carrier shall in-
34 clude a summary description of the external review procedures in or attached
35 to the policy, certificate, membership booklet, outline of coverage or other
36 evidence of coverage it provides to covered persons. The disclosure shall be
37 in a format prescribed by the director.

38 (2) The description required under subsection (1) of this section shall
39 include:

40 (a) A statement that informs the covered person of the right of the cov-
41 ered person to file a request for an external review of a final adverse
42 benefit determination with the director;

43 (b) An explanation that external review and, in certain circumstances,
44 expedited external review are available when the final adverse benefit
45 determination involves an issue of medical necessity, appropriateness,
46 health care setting, level of care, effectiveness or investigational
47 service or supply;

1 (c) The website, telephone number and address of the director; and

2 (d) A statement informing the covered person that, when filing a re-
3 quest for an external review, the covered person will be required to au-
4 thorize the release of any medical records of the covered person that
5 may be required to be reviewed for the purpose of reaching a decision on
6 the external review including any judicial review of the external re-
7 view decision pursuant to ERISA, if applicable.

8 (e) If the health plan is not subject to ERISA, a statement inform-
9 ing the covered person that the plan is not subject to ERISA and that
10 if the covered person elects to request external review, the external
11 review decision of the independent review organization shall be final
12 and binding on both the covered person and the health carrier, as pro-
13 vided in section 41-5910, Idaho Code. If the health plan is subject to
14 ERISA, the statement shall inform the covered person that the plan is
15 subject to ERISA and that if the covered person elects to request ex-
16 ternal review, the external review decision of the independent review
17 organization shall be final and binding on the health carrier but not
18 the covered person, as provided in section 41-5910, Idaho Code, and that
19 the covered person may have the right to judicial review under ERISA in
20 a court of competent jurisdiction.