SLS 12RS-616 **ENGROSSED**

Regular Session, 2012

SENATE BILL NO. 225

BY SENATOR MORRISH

HEALTH/ACC INSURANCE. Provides relative to Medical Necessity Review Organizations. (see Act.)

AN ACT

To amend and reenact R.S. 22:1122(1), 1132(A) and (B)(introductory paragraph), 1133, 1135(A), (B), and (D)(introductory paragraph), 1137(A), and 1144(B) and to enact R.S. 22:1122(27.1), 1132(B)(3), (4), and (5), and 1137(E), and to repeal R.S. 22:1122(18), relative to Medical Necessity Review Organizations; to provide definitions; to provide with respect to independent external review and appeal processes; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1122(1), 1132(A) and (B)(introductory paragraph), 1133, 1135(A), (B), and (D)(introductory paragraph), 1137(A) and 1144(B) are hereby amended and reenacted and R.S. 22:1122(27.1), 1132(B)(3), (4), and (5), and 1137(E) are hereby enacted to read as follows:

§1122. Definitions

As used in this Subpart, the following terms shall be defined as follows:

(1) "Adverse determination" means a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and denied, reduced, or terminated by a reviewer based

on medical necessity, appropriateness, health care setting, level of care, or effectiveness **of a covered benefit**, or because an item or health care service for which benefits are otherwise provided is determined to be experimental or investigational.

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(27.1) "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations and whose accreditation or certification has been reviewed and approved by the department of insurance.

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§1132. Request for external review

A. Each health benefit plan shall provide an independent review process to examine the plan's coverage decisions based on medical necessity **or medical judgment**. A covered person ~~with the concurrence of the treating healthcare provider~~ **or a covered person's authorized representative** may make a request for an external review of a second level appeal adverse determination.

B. Except as provided in this Subsection, an MNRO shall not be required to grant a request for an external review until the second level appeal process as set forth in this Subpart has been exhausted. A request for external review of an adverse determination may be made before the covered person has exhausted the MNRO's appeal **process**, if any of the following circumstances apply:

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(3) The covered person is enrolled for covered benefits in the individual health insurance market.

(4) The health benefit plan has failed to comply with the requirements of the internal appeals process specified in R.S. 22:1128 through 1130. However, such requirements shall not be deemed exhausted based on de minimis violations that do not cause and are not likely to cause prejudice or harm to the covered person, as long as the MNRO demonstrates that the

violation was for good cause or due to matters beyond its control and that the violation occurred in the context of an ongoing, good-faith exchange of information between the MNRO and the covered person. This exception shall not apply if the violation is part of a pattern or practice of violations by the MNRO. The covered person may request a written explanation of the violation from the MNRO, and the MNRO shall provide such explanation within ten days of receipt of the request, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

(5) The covered person or the covered person's authorized representative simultaneously requests an expedited internal appeal and an expedited external review.

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§1133. Standard external review

A. Within ~~sixty~~ **one hundred twenty** days after the date of receipt of a notice of a second level appeal adverse determination, the covered person whose medical care was the subject of such determination~~, with the concurrence of the treating healthcare provider,~~ **or the covered person's authorized representative** may file a request for an external review with the MNRO. Within seven days after the date of receipt of the request for an external review **or the designation of the independent review organization, whichever is later,** the MNRO shall provide the documents and any information used in making the second level appeal adverse determination to ~~it's~~ **the** designated independent review organization **and shall notify the covered person or the covered person's authorized representative of the right to submit additional information**. The independent review organization shall review all of the information and documents received and any other information submitted in writing by the covered person**, the covered person's authorized representative,** or the covered person's health care provider. The independent review organization may consider the following in reaching a decision or making a

recommendation:

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

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

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

(4) Any applicable generally accepted practice guidelines, including but not limited to those developed by the federal government or national or professional medical societies, boards, and associations.

(5) Any applicable clinical review criteria developed exclusively and used by the MNRO that are within the appropriate standard for care, provided such criteria were not the sole basis for the decision or recommendation unless the criteria had been reviewed and certified by the appropriate licensing board of this state.

B. The independent review organization, in reaching a decision or making a recommendation, shall also consider any additional information submitted in writing by the covered person or the covered person's authorized representative. The independent review organization shall allow the covered person at least five business days to submit additional information and shall forward such information to the MNRO within one business day of its receipt.

~~B.~~ **C.** The independent review organization shall provide notice of its recommendation to the MNRO, the covered person or his authorized representative, and the covered person's health care provider within ~~thirty~~ **forty-five** days after the date of receipt of the ~~second level determination information subject to an~~ **request for** external review, unless a longer period is agreed to by all parties.

D. The commissioner shall maintain a list of authorized independent review organizations and shall provide for the timely designation of an independent review organization using a method that assures the independence and impartiality of the designation. Neither the health insurance issuer nor the MNRO nor the covered person shall select the independent review organization.

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§1135. Expedited external review

A. At the time that a covered person receives an adverse determination involving an **urgent or** emergency medical condition of the covered person, the covered ~~person's health care provider~~ **person or the covered person's authorized representative** may request an expedited external review.

B. For **urgent or** emergency medical conditions, the MNRO shall provide or transmit all necessary documents and information used in making the adverse determination to the independent review organization by telephone, telefacsimile, or any other available expeditious method.

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D. Within seventy-two hours after receiving ~~appropriate medical information for an~~ **a request for a qualified** expedited external review, the independent review organization shall do the following:

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§1137. Minimum qualifications **and requirements** for independent review organizations

A. To qualify to conduct external reviews for an MNRO, an independent review organization shall meet the following minimum qualifications:

(1) Achieve accreditation by a nationally-recognized private accrediting organization.

(2) Demonstrate qualifications to conduct specific types of reviews based on the nature of health care services that are the subject of reviews.

~~(1)~~ **(3)** Develop written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process that include, at a minimum, the following:

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

(b) Procedures to ensure the selection of qualified and impartial clinical peer

reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases.

(c) Procedures to ensure the confidentiality of medical and treatment records and clinical review criteria.

(d) Procedures to ensure that any individual employed by or under contract with the independent review organization adheres to the requirements of this Subpart.

~~(2)~~ **(4)** Establish a quality assurance program.

~~(3)~~ **(5)** Establish a toll-free telephone service to receive information related to external reviews on a twenty-four-hour-**a-**day, seven-day-a-week basis that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.

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E. An independent review organization shall maintain written records of cases it reviews for a minimum of three years and shall make such records available upon request by the commissioner.

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§1144. Appeal and external review of experimental or investigational determinations

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B. In order to be eligible for the second level internal appeal or external review process described in this Subpart, an item or health care service deemed to be experimental or investigational in an adverse determination shall meet all of the following criteria:

~~(1) The allowable charge designated by the health insurance issuer shall be greater than five hundred dollars.~~

~~(2)(a)~~ **(1)** An item or health care service shall be approved by the federal Food and Drug Administration (FDA), if subject to FDA approval; however, absence of FDA approval for off label use shall not preclude eligibility.

~~(b)~~ **(2)** If not subject to approval by the federal Food and Drug Administration (FDA), support of use of the item or health care service by medical or scientific evidence.

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Section 2. R.S. 22:1122(18) is hereby repealed.

Section 3. The provisions of this Act shall be effective thirty days after a final, non-appealable judgment by the United States Supreme Court that includes the merits of the provisions of Section 2719 of the Public Health Service Act and that affirms the validity of such provisions, together with any and all federal regulations promulgated in accordance therewith by any federal agency. The provisions of this Act shall become null and void immediately upon Congressional repeal of Section 2719 of the Public Health Service Act.

The original instrument and the following digest, which constitutes no part of the legislative instrument, were prepared by Cheryl Horne.

DIGEST

Morrish (SB 225)

Present law requires each health benefit plan to provide an independent review process to examine the plan's coverage decisions based on medical necessity. Further provides a covered person with the concurrence of the treating healthcare provider may make a request for an external review of a second level appeal adverse determination.

Proposed law retains present law and includes a review process to examine the health plan's coverage decisions based on medical necessity or medical judgment. Further provides a covered person or a covered person's authorized representative may make a request for an external review of a second level appeal adverse determination.

Proposed law permits a request for external review of an adverse determination to be made before the covered person has exhausted the MNRO's appeal process if the covered person is enrolled for covered benefits in the individual health insurance market or the health benefit plan has failed to comply with the requirements of the internal appeals process specified in present law. Further provides that such requirements shall not be deemed exhausted based on de minimis violations that do not cause prejudice or harm to the covered person as long as the MNRO demonstrates that the violation was for good cause or due to matters beyond its control; however, this exception shall not apply if the violation is part of a pattern or practice of violations by the MNRO.

Present law permits a covered person whose medical care was the subject of an adverse determination within 60 days after the date of receipt of a notice of such determination to file a request for external review with the MNRO. Proposed law gives the covered person 120 days to file such a request.

Proposed law requires the independent review organization to consider any additional information submitted in writing by the covered person or his or her authorized representative in reaching a decision or making a recommendation. Further requires the independent review organization to allow the covered person at least five business days to

submit additional information which must be forwarded to the MNRO within one business day of its receipt.

Present law requires the independent review organization to provide notice of its recommendation to the MNRO, the covered person or his representative, and the covered person's health care provider with 30 days after the date of receipt of the second level determination information subject to external review. Proposed law extends the period to 45 days.

Proposed law requires the commissioner to maintain a list of authorized independent review organizations and to provide for the timely designation of such an organization using a method that assures the independence and impartiality of the designation. Further prohibits the health insurance issuer, the MNRO, or the covered person from selecting the independent review organization.

Proposed law requires an independent review organization to achieve accreditation by a nationally recognized private accrediting organization and demonstrate qualifications to conduct specific types of review based on the nature of the health care services that are subject of reviews.

Proposed law requires an independent review organization to maintain written records of cases it reviews for a minimum of three years and to make such records available upon request by the commissioner.

Present law provides that in order to be eligible for the second level internal appeal or external review process, an item or health care service deemed to be experimental or investigational in an adverse determination, the allowable charge designated by the health insurance issuer shall be greater than $500. Proposed law deletes this requirement.

Effective 30 days after a final, non-appealable judgment by the United States Supreme Court that includes the merits of the provisions of Section 2719 of the Public Health Service Act and that affirms the validity of such provisions, together with any and all federal regulations promulgated in accordance therewith by any federal agency.

The provisions of proposed law shall become null and void immediately upon Congressional repeal of Section 2719 of the Public Health Service Act.

(Amends R.S. 22:1122(1), 1132(A) and (B)(intro para), 1133, 1135(A), (B), and (D)(intro para), 1137(A), and 1144(B); adds R.S. 22:1122(27.1), 1132(B)(3), (4), and (5), and 1137(E); repeals R.S. 22:1122(18))