LEGISLATURE OF NEBRASKA

ONE HUNDRED EIGHTH LEGISLATURE

SECOND SESSION

# LEGISLATIVE BILL 1024

Introduced by Bostar, 29.

Read first time January 05, 2024

Committee:

1 A BILL FOR AN ACT relating to the Health Carrier External Review Act; to
2 amend section 44-1308, Reissue Revised Statutes of Nebraska; to
3 change provisions relating to documents and information provided to
4 an independent review organization; and to repeal the original
5 section.
6 Be it enacted by the people of the State of Nebraska,

1 Section 1. Section 44-1308, Reissue Revised Statutes of Nebraska, is
2 amended to read:
3 44-1308 (1)(a) Within four months after the date of receipt of a
4 notice of an adverse determination or final adverse determination
5 pursuant to section 44-1305, a covered person or the covered person's
6 authorized representative may file a request for an external review with
7 the director.
8 (b) Within one business day after the date of receipt of a request
9 for an external review pursuant to subdivision (1)(a) of this section,
10 the director shall send a copy of the request to the health carrier.
11 (2) Within five business days following the date of receipt of the
12 copy of the external review request from the director under subdivision
13 (1)(b) of this section, the health carrier shall complete a preliminary
14 review of the request to determine whether:
15 (a) The individual is or was a covered person in the health benefit
16 plan at the time that the health care service was requested or, in the
17 case of a retrospective review, was a covered person in the health
18 benefit plan at the time that the health care service was provided;
19 (b) The health care service that is the subject of the adverse
20 determination or the final adverse determination is a covered service
21 under the covered person's health benefit plan, but for a determination
22 by the health carrier that the health care service is not covered because
23 it does not meet the health carrier's requirements for medical necessity,
24 appropriateness, health care setting, level of care, or effectiveness;
25 (c) The covered person has exhausted the health carrier's internal
26 grievance process as set forth in the Health Carrier Grievance Procedure
27 Act unless the covered person is not required to exhaust the health
28 carrier's internal grievance process pursuant to section 44-1307; and
29 (d) The covered person has provided all the information and forms
30 required to process an external review, including the release form
31 provided under subsection (2) of section 44-1305.

1 (3)(a) Within one business day after completion of the preliminary
2 review, the health carrier shall notify the director and covered person
3 and, if applicable, the covered person's authorized representative, in
4 writing whether:

5 (i) The request is complete; and

6 (ii) The request is eligible for external review.

7 (b) If the request:

8 (i) Is not complete, the health carrier shall inform the covered
9 person and, if applicable, the covered person's authorized representative
10 and the director in writing and include in the notice what information or
11 materials are needed to make the request complete; or

12 (ii) Is not eligible for external review, the health carrier shall
13 inform the covered person and, if applicable, the covered person's
14 authorized representative and the director in writing and include in the
15 notice the reasons for its ineligibility.

16 (c)(i) The director may specify the form for the health carrier's
17 notice of initial determination under this subsection and any supporting
18 information to be included in the notice.

19 (ii) The notice of initial determination shall include a statement
20 informing the covered person and, if applicable, the covered person's
21 authorized representative that a health carrier's initial determination
22 that the external review request is ineligible for review may be appealed
23 to the director.

24 (d)(i) The director may determine that a request is eligible for
25 external review under subsection (2) of this section notwithstanding a
26 health carrier's initial determination that the request is ineligible and
27 require that it be referred for external review.

28 (ii) In making a determination under subdivision (3)(d)(i) of this
29 section, the director's decision shall be made in accordance with the
30 terms of the covered person's health benefit plan and shall be subject to
31 all applicable provisions of the Health Carrier External Review Act.

1 (4)(a) Whenever the director receives a notice that a request is
2 eligible for external review following the preliminary review conducted
3 pursuant to subsection (3) of this section, the director shall, within
4 one business day after the date of receipt of the notice:
5 (i) Assign an independent review organization from the list of
6 approved independent review organizations compiled and maintained by the
7 director pursuant to section 44-1312 to conduct the external review and
8 notify the health carrier of the name of the assigned independent review
9 organization; and
10 (ii) Notify in writing the covered person and, if applicable, the
11 covered person's authorized representative of the request's eligibility
12 and acceptance for external review.
13 (b) In reaching a decision, the assigned independent review
14 organization is not bound by any decisions or conclusions reached during
15 the health carrier's utilization review process as set forth in the
16 Utilization Review Act or the health carrier's internal grievance process
17 as set forth in the Health Carrier Grievance Procedure Act.
18 (c) The director shall include in the notice provided to the covered
19 person and, if applicable, the covered person's authorized representative
20 a statement that the covered person or his or her authorized
21 representative may submit in writing to the assigned independent review
22 organization within five business days following the date of receipt of
23 the notice provided pursuant to subdivision (4)(a) of this section
24 additional information that the independent review organization shall
25 consider when conducting the external review. The independent review
26 organization is not required to but may accept and consider additional
27 information submitted after five business days.
28 (5)(a) Within five business days after the date of receipt of the
29 notice provided pursuant to subdivision (4)(a) of this section, the
30 health carrier or its designee utilization review organization shall
31 provide to the assigned independent review organization the documents and

1 any information considered in making the adverse determination or final
2 adverse determination. Any documents or information solely related to
3 cost shall not be provided.
4 (b) Except as provided in subdivision (5)(c) of this section,
5 failure by the health carrier or its utilization review organization to
6 provide the documents and information within the time specified in
7 subdivision (5)(a) of this section shall not delay the conduct of the
8 external review.
9 (c)(i) If the health carrier or its utilization review organization
10 fails to provide the documents and information within the time specified
11 in subdivision (5)(a) of this section, the assigned independent review
12 organization may terminate the external review and make a decision to
13 reverse the adverse determination or final adverse determination.
14 (ii) Within one business day after making the decision under
15 subdivision (5)(c)(i) of this section, the independent review
16 organization shall notify the covered person and, if applicable, the
17 covered person's authorized representative, the health carrier, and the
18 director.
19 (6)(a) The assigned independent review organization shall review all
20 of the information and documents received pursuant to subsection (5) of
21 this section and any other information submitted in writing to the
22 independent review organization by the covered person or the covered
23 person's authorized representative pursuant to subdivision (4)(c) of this
24 section.
25 (b) Upon receipt of any information submitted by the covered person
26 or the covered person's authorized representative pursuant to subdivision
27 (4)(c) of this section, the assigned independent review organization
28 shall forward the information to the health carrier within one business
29 day.
30 (7)(a) Upon receipt of the information, if any, required to be
31 forwarded pursuant to subdivision (6)(b) of this section, the health

1 carrier may reconsider its adverse determination or final adverse
2 determination that is the subject of the external review.
3 (b) Reconsideration by the health carrier of its adverse
4 determination or final adverse determination pursuant to subdivision (7)
5 (a) of this section shall not delay or terminate the external review.
6 (c) The external review may only be terminated if the health carrier
7 decides, upon completion of its reconsideration, to reverse its adverse
8 determination or final adverse determination and provide coverage or
9 payment for the health care service that is the subject of the adverse
10 determination or final adverse determination.
11 (d)(i) Within one business day after making the decision to reverse
12 its adverse determination or final adverse determination as provided in
13 subdivision (7)(c) of this section, the health carrier shall notify the
14 covered person and, if applicable, the covered person's authorized
15 representative, the assigned independent review organization, and the
16 director in writing of its decision.
17 (ii) The assigned independent review organization shall terminate
18 the external review upon receipt of the notice from the health carrier
19 sent pursuant to subdivision (7)(d)(i) of this section.
20 (8) In addition to the documents and information provided pursuant
21 to subsection (5) of this section, the assigned independent review
22 organization, to the extent the information or documents are available
23 and the independent review organization considers them appropriate, shall
24 consider the following in reaching a decision:
25 (a) The covered person's medical records;
26 (b) The attending health care professional's recommendation;
27 (c) Consulting reports from appropriate health care professionals
28 and other documents submitted by the health carrier, covered person, the
29 covered person's authorized representative, or the covered person's
30 treating provider;
31 (d) The terms of coverage under the covered person's health benefit

1 plan with the health carrier to ensure that the independent review
2 organization's decision is not contrary to the terms of coverage under
3 the covered person's health benefit plan with the health carrier;
4 (e) The most appropriate practice guidelines, which shall include
5 applicable evidence-based standards and may include any other practice
6 guidelines developed by the federal government, national or professional
7 medical societies, boards, or associations;
8 (f) Any applicable clinical review criteria developed and used by
9 the health carrier or its designee utilization review organization; and
10 (g) The opinion of the independent review organization's clinical
11 reviewer or reviewers after considering subdivisions (8)(a) through (f)
12 of this section to the extent that the information or documents are
13 available and the clinical reviewer or reviewers consider it appropriate.
14 (9)(a) Within forty-five days after the date of receipt of the
15 request for an external review, the assigned independent review
16 organization shall provide written notice of its decision to uphold or
17 reverse the adverse determination or the final adverse determination to
18 the covered person, if applicable, the covered person's authorized
19 representative, the health carrier, and the director.
20 (b) The independent review organization shall include in the notice
21 sent pursuant to subdivision (9)(a) of this section:
22 (i) A general description of the reason for the request for external
23 review;
24 (ii) The date that the independent review organization received the
25 assignment from the director to conduct the external review;
26 (iii) The date that the external review was conducted;
27 (iv) The date of its decision;
28 (v) The principal reason or reasons for its decision, including what
29 applicable, if any, evidence-based standards were a basis for its
30 decision;
31 (vi) The rationale for its decision; and

1 (vii) References to the evidence or documentation, including the
2 evidence-based standards, considered in reaching its decision.
3 (c) Upon receipt of a notice of a decision pursuant to subdivision
4 (9)(a) of this section reversing the adverse determination or final
5 adverse determination, the health carrier shall immediately approve the
6 coverage that was the subject of the adverse determination or final
7 adverse determination.
8 (10) The assignment by the director of an approved independent
9 review organization to conduct an external review in accordance with this
10 section shall be done on a random basis among those approved independent
11 review organizations qualified to conduct the particular external review
12 based on the nature of the health care service that is the subject of the
13 adverse determination or final adverse determination and other
14 circumstances, including conflict of interest concerns pursuant to
15 subsection (4) of section 44-1313.
16 Sec. 2. Original section 44-1308, Reissue Revised Statutes of
17 Nebraska, is repealed.