

R590. Insurance, Administration.

R590-261. Health Benefit Plan Adverse Benefit Determinations.

R590-261-1. Authority.

This rule is promulgated pursuant to Subsection 31A-22-629(4) which requires the commissioner to adopt rules that establish standards for independent reviews, Subsection 31A-2-201(3)(a) wherein the commissioner may make rules to implement the provisions of Title 31A and 31A-2-212(5)(b) wherein the commissioner requires compliance with the Patient Protection and Affordable Care Act.

R590-261-2. Purpose.

The purpose of this rule is to provide a uniform standard for the establishment and maintenance of an independent review procedure to assure that a claimant has the opportunity for an independent review of an adverse benefit determination.

R590-261 -3. Scope.

(1) This rule applies to all health benefit plans as defined in 31A-1-301 except for a grandfathered health plan as described in 45 CFR 147.140.

(2) A grandfathered health benefit plan is subject to R590-203 or may voluntarily comply with this rule upon the written consent of the policyholder.

(3) A self-funded health plan may voluntarily comply with the independent review process set forth in this rule.

R590-261-4. Incorporation by Reference.

The following appendices are hereby incorporated by reference within this rule and are available at www.insurance.utah.gov/legalresources/currentrules.html:

(1) Appendix A, Independent Review Organization Application and Checklist, dated 2011.

(2) Appendix B, Independent Review Request Form, dated 2011

R590-261-5. Definitions.

In addition to the definitions in Section 31A-1-301, the following definitions apply for purposes of this rule:

(1)(a) "Adverse benefit determination" means, that based on the carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, the:

(i) denial of a benefit;

(ii) reduction of a benefit;

(iii) termination of a benefit;

(iv) failure to provide or make payment, in whole or part, for a benefit; or

(v) rescission of coverage.

(b) "Adverse benefit determination" includes:

(i) denial, reduction, termination, failure to provide or make payment, or rescission that is based on a determination of an insured's eligibility to participate in a health benefit plan;

(ii) failure to provide or make payment, in whole or part, for a benefit resulting from the application of a utilization review; and

(c) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:

(i) experimental;

(ii) investigational; or

(iii) not medically necessary or appropriate.

(2) "Carrier" means any person or entity that provides health insurance in this state including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) any other person or entity providing a health insurance plan under Title 31A.

(3) "Claimant" means an insured or legal representative of the insured, including a member of the insured's immediate family designated by the insured, making a claim under a policy.

(4) "Clinical reviewer" means a physician or other appropriate health care provider who:

(a) is an expert in the treatment of the claimant's medical condition that is the subject of the review

(b) is knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition;

(c) holds an appropriate license or certification; and

(d) has no history of disciplinary actions or sanctions.

(5)(a) "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.

(b) "Rescission" does not include a cancellation or discontinuance of coverage under a health benefit plan if the cancellation or discontinuance of coverage:

(i) has only a prospective effect; or

(ii) is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

R590-261-6. Adverse Benefit Determination Procedure Compliance.

An adverse benefit determination procedure shall be compliant with this rule and the requirements for adverse benefit determinations set forth in 29 CFR §2560.503-1 and 45 CFR §147.136.

R590-261-7. Notice of right to independent review.

(1) With each notice of a final adverse benefit determination, the carrier shall provide written notice of the claimant's right for an independent review of the determination.

(2) The notice in Subsection (1) shall include the following, or substantially equivalent, statement:

"We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by a health care professional who has no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or

effectiveness of the health care service or treatment you requested. To receive additional information about an independent review, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City UT 84114; by phone at 801 538-3077; or electronically at healthappeals.uid@utah.gov."

R590-261-8. Exhaustion of internal review process.

The carrier's internal review process shall be exhausted prior to an independent review unless:

- (1) the carrier agrees to waive the internal review process;
- (2) the carrier has not complied with the requirements for the carrier's internal review process; or
- (3) the claimant has requested an expedited independent review pursuant to Section 10 at the same time as requesting an expedited internal review.

R590-261-9. Independent Review Organizations.

(1) The commissioner shall compile and maintain a list of approved independent review organizations.

(2) To be considered for placement on the list of approved independent review organizations, an independent review organization shall:

- (a) be accredited by a nationally recognized private accrediting entity;
- (b) meet the requirements of this rule; and
- (c) have written policies and procedures that ensure:
 - (i) that all reviews are conducted within the specified time frames;
 - (ii) the selection of qualified and impartial clinical reviewers;
 - (iii) the confidentiality of medical and treatment records and clinical review criteria; and
 - (iv) that any person employed by or under contract with the independent review organization adheres to the requirements of this rule.

(3) An applicant requesting placement on the list of approved independent review organizations shall submit for the commissioner's review:

- (a) the application form attached to this rule as Appendix A;
- (b) all documentation and information requested on the application, including proof of being accredited by a nationally recognized private accrediting entity; and
- (c) the application fee.

(4) The commissioner shall terminate the approval of an independent review organization if the commissioner determines that the independent review organization has lost its accreditation or no longer satisfies the minimum requirements for approval.

(5)(a) An independent review organization may not own or control, or be owned or controlled by:

- (i) a carrier;
- (ii) a health benefit plan;
- (iii) a health benefit plan's fiduciary;
- (iv) an employer or sponsor of a health benefit plan;
- (v) a trade association of:
 - (A) health benefit plans;
 - (B) carriers; or
 - (C) health care providers; or

- (vi) an employee or agent of any one listed in Subsection (5)(a)(i) through (v).
- (b) An independent review organization and the clinical reviewer assigned to conduct an independent review may not have a material professional, familial, or financial conflict of interest with:
- (i) the carrier;
 - (ii) an officer, director, or management employee of the carrier;
 - (iii) the health benefit plan;
 - (iv) the plan administrator, plan fiduciaries, or plan employees;
 - (v) the insured or claimant;
 - (vi) the claimant's health care provider;
 - (vii) the health care provider's medical group or independent practice association;
 - (viii) a health care facility where the service would be provided; or
 - (ix) the developer or manufacturer of the service that would be provided.

R590-261-10. Standard Independent Review.

- (1) The carrier shall pay the cost of the independent review organization for conducting the independent review.
- (2) The independent review of an adverse benefit determination is available to the claimant regardless of the dollar amount of the claim involved.
- (3)(a) The claimant shall have 180 calendar days after the receipt of a notice of an adverse benefit determination to file a request with the commissioner for an independent review.
- (b) The claimant shall use the Independent Review Request Form attached to this rule as Appendix B to file the request.
- (c) A request for an independent review sent to the carrier instead of the commissioner shall be forwarded to the commissioner by the carrier within one business day of receipt.
- (4)(a) Upon receipt of a request for an independent review, the commissioner shall send a copy of the request to the carrier for a preliminary review.
- (b) Within five business days following receipt of the copy of the request, the carrier shall determine whether:
- (i) the individual is or was a covered person in the health benefit plan;
 - (ii) the health care service that is the subject of the adverse benefit determination is a covered expense;
 - (iii) the claimant has exhausted the carrier's internal review process; and
 - (iv) the claimant has provided all the information and forms required to process an independent review.
- (c)(i) Within one business day after completion of the preliminary review, the carrier shall notify the commissioner and claimant in writing whether:
- (A) the request is complete; and
 - (B) the request is eligible for independent review.
- (ii) If the request:
- (A) is not complete, the carrier shall inform the claimant and commissioner in writing what information or materials are needed to make the request complete; or
 - (B) is not eligible for independent review, the carrier shall inform the claimant and commissioner in writing the reasons for ineligibility.

(iii) If the carrier determines that the request for independent review is ineligible, the carrier's notice of ineligibility shall inform the claimant that the determination may be appealed to the commissioner.

(d)(i) The commissioner may determine that a request is eligible for independent review notwithstanding the carrier's initial determination that the request is ineligible and require that the request be referred for independent review.

(ii) In making the determination in (d)(i), the commissioner's decision shall be made in accordance with the terms of the claimant's health benefit plan and shall be subject to all applicable provisions of this rule.

(5) Upon receipt of the carrier's preliminary determination, the commissioner shall:

(a)(i) assign on a random basis an independent review organization from the list of approved independent review organizations based on the nature of the health care service that is the subject of the review;

(ii) notify the carrier of the assignment; and

(b) notify the claimant that the request has been accepted and that the claimant may submit additional information to the independent review organization within five business days of receipt of the commissioner's notification..

(5) Within 45 calendar days after receipt of the request for an independent review, the independent review organization shall provide written notice of its decision to uphold or reverse the adverse benefit determination to:

(a) the claimant;

(b) the carrier; and

(c) the commissioner.

(6) The independent review decision is binding on the carrier and claimant except to the extent that other remedies are available under federal or state law.

R590-261-11. Expedited Independent Review.

(1) An expedited independent review process shall be available if the adverse benefit determination:

(a) involves a medical condition of the claimant which would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; or

(b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse benefit determination.

(2) The independent review organization shall as soon as possible, but no later than 72 hours after receipt of the request for an expedited independent review, make a decision to uphold or reverse the adverse benefit determination and notify the carrier and claimant.

R590-261-12. Independent Review of Experimental or Investigational Treatment Adverse Benefit Determinations.

(1) The claimant has 180 calendar days after the receipt of an adverse benefit determination that involves a denial of coverage based on a determination that the service or treatment recommended or requested is experimental or investigational to file a request with the commissioner for an independent review.

(2) In addition to the requirements for an independent review set forth in Sections 9 and 10, the following apply to an independent review involving experimental or investigational treatment:

(a) the request for an independent review based on experimental or investigational treatment shall be submitted with certification from the claimant's physician that:

(i) standard health care services or treatments have not been effective in improving the claimant's condition;

(ii) standard health care service or treatment is not medically appropriate for the claimant; or

(iii) there is no available standard health care service or treatment covered by the carrier that is more beneficial than the recommended or requested health care service or treatment.

(b) Within one business day after receipt of the request, the independent review organization shall select one or more clinical reviewers to conduct the review.

(c) The clinical reviewer shall provide to the independent review organization a written opinion within 20 calendar days after being selected.

(d) The independent review organization shall make a decision based on the clinical reviewer's opinion within 20 calendar days of receiving the opinion and shall notify the:

(i) claimant;

(ii) carrier; and

(iii) commissioner.

R590-261-13. Disclosure Requirements.

(1) Each carrier shall include a description of the independent review procedure in or attached to the policy and certificate, and may include a description with other evidence of coverage provided to the insured.

(2) The description required in Subsection (1) shall include a statement that informs the insured:

(a) of the right to file a request for an independent review of a final adverse benefit determination and include the contact information for the commissioner; and

(b) that an authorization to obtain medical records may be required for the purpose of reaching a decision.

R590-261-14. Records.

(1) An independent review organization shall maintain a written record of each independent review for the current year plus 5 years.

(2) The records of an independent review organization shall be available for review by the commissioner upon request.

R590-261-15. Penalties.

A person found to be in violation of this rule shall be subject to penalties as provided under Section 31A-2-308.

R590-261-16. Enforcement Date.

The commissioner shall begin enforcing the provisions of this rule July 1, 2011.

R590-261-17. Severability.

If any provision of this rule or its application to any person or situation is held to be invalid, that invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

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