Dear Senators ANDREASON, McKague, Stennett, and
Representatives BLACK, Henderson, Smith:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of the Department of Insurance:

IDAPA 18.01.05 - Rules Pertaining To The Health Carrier External Review (Docket No. 18-0105-1101).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research and Legislation no later than fourteen (14) days after receipt of the rules analysis from Legislative Services. The final date to call a meeting on the enclosed rules is no later than 09/19/2011. If a meeting is called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules analysis from Legislative Services. The final date to hold a meeting on the enclosed rules is 10/17/2011.

The germane joint subcommittee may request a statement of economic impact with respect to a proposed rule by notifying Research and Legislation. There is no time limit on requesting this statement, and it may be requested whether or not a meeting on the proposed rule is called or after a meeting has been held.

To notify Research and Legislation, call 334-4845, or send a written request to the address or FAX number indicated on the memorandum enclosed.

Legislative Services Office
Idaho State Legislature

Serving Idaho's Citizen Legislature

Jeff Youtz
Director

MEMORANDUM

TO: Rules Review Subcommittee of the Senate Commerce & Human Resources Committee and the House Business Committee

FROM: Legislative Research Analyst - Ryan Bush

DATE: August 30, 2011

SUBJECT: Department of Insurance

IDAPA 18.01.05 - Rules Pertaining To The Health Carrier External Review (Docket No. 18-0105-1101)

The Idaho Department of Insurance submits notice of temporary and proposed rulemaking at IDAPA 18.01.05 - Health Carrier External Review. The Department's rulemaking is prompted by House Bills No. 131 and No. 299 that were passed by the 2011 Legislature, amending the Idaho Health Carrier External Review Act. The Department states that the proposed rule more closely conforms to the model external review law developed by the National Association of Insurance Commissioners. The Department further states that the proposed changes expand the types of claims eligible for external review to include denials based on appropriateness, health care setting, level of care and effectiveness; clarify the definition of an "urgent care request"; permit a person to simultaneously file for internal and external review of an urgent care request in certain circumstances; allow self-funded ERISA health plans to opt into the state external review process if they do not wish to use the federal external review process and include changes to notices to be given by health carriers to covered persons. Specifically, this rulemaking accomplishes the following:

(1) Revises references of the appendices to be used by health carriers in disclosure and notice to covered persons;

(2) Creates requirements for voluntary election by ERISA plan administrators;

(3) Revises the grounds for disapproval of existing health benefit plans with terms that are misleading or unfairly prejudicial;

(4) Amends Appendix A - Health Carrier Disclosures - to allow for further independent review if a plan is subject to ERISA; to include review for appropriateness, health care setting, level of care or effectiveness; to revise the definition of urgent care request; to provide for expedited review of an urgent care request and to clarify how a covered person is notified of a health carrier's intent to pay;

(5) Amends Appendix B - Health Carrier Notice - to allow for further independent review if a plan is subject to ERISA; to include review for appropriateness, health care setting, level of care or effectiveness; to revise the definition of urgent care request; to provide for expedited review of an urgent care request and to clarify how a covered person is notified of a health carrier's intent to pay;

(6) Renames Appendix C - Authorization for Release of Medical Records - to Appendix C-1;

(7) Creates Appendix C-2 to authorize the release of drug or alcohol abuse records and psychotherapy notes of covered persons;

(8) Amends Appendix D - Health Carrier's Notice of Initial Determination - to notify the covered person that appropriateness, health care setting, level of care and effectiveness were considered and that the health carrier's adherence to its grievance process, an urgent care request and application for an expedited internal review were also considered.

The proposed rule appears to comply with the requirements of House Bills No. 131 and No. 299 as codified in Sections 41-5903 through 41-5909, 41-5915 and 41-5916, Idaho Code.

The Department states that negotiated rulemaking was not conducted because the proposed rule change is required by a change to the governing law and a draft of the proposed rule was circulated to interested parties. There is no negative fiscal impact resulting from this rulemaking

The proposed rule appears to be within the authority granted to the Idaho Department of Insurance in Sections 41-211, 41-5905(2), 41-5906, 41-5908(7), 41-5909(3)(a) and 41-5911(9), Idaho Code.

cc: Department of Insurance
William W. Deal
Eileen Mundorff

IDAPA 18 - DEPARTMENT OF INSURANCE

18.01.05 - HEALTH CARRIER EXTERNAL REVIEW

DOCKET NO. 18-0105-1101

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2011.

AUTHORITY: In compliance with Section 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 41-211, 41-5905, 41-5906, 41-5908, 41-5909, 41-5911, and 41-5916, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 28, 2011.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rulemaking implements House Bills 131 and 299, amending the Idaho Health Carrier External Review Act to more closely conform to the model external review law developed by the National Association of Insurance Commissioners (NAIC). The changes expand the types of claims eligible for external review to include denials based on appropriateness, health care setting, level of care and effectiveness. The changes also clarify the definition of an "urgent care request," and permit a person to simultaneously file for internal and external review of an urgent care request in certain circumstances. In addition, self-funded ERISA health plans may opt into the state external review process if they do not wish to use the federal external review process. The rulemaking also includes changes to notices to be given by health carriers to covered persons.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that the temporary adoption of the rule is appropriate for the following reason: The rule is necessary to implement changes to the governing law effective July 1, 2011.

FEE SUMMARY: The following is a descriptive summary of the fee or charge being imposed or increased: The rule does not impose or increase a fee.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: No fiscal impact.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the change is required by a change to the governing law. A draft of the rule was circulated to interested parties.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary and proposed rule, contact Eileen Mundorff, 208-334-4326 or Eileen.Mundorff@doi.idaho.gov.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 28, 2011.

DATED this 4th day of August, 2011.

William W. Deal, Director
Idaho Department of Insurance
700 West State Street, 3rd Floor
Boise, Idaho 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

THE FOLLOWING IS THE TEMPORARY RULE & PROPOSED TEXT OF DOCKET NO. 18-0105-1101

020. NOTICE OF RIGHT TO EXTERNAL REVIEW.

01. Disclosure to Covered Persons. Each health carrier must provide a summary description of external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage the health carrier provides to covered persons. Health carriers must use the summary description in Appendix A or one that in the discretion of the Director is substantially identical. This ~~*form*~~ summary description in Appendix A has been approved by the Director as meeting the requirements of Section 41-5916, Idaho Code, and this rule. Health carriers must submit summary description forms to the Director for review.
~~*(4-7-11)*~~(7-1-11)T

02. Notice to Covered Person. When a health carrier sends written notice to a covered person of a final adverse benefit determination ~~*for medical necessity or as investigational*~~, the health carrier must send written notice at the same time of the covered person's right to request an external review. ~~*(4-7-11)*~~(7-1-11)T

a. The written notice of the covered person's right to request an external review must use the form set forth in Appendix B or one that in the discretion of the Director is substantially identical. The notice form in Appendix B has been approved by the Director as meeting the requirements of Section 41-5905, Idaho Code, and this rule. Health carriers must submit notice forms to the Director for review. ~~*(4-7-11)*~~(7-1-11)T

b. The written notice sent by the health carrier as required by this subsection must include an authorization form to disclose protected health information in compliance with the federal regulation 45 CFR section 164.508. The authorization forms in Appendix C-1 and C-2 ~~*has*~~ have been approved by the Director as meeting the requirements of Section 41-5905, Idaho Code, and this rule and health carriers must use these forms or ones that in the discretion of the Director are substantially identical. Health carriers must submit authorization forms to the Director for review. ~~*(4-7-11)*~~(7-1-11)T

021. REQUEST FOR EXTERNAL REVIEW.

01. Request Form. The form for a covered person to request an external review will be available from the department and will be posted on the department's web site. (4-7-11)

02. Authorization Form. The covered person's request for an external review must include ~~*the*~~ an authorization form to disclose protected health information required in ~~*Subsection*~~ Paragraph 020.0~~3~~2.b. The department will not act on an external review request until the department receives ~~*this*~~ the applicable form completed by the covered person or the covered person's authorized representative. ~~*(4-7-11)*~~(7-1-11)T

03. Appointment of an Authorized Representative. A covered person may name another person, including the treating health care provider, to act as the covered person's authorized representative for an external review request. (4-7-11)

022. HEALTH CARRIER NOTICE OF INITIAL DETERMINATION OF AN EXTERNAL REVIEW REQUEST.
Health carriers must use the form set forth in Appendix D or one that in the discretion of the Director is substantially identical for notice of initial determination by a health carrier for a standard external review required by Section 41-5908, Idaho Code, and for an expedited external review required by Section 41-5909, Idaho Code. Health carriers must submit notice forms to the Director for review. ~~*(4-7-11)*~~(7-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

024. ~~*ANNUAL REPORTING REQUIREMENTS*~~ VOLUNTARY ELECTION BY ERISA PLAN ADMINISTRATOR.

~~*All independent review organizations and health carriers must file with the Director, on or before March 1st of each year, an annual statement on the form available from the Department of Insurance and posted on the department's web site. An annual report is required regardless of whether any external review requests were sent to the independent review organization or health carrier during the year.*~~ ~~*(4-7-11)*~~

01. **Written Notice and Compliance**. If a single employer self-funded ERISA employee benefit plan administrator or designee voluntarily elects to comply with Title 41, Chapter 59, Idaho Code, the administrator or designee must: (7-1-11)T

a. Provide timely and appropriate written notice to the Director of such election. The written notice must include the name of the administrator or designee, the contact name and title of the person to receive correspondence for the administrator or designee, that person's email address, voice and facsimile numbers, and the name of the employer or plan; (7-1-11)T

b. Provide written notice to the plan beneficiary of any final adverse benefit determination and of the beneficiary's right to an external review pursuant to Title 41, Chapter 59, Idaho Code, as required by Subsection 020.02 of this rule; and (7-1-11)T

c. Comply with all other provisions of Title 41, Chapter 59, Idaho Code, and this rule, as if it were a health carrier, except the administrator or designee is not required to submit for the Director's review the forms attached to this rule as appendices. (7-1-11)T

02. **Single Plan Beneficiary**. The written notice to the Director required in Subsection 024.01 of this rule for a single plan beneficiary must be included with the notice of initial determination of an external review request in Section 022. The notice must include the plan beneficiary's name and identification number. The administrator or designee may not request the Director terminate an external review for a single plan beneficiary while the review is in progress unless the administrator or designee has reversed the final adverse benefit determination and has notified the beneficiary it will pay benefits for the disputed service or supply. (7-1-11)T

03. **Specific Period of Time**. The written notice to the Director required in Subsection 024.01 for a specific period of time must include the start date and end date for that period of time. The notice must be received by the Director at least thirty (30) days in advance of the date the specific period of time will begin. Any change in the start or end date for a specific period of time on file with the Director must be received in writing at least thirty (30) days in advance of the date the change will take effect. The termination of the specific period of time will not terminate an external review in progress unless the administrator or designee has reversed the final adverse benefit determination and has notified the beneficiary it will pay benefits for the disputed service or supply. (7-1-11)T

04. **Effect of Election**. Any single employer self-funded ERISA employee benefit plan administrator or designee that voluntarily elects to comply with Title 41, Chapter 59, Idaho Code, and this chapter of rules, does not, solely by such election and/or compliance, waive any rights, remedies, duties, causes of action, or defenses it otherwise has under ERISA or other applicable law. (7-1-11)T

025. -- 029. (RESERVED)

030. EFFECTIVE DATE -- EXISTING HEALTH BENEFIT PLANS -- GROUNDS FOR DISAPPROVAL.

01. **Effective Date of Rule**. This rule is applicable to every health benefit plan issued or renewed on and after January 1, 2010. (4-7-11)

02. **Health Benefit Plan Compliance**. A health benefit plan issued before the effective date of this rule must be brought into compliance with this rule by the anniversary date or renewal date of the plan following the effective date of this rule. (4-7-11)

03. **Grounds for Disapproval**. ~~*Any health benefit plan containing terms inconsistent with the provisions of this rule is misleading, inequitable and unfairly prejudicial to the covered person and the insurance buying public.*~~ In addition to any other sanction or remedy afforded by Title 41, Idaho Code, the use of provisions

inconsistent with this rule in a health benefit plan will be grounds for the Director to disapprove the health benefit plan in accordance with Section 41-1813, Idaho Code, on the basis that the terms are deemed to be misleading and unfairly prejudicial. ~~(4-7-11)~~(7-1-11)T

031. -- 999. (RESERVED)

APPENDICES:

A	Health Carrier Disclosures - "Your Right to an Independent External Review
B	Health Carrier Notice - "Notice of Your Right to an Independent External Review"
C-1	Authorization for Release of Medical Records
C-2	Authorization for Release of Drug or Alcohol Abuse Records and Psychotherapy Notes
D	Health Carrier's Notice of Initial Determination

Appendix A

The summary description below provides an acceptable format approved by the director as meeting the requirements of Idaho Code Section 41-5916. A health carrier may change the terms "you, your" to "covered person" and "we, our" to the health carrier's name, or similar references consistent with the health carrier's typical terminology.

YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final on the health carrier. ~~Except in limited circumstances, y~~Y~~ou will have ~~no further~~ the right to ~~have~~ further review of your claim ~~reviewed~~ by a court, arbitrator, mediator or other dispute resolution entity only if your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as more fully explained below under "Binding Nature of the External Review Decision."

If we issue a final adverse benefit determination of your request to provide or pay for a health care service or supply, you may have the right to have our decision reviewed by health care professionals who have no association with us. You have this right only if our denial decision involved:

- The medical necessity, appropriateness, health care setting, level of care, or effectiveness of your health care service or supply, or
- Our determination your health care service or supply was investigational.

You must first exhaust our internal grievance and appeal process. Exhaustion of that process includes completing all levels of appeal, or unless you requested or agreed to a delay, our failure to respond to a standard appeal within 35 days in writing or to an urgent appeal within three business days of the date you filed your appeal. We may also agree to waive the exhaustion requirement for an external review request. You may file for an internal urgent appeal with us and for an expedited external review with the Idaho Department of Insurance at the same time if your request qualifies as an "urgent care request" defined below.

You may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St., 3rd Floor
Boise ID 83720-0043

For more information and for an external review request form:

- See the department's website at http://www.doi.idaho.gov, or
- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

You may represent yourself in your request or you may name another person, including your treating health care provider, to act as your authorized representative for your request. If you want someone else to represent you, you must include a signed "Appointment of an Authorized Representative" form with your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records the independent review organization may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The department will not act on an external review request without your completed authorization form.

If your request qualifies for external review, our final adverse benefit determination will be reviewed by an independent review organization selected by the department. We will pay the costs of the review.

Standard External Review Request: You must file your written external review request with the department within four months after the date we issue a final notice of denial.

1. Within seven days after the department receives your request, the department will send a copy to us.
2. Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may appeal that determination to the department.
3. If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
4. Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to you, to us and to the department within 42 days after receipt of an external review request.

Expedited External Review Request: You may file a written "urgent care request" with the department for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

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

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
2. In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of ~~*the approval of coverage*~~ our intent to pay the covered benefit as soon as reasonably practicable, but not later than one business day after ~~*making the determination*~~ receiving notice of the decision.

Binding Nature of the External Review Decision: If your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees), the external review decision by the independent review organization will be final and binding on us. You may have additional review rights provided under federal ERISA laws.

If your plan is not subject to ERISA requirements, the external review decision by the independent review organization will be final and binding on both you and us. **This means that if you elect to request external review, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of our denial after the independent review organization issues its final decision.** If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

Appendix B

The notice below provides an acceptable format approved by the director as meeting the requirements of Idaho Code Section 41-5905. A health carrier may change the terms "you, your" to "covered person" and "we, our" to the health carrier's name, or similar references consistent with the health carrier's typical terminology.

NOTICE OF YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final on the health carrier. ~~*Except in limited circumstances, y*~~Y~~ou will have ~~*no further*~~ the right to ~~*have*~~ further review of your claim reviewed by a court, arbitrator, mediator or other dispute resolution entity only if your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA) -- see below under "Binding Nature of the External Review Decision" for more information.

We have denied your request to provide or pay for a health care service or supply. You may have the right to have our decision reviewed by health care professionals who have no association with us. You have this right only if our denial decision involved:

- The medical necessity, appropriateness, health care setting, level of care, or effectiveness of your health care service or supply, or
- Our determination your health care service or supply was investigational.

No later than four months from the date of this denial, you may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St., 3rd Floor
Boise ID 83720-0043

For more information and for an external review request form:

- See the department's website at http://www.doi.idaho.gov, or
- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

You may represent yourself in your request or you may name another person, including your treating health care provider, to act as your authorized representative for your request. If you want someone else to represent you, you must include a signed "Appointment of an Authorized Representative" form with your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records the independent review organization may require for review to reach a decision on the external review. The department will not act on an external review request without your completed authorization form.

If your request qualifies for external review, our decision will be reviewed by an independent review organization selected by the department. We will pay the costs of the review.

Standard External Review Request: You must file your written external review request with the department **within four months** after the date we issued this notice of denial.

1. Within seven days after the department receives your request, the department will send a copy to us.
2. Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may appeal that determination to the department.
3. If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
4. Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to you, to us and to the department within 42 days after receipt of an external review request.

Expedited External Review Request: You may file a written "urgent care request" with the department for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

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

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
2. In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of ~~*the approval of coverage*~~ our intent to pay the covered benefit as soon as reasonably practicable, but not later than one business day after ~~*making the determination*~~ receiving notice of the decision.

Binding Nature of the External Review Decision: *[NOTE TO HEALTH CARRIERS: The carrier must include one of the applicable paragraphs below for the covered person's health benefit plan.]*

*[*Your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees). The external review decision by the independent review organization will be final and binding on the health insurer, but you may have additional review rights provided under federal ERISA laws.*]*

*[*The external review decision by the independent review organization will be final and binding on both you and us. **This means that if you elect to request external review of your claim, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of your claim after the independent review organization issues its final decision.** If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.*]*

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

Appendix C-1

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I have requested an external review pursuant to Idaho Code Section 41-5906. In order to obtain that review, I understand that I must sign below to authorize my health carrier, whose decision is the subject of this request, and its subcontractors and all applicable medical providers, to release all information relating to the decision to be reviewed including, but not limited to, my files and medical record information, which may include mental health information to the Idaho Department of Insurance (DOI). I authorize the DOI to provide or to instruct the health carrier and/or its subcontractors and providers to provide such information to the independent review organization (IRO) assigned by the DOI to perform the external review.

I, _____, hereby reaffirm my request for an external review. I attest that the information provided in this request is true and accurate to the best of my knowledge. I authorize my health carrier, its subcontractors and agents, and my health care providers to release all relevant medical or treatment records to the independent review organization (IRO) and the Idaho Department of Insurance (DOI). I understand the IRO will use this information to make a determination on my external review and the information will be kept confidential and not be released to anyone else. This release is valid for one year unless it expires sooner upon the IRO rendering a final decision or upon revocation. I understand that the decision of the IRO may be binding and that neither the DOI nor the IRO may authorize services in excess of those covered by my health plan.

I acknowledge that I may revoke this authorization at any time. My revocation will be effective upon receipt, but will not affect actions already taken on the basis of the authorization. In any event, this authorization expires upon the IRO rendering a final decision regarding this external review.

_____

Signature of Covered Person (or authorized representative)* Date

_____

*(Parent, Guardian, Conservator or Other - Please Specify)

_____

Printed Name of Authorized Representative

Complete the following form only if applicable:

Appendix C-2

AUTHORIZATION FOR RELEASE OF DRUG OR ALCOHOL ABUSE RECORDS AND PSYCHOTHERAPY NOTES

I have requested an external review pursuant to Idaho Code Section 41-5906. In order to obtain that review, I understand that I must sign below to authorize my health carrier, whose decision is the subject of this request, and its subcontractors and all applicable medical providers, to release all information relating to the decision to be reviewed including, but not limited to, my files and medical record information, which may include mental health information to the Idaho Department of Insurance (DOI). I authorize the DOI to provide or to instruct the health carrier and/or its subcontractors and providers to provide such information to the independent review organization (IRO) assigned by the DOI to perform the external review. I acknowledge that information to be used or disclosed as a result of this authorization may include records that are protected by federal and/or state laws applicable to substance abuse and psychotherapy. I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO PSYCHOTHERAPY, DRUG AND/OR ALCOHOL ABUSE. The recipient of drug and/or alcohol abuse and psychotherapy information disclosed as a result of this authorization will need my further written authorization to re-disclose this information.

I, _____, hereby reaffirm my request for an external review. I attest that the information provided in this request is true and accurate to the best of my knowledge. I authorize my health carrier, its subcontractors and agents, and my health care providers to release all relevant medical or treatment records to the independent review organization (IRO) and the Idaho Department of Insurance (DOI). I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO PSYCHOTHERAPY, DRUG AND/OR ALCOHOL ABUSE. I understand the IRO will use this information to make a determination on my external review and the information will be kept confidential and not be released to anyone else. This release is valid for one year unless it expires sooner upon the IRO rendering a final decision or upon revocation. I understand that the decision of the IRO may be binding and that neither the DOI nor the IRO may authorize services in excess of those covered by my health plan.

I acknowledge that I may revoke this authorization at any time. My revocation will be effective upon receipt, but will not affect actions already taken on the basis of the authorization. In any event, this authorization expires upon the IRO rendering a final decision regarding this external review.

_____

Signature of Covered Person (or authorized representative)* Date

_____

*(Parent, Guardian, Conservator or Other - Please Specify)

_____

Printed Name of Authorized Representative

*Parent (if patient is under 18 years old), guardian (if other than patient), conservator, attorney or other. If other than parent of minor, attach a written authorization to represent patient.

Return to:
Idaho Dept of Insurance
PO Box 83720
Boise, ID 83720-0043

Appendix D

HEALTH CARRIER'S NOTICE OF INITIAL DETERMINATION

[Date]

[Covered Person/Authorized Representative]

[Address]

RE: Initial Determination of Your Request for an External Review

We completed our preliminary review of your request for an external review sent to us by the Idaho Department of Insurance. As part of our review, we considered:

1. Eligibility of the covered person under the health benefit plan at the time the health care service was requested, or, for a post-service review, the health care service was performed;
2. If the health care service is a covered service under the health benefit plan, except for our determination the health care service does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or the service or supply is investigational;
3. If the covered person has exhausted our internal grievance process, or if we failed to provide a timely determination ~~to~~ for a grievance under that process; or if we waived the exhaustion requirement under that process; or if we failed to strictly follow our duties in affording a timely, full and fair opportunity for you to take advantage of that grievance process; or if the request qualifies as an urgent care request and you've simultaneously applied for an expedited internal review; and
4. All information and forms required to process an external review, including your signed authorization to disclose protected health information.

[*If the request is complete and eligible for review:*
We determined your request is complete and eligible for external review. We sent a copy of this notice to the Idaho Department of Insurance. The Department of Insurance will assign an independent review organization to perform the review and will notify you of the name of that organization.]

[*OR if the request is not complete:*
We have determined your request is not complete. In order to complete your request, you must provide the following: *(Provide details of what information or materials are needed to make the request complete.)]*

[*OR if the request is not eligible for external review:*
We have determined your request is not eligible for external review. Your request is ineligible for the following reasons: *(Provide details of the reasons for denial.)*
If you disagree with our initial determination that your request is ineligible, you may file a written appeal with the Director of the Idaho Department of Insurance within 30 days of the date of this notice. Your appeal must include adequate detail and documentation to show proof of your eligibility. The Director may determine a request is eligible based on the terms and conditions of the covered person's health benefit plan and the applicable provision of Idaho Code, Title 41, Chapter 59.]

[Include the following for all notices:]

For further information, please contact the Idaho Department of Insurance, (208) 334-4250, or toll-free, 1-800-721-3272. The department's fax number is (208) 334-4398. The department's website ~~at~~ is http://www.doi.idaho.gov.

Sincerely,

[Health Carrier]

C: Idaho Department of Insurance/External Review