LEGISLATURE OF THE STATE OF IDAHO

Sixty-first Legislature First Regular Session - 2011

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 131

BY BUSINESS COMMITTEE

AN ACT

RELATING TO THE IDAHO HEALTH CARRIER EXTERNAL REVIEW ACT; AMENDING SECTION 41-5903, IDAHO CODE, TO REVISE DEFINITIONS; AMENDING SECTION 41-5904, IDAHO CODE, TO REMOVE LANGUAGE RELATING TO CERTAIN FINAL ADVERSE BENEFIT DETERMINATIONS AND TO MAKE A TECHNICAL CORRECTION; AMENDING SECTION 41-5905, IDAHO CODE, TO REVISE PROVISIONS RELATING TO NOTICE OF THE RIGHT TO AN EXTERNAL REVIEW; AMENDING SECTION 41-5906, IDAHO CODE, TO REMOVE PROVISIONS RELATING TO THE DUTY OF THE DIRECTOR TO PRESCRIBE A CERTAIN RULE AND TO CORRECT A CODIFIER'S ERROR; AMENDING SECTION 41-5907, IDAHO CODE, TO REVISE PROVISIONS RELATING TO THE EXHAUSTION OF THE INTERNAL GRIEVANCE PROCESS; AMENDING SECTION 41-5908, IDAHO CODE, TO REVISE AND TO PROVIDE ADDITIONAL PROVISIONS RELATING TO A STANDARD EXTERNAL REVIEW AND TO PROVIDE CORRECT TERMINOLOGY; AMENDING SECTION 41-5909, IDAHO CODE, TO REVISE PROVISIONS RELATING TO AN EXPEDITED EXTERNAL REVIEW; AMENDING SECTION 41-5915, IDAHO CODE, TO REMOVE PROVISIONS RELATING TO THE AUTHORITY OF THE DIRECTOR TO PROVIDE BY RULE FOR A CERTAIN FEE; AND AMENDING SECTION 41-5916, IDAHO CODE, TO PROVIDE ADDITIONAL DISCLOSURE REQUIREMENTS.

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

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

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

(1) "Administrative record" means all nonprivileged documents, records or other health information which was submitted, considered, generated or relied upon by the health carrier in the course of making the adverse benefit determination, including, but not limited to, documents, records or other information that constitutes the plan's policy statements or guidance concerning the denied treatment or benefit, all records provided by the covered person or the covered person's medical care provider related to the denied treatment or benefit, all records provided to an independent review organization as part of the independent review of the denied treatment or benefit and the opinion issued by the independent review organization.

(2) "Adverse benefit determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity<u>, appropriateness, health care setting, level of care, effectiveness</u> or has been determined to be an investigational service<u>,</u> and the requested service or payment for the service is therefore terminated, denied or reduced.

(3) "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

(4) "Authorized representative" means:

(a) A person to whom a covered person has given express written consent to represent the covered person in an external review;

(b) A person authorized by law to provide substituted consent for a covered person; or

(c) A family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

(5) "Best evidence" means evidence based on randomized clinical trials.

(a) If randomized clinical trials are not available, then cohort studies or case-control studies;

(b) If studies in paragraph (a) of this subsection (5) are not available, then case-series.

(6) "Case-control study" means a retrospective evaluation of two (2) groups of patients with different outcomes to determine which specific interventions the patients received.

(7) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

(8) "Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

(9) "Certification" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

(10) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

(11) "Cohort study" means a prospective evaluation of two (2) groups of patients with only one (1) group of patients receiving a specific intervention(s).

(12) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(13) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms and conditions of a health benefit plan.

(14) "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan. A covered person includes the authorized representative of the covered person.

(15) "Director" means the director of the Idaho department of insurance.

(16) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

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

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

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

(20) "Expert" means a specialist with experience in a specific area about the scientific evidence pertaining to a particular service, intervention or therapy.

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

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

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

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

(25) "Health care provider" or "provider" means a health care professional or a facility.

(26) "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

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

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

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

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

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

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

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

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

(b) Medical or scientific evidence regarding the technology is sufficiently comprehensive to permit well substantiated conclusions concerning the safety and effectiveness of the technology;

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

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

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

(31) "Medically necessary" or "Mmedical necessity" means the definition provided in the covered person's health benefit plan; if the covered person's health benefit plan does not define "medically necessary" or "medical necessity," these terms shall mean health care services and supplies that a physician or other health care provider, exercising prudent clinical judgment, would provide to a covered person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

(a) In accordance with generally accepted standards of medical practice;

(b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease;

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

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

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

(32) "Medical or scientific evidence" means evidence found in the following sources:

(a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

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

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

(d) The following standard reference compendia:

(i) The American hospital formulary service -- drug information;

(ii) Drug facts and comparisons;

(iii) The United States pharmacopoeia -- drug information; and

(iv) The American dental association accepted dental therapeutics.

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

(i) The federal agency for healthcare research and quality;

(ii) The national institutes of health;

(iii) The national cancer institute;

(iv) The national academy of sciences;

(v) The centers for medicare and medicaid services;

(vi) The federal food and drug administration; and

(vii) Any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services; or

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

(33) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

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

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

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

(a) That identifies an individual who is the subject of the information; or

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

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

(38) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

(39) "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:

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

(b) 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

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

The opinion of the covered person's treating health care professional with knowledge of the covered person's medical condition that a request is an urgent care request should be treated with deference.

(40) "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. Techniques may include ambulatory review, pre-service review, second opinion, certification, concurrent review, case management, discharge planning or post service review.

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

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

41-5904. APPLICABILITY AND SCOPE. (1) Except as provided in subsection (2) of this section, this chapter shall apply to all health carriers~~' final adverse benefit determinations which involve an issue of medical necessity or investigational service or supply~~.

(2) The provisions of this chapter shall not apply to a plan, policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage; nor shall this chapter apply to a credit, dental, disability income, hospital indemnity, long-term care insurance, vision care, limited benefit health plans or any other limited supplemental benefit; nor shall this chapter apply to a medicare advantage plan or medicare supplemental policy of insurance, as defined by the director by rule, coverage under a plan through medicare, medicaid, or the federal employees health benefits program, any coverage issued under chapter 55, title 10, of the United States Code and any coverage issued as supplemental to that coverage; nor shall this chapter apply to any coverage issued as supplemental to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or any insurance under which benefits

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

(3) The availability or use of external review pursuant to this chapter shall not alter the standard of review used by a court of competent jurisdiction when adjudicating the health carrier's final adverse benefit determination.

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

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

(2) The director may prescribe by rule the form and content of the notice required under this section, which shall include:

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

"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 health care professionals who have 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 your health care service or supply, or your health care service or supply was denied based upon a determination that it was investigational. You may request an external review by submitting a written request to the department of insurance."

The notice shall include contact information for the department of insurance, including the website, address and telephone number.

(b) If the adverse benefit determination is for a pre-service or concurrent service ~~and was denied based upon a failure to meet medical necessity criteria or because the service was determined to be investigational~~, the health carrier shall notify the covered person of the right to an expedited external review if the request is an urgent care request. The notification shall include the definition of urgent care request.

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

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

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

41-5906. REQUEST ~~TO~~ FOR EXTERNAL REVIEW. A covered person may make a request for an external review of a final adverse benefit determination. Except for a request for an expedited external review as set forth in section 41-5909, Idaho Code, all requests for external review shall be made in writing to the director. The director may prescribe by rule the form and content of external review requests required to be submitted under this section. ~~The director shall prescribe by rule the amount of the administrative filing fee, if any, to be paid by the covered person when the external review request is submitted.~~

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

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

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

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

(~~ii~~b) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within thirty-five (35) days following the date the covered person filed the grievance with the health carrier, or the covered person filed a grievance on an urgent care request on a pre-service or concurrent care adverse benefit determination and has not received a determination from the health carrier within three (3) business days after filing.

(~~b~~2) A request for an external review of an adverse benefit determination may be made before the covered person has exhausted the health carrier's internal grievance procedures as set forth in the health carrier's grievance appeal process whenever:

(a) T~~t~~he health carrier agrees to waive the exhaustion requirement;

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

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

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

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

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

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

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

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

(b) The health care service that is the subject of the final adverse benefit determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness or the service or supply is investigational;

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

(d) The covered person has provided all the information and forms required to process an external review, including the release form provided under section 41-5905(2)(d), Idaho Code.

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

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

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

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

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

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

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

(a) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the director pursuant to section 41-5911, Idaho Code, to conduct the external review and notify the health carrier of the name of the assigned independent review organization; and

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

(c) The director shall include in the notice provided to the covered person a statement that the covered person may submit, in writing, to the assigned independent review organization within seven (7) days following the date of receipt of the notice provided pursuant to subsection (9)(b) of this section, additional information that the independent review organization shall consider when conducting the external review.

(10) In reaching a decision, the assigned independent review organization is not bound by the exercise of discretion or any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal grievance process.

(11) Within fourteen (14) days after the date of receipt of the notice provided pursuant to subsection (9)(a) of this section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse benefit determination or final adverse benefit determination.

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

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

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

(14) Within one (1) business day after making the decision to terminate the external review pursuant to subsection (13) of this section, the independent review organization shall notify the covered person, the health carrier and the director.

(15) The assigned independent review organization shall review all of the information and documents received pursuant to subsection (11) of this section, and any other information submitted in writing to the independent review organization by the covered person pursuant to subsection (9)(c) of this section; provided however, that if the covered person does submit new information in writing to the ~~internal~~ independent review organization pursuant to subsection (9)(c) of this section, then the health carrier is entitled to seven (7) days following its receipt thereof to submit additional responsive information to the internal review organization.

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

(17) Upon receipt of the information, if any, required to be forwarded pursuant to subsection (16) of this section, the health carrier may reconsider its adverse determination or final adverse benefit determination that is the subject of the external review. Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review. The assigned independent review organization shall review all of the information and documents received pursuant to subsection (15) of this section.

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

(19) In addition to the documents and information provided pursuant to subsection (11) of this section, the assigned independent review organization, to the extent the information or documents are available, shall consider the following in reaching a decision:

(a) The covered person's medical records;

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

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

(d) The terms and conditions of coverage under the covered person's health benefit plan with the health carrier to ensure that the inde-

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

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

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

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

(h) The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (a) through (g) of this subsection (19) to the extent the information or documents are available.

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

(a) A general description of the reason for the request for external review;

(b) The date the independent review organization received the assignment from the director to conduct the external review;

(c) The date the external review was conducted;

(d) The date of its decision;

(e) The principal reason or reasons for its decision, including an explanation of the scientific or clinical judgment applied to reach its decision;

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

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

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

(22) Upon receipt of a notice of a decision pursuant to subsection (20) of this section reversing the adverse benefit determination or final adverse benefit determination, the health carrier shall approve as soon as reasonably practicable but not later than one (1) business day after receipt of the notice the coverage that was the subject of the adverse benefit determination or final adverse benefit determination.

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

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

(2) Upon receipt of a request for an expedited external review, the director shall send a copy of the request to the health carrier.

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

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

(b) The notice of initial determination shall include a statement informing the covered person that a health carrier's initial determination that an external review request is ineligible for review, may be appealed to the director.

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

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

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

(7) Upon receipt of the notice from the director of the name of the independent review organization assigned to conduct the expedited external review pursuant to subsection (5) of this section, the health carrier or its

designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse benefit determination and the final adverse benefit determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

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

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

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

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

(d) The terms and conditions of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is controlled by the terms and conditions of coverage under the covered person's health benefit plan with the health carrier to the extent the health plan's terms and conditions are not in conflict with this chapter;

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

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

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

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

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

(a) Make a decision to uphold or reverse the final adverse benefit determination; and

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

(10) If the notice provided pursuant to subsection (9)(b) of this section was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall:

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

~~the medical necessity criteria as defined in this chapter or, where the appeal is based upon a denial of a service as investigational, addressing the criteria for determination of investigational status as defined in this chapter~~; and

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

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

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

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

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

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

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

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

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

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

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

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

(d) A statement informing the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review including any judicial review of the external review decision pursuant to ERISA, if applicable.

(e) If the health plan is not subject to ERISA, a statement informing the covered person that the plan is not subject to ERISA and that if the covered person elects to request external review, the external review decision of the independent review organization shall be final and binding on both the covered person and the health carrier, as provided in section 41-5910, Idaho Code. If the health plan is subject to ERISA, the statement shall inform the covered person that the plan is subject to ERISA and that if the covered person elects to request external review, the external review decision of the independent review organization shall be final and binding on the health carrier but not the covered person, as provided in section 41-5910, Idaho Code, and that the covered person may have the right to judicial review under ERISA in a court of competent jurisdiction.