TITLE 41
INSURANCE

CHAPTER 59
IDAHO HEALTH CARRIER EXTERNAL REVIEW ACT

41-5901. SHORT TITLE. This chapter shall be known and may be cited as the "Idaho Health Carrier External Review Act."

[41-5901, added 2009, ch. 87, sec. 1, p. 240.]

41-5902. PURPOSE AND INTENT. The purpose of this chapter is to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of a final adverse benefit determination, as defined in this chapter.

[41-5902, added 2009, ch. 87, sec. 1, p. 240.]

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, appropriateness, health care setting, level of care, effectiveness or has been determined to be an investigational service, 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 "medical 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.

[41-5903, added 2009, ch. 87, sec. 1, p. 241; am. 2011, ch. 122, sec. 1, p. 333.]

41-5904. APPLICABILITY AND SCOPE. (1) Except as provided in subsection (2) of this section, this chapter shall apply to all health carriers.

(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); provided however, the single employer self-funded ERISA employee benefit plan administrator or designee may, by timely and appropriate written notice to the director, voluntarily elect to comply with the provisions of this chapter either for a single plan beneficiary or for a specific period of time. The director may promulgate rules establishing the procedure for an employee benefit plan administrator or designee, to voluntarily comply with the provisions of this chapter and to provide for an administrative fee to be paid by the employee benefit plan administrator for each voluntary external review request submitted to the department pursuant to this chapter.

(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.

[41-5904, added 2009, ch. 87, sec. 1, p. 245; am. 2011, ch. 122, sec. 2, p. 337; am. 2011, ch. 258, sec. 1, p. 703.]

41-5905. NOTICE OF RIGHT TO EXTERNAL REVIEW. (1) 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, 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.

[41-5905, added 2009, ch. 87, sec. 1, p. 245; am. 2011, ch. 122, sec. 3, p. 338.]

41-5906. REQUEST 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.

[41-5906, added 2009, ch. 87, sec. 1, p. 246; am. 2011, ch. 122, sec. 4, p. 339.]

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

(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

(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.

(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) The 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.

[41-5907, added 2009, ch. 87, sec. 1, p. 246; am. 2011, ch. 122, sec. 5, p. 339.]

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 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 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 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.

[41-5908, added 2009, ch. 87, sec. 1, p. 247; am. 2011, ch. 122, sec. 6, p. 340.]

41-5909. EXPEDITED EXTERNAL REVIEW. (1) A covered person may make a request for an expedited external review of a pre-service or concurrent service adverse benefit determination 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; 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 intent

to pay the covered benefit as soon as reasonably practicable but not later than one (1) business day after 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.

[41-5909, added 2009, ch. 87, sec. 1, p. 250; am. 2011, ch. 122, sec. 7, p. 343.]

41-5910. BINDING NATURE OF EXTERNAL REVIEW DECISION. (1) For a health care benefit plan not subject to the employee retirement income security act of 1974 (ERISA), the external review decision is final and binding on the health carrier and on the covered person. No judicial action or proceeding arising out of the external review decision or the issues determined by the external review decision shall be permitted. For a health care benefit plan subject to ERISA, the external review decision is final and binding on the health carrier; however, should the covered person seek judicial review of the external review decision, then the external review record and decision shall be included as a part of the administrative record for the purpose of review by any court of competent jurisdiction.

(2) A covered person may not file a subsequent request for external review involving the same adverse benefit determination or final adverse benefit determination for which the covered person has already received an external review decision pursuant to this chapter.

[41-5910, added 2009, ch. 87, sec. 1, p. 252.]

41-5911. APPROVAL OF INDEPENDENT REVIEW ORGANIZATIONS. (1) The director shall approve independent review organizations eligible to be assigned on a random basis to conduct external reviews under this chapter.

(2) In order to be eligible for approval by the director under this section to conduct external reviews under this chapter an independent review organization shall:

(a) Except as otherwise provided in this section, be accredited by a nationally recognized private accrediting entity that the director has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under section 41-5912, Idaho Code; and

(b) Submit an application for approval in accordance with subsection (4) of this section.

(3) The director shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

(4) Any independent review organization wishing to be approved to conduct external reviews under this chapter shall submit the application form and include with the form all documentation and information necessary for the director to determine whether the independent review organization sat-

isfies the minimum qualifications established under section 41-5912, Idaho Code.

(5) The director shall publish prominently on the department of insurance website notice of a submitted application or reapplication by an independent review organization to provide external reviews under this chapter.

(a) Any person wishing to comment on an application shall have forty-two (42) days, from the publication of notice by the director, to provide written comments to the director on the application or reapplication submitted by an independent review organization.

(b) The director shall review and consider the written comments received in determining whether to approve the application or reapplication of an independent review organization.

(c) The director may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

(6) The director may charge an application fee that independent review organizations shall submit to the director with an application for approval and reapproval.

(7) An approval is effective for two (2) years, unless the director determines before its expiration that the independent review organization no longer satisfies the minimum qualifications established under section 41-5912, Idaho Code.

(8) The director shall maintain and periodically update a list of approved independent review organizations. Whenever the director determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under section 41-5912, Idaho Code, the director shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this chapter. The director may also establish a standard flat fee schedule for each external review performed by the independent review organization.

(9) The director may promulgate administrative rules to carry out the provisions of this section.

[41-5911, added 2009, ch. 87, sec. 1, p. 252.]

41-5912. MINIMUM QUALIFICATIONS FOR INDEPENDENT REVIEW ORGANIZATIONS. (1) To be approved to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this chapter that include, at a minimum:

(a) A quality assurance mechanism in place that:

(i) Ensures that external reviews are conducted within the specified time frames and that required notices are provided in a timely manner;

(ii) Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;

(iii) Ensures the confidentiality of medical and treatment records and clinical review criteria; and

(iv) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this chapter;

(b) A toll free telephone service to receive information on a twenty-four (24) hour day, seven (7) day a week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

(c) An agreement to maintain and provide to the director the information set out in section 41-5914, Idaho Code.

(2) All clinical reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

(a) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

(b) Be 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 of the covered person;

(c) Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

(d) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental or professional competence or moral character.

(3) In addition to the requirements set forth in subsection (1) of this section, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of health care providers.

(4) In addition to any other requirements, to be approved to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review, nor any clinical reviewer assigned by the independent organization to conduct the external review, may have a material professional, familial or financial conflict of interest with any of the following:

(a) The health carrier that is the subject of the external review;

(b) The covered person whose treatment is the subject of the external review;

(c) Any officer, director or management employee of the health carrier that is the subject of the external review;

(d) The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(e) The facility at which the recommended health care service or treatment would be provided; or

(f) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(5) In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of subsection (4) of this section, the director shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case, or a clinical reviewer to be assigned by the independent review organization to conduct an external review of a specified case, may have an apparent professional, familial or financial relationship or connection with a person described in subsection (4) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

(6) An independent review organization that is accredited by a nationally recognized private accrediting entity, which has independent review accreditation standards that the director has determined are equivalent to or exceed the minimum qualifications of this section, shall be presumed in compliance with this section to be eligible for approval under section 41-5911, Idaho Code.

(7) The director shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section.

(8) Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the director in order for the director to determine whether the entity's standards are equivalent to or exceed the minimum qualifications established under this section.

(9) An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.

(10) Each independent review organization applying to the director to be approved shall include in its application its schedule of costs and fees for performing external reviews and shall file with the director any subsequent changes to its fee schedule. If the director finds that the proposed fees are excessive or unreasonable, the director shall disapprove the application or, if the review organization has already been approved, remove the organization from the list of eligible review organizations. An independent review organization may not impose charges for a review under this chapter that exceed those set forth on its schedule of fees filed with the director.

[41-5912, added 2009, ch. 87, sec. 1, p. 253.]

41-5913. HOLD HARMLESS FOR INDEPENDENT REVIEW ORGANIZATIONS. No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent or contractor of an independent review organization shall be liable in damages or otherwise to any person for any opinions rendered or acts or omissions performed within

the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this chapter unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence; provided that the health carrier shall not be liable in damages or otherwise to any person for any opinions rendered or acts or omissions performed by the independent review organization, its employees, agents or contractors within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this chapter.

[41-5913, added 2009, ch. 87, sec. 1, p. 255.]

41-5914. EXTERNAL REVIEW REPORTING REQUIREMENTS. (1) An independent review organization assigned pursuant to this chapter to conduct an external review shall maintain written records in the aggregate for Idaho by health carrier on all requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the director, as required under this section. Each independent review organization required to maintain written records on all requests for external review pursuant to this section for which it was assigned to conduct an external review shall submit to the director, upon request or at specified intervals, a report in the format specified by the director.

(2) The report shall include in the aggregate for Idaho for each health carrier:

(a) The total number of requests for external review;

(b) The number of requests for external review resolved and, of those resolved, the number resolved upholding the final adverse benefit determinations and the number resolved reversing the final adverse benefit determinations;

(c) The average length of time for resolution;

(d) A summary of the types of coverages or cases for which an external review was sought;

(e) The number of external reviews pursuant to section 41-5908(18), Idaho Code, that were terminated as the result of a reconsideration by the health carrier of its final adverse benefit determination after the receipt of additional information from the covered person; and

(f) Any other information the director may reasonably request or require.

(3) The independent review organization shall retain the written records required pursuant to this section for at least five (5) years.

(4) Each health carrier shall maintain written records in the aggregate for Idaho for each type of health benefit plan offered by the health carrier on all requests for external review that the health carrier receives notice of from the director pursuant to this chapter.

(5) Each health carrier is required to maintain written records on all requests for external review pursuant to subsection (1) of this section and shall submit to the director, upon request or at specified intervals, a report in the format specified by the director. The report shall include in the aggregate for Idaho and by type of health benefit plan:

(a) The total number of requests for external review;

(b) From the total number of requests for external review reported, the number of requests determined eligible for a full external review; and

(c) Any other information the director may reasonably request or require.

(6) The health carrier shall retain the written records required pursuant to this section for at least five (5) years.

[41-5914, added 2009, ch. 87, sec. 1, p. 255.]

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.

[41-5915, added 2009, ch. 87, sec. 1, p. 256; am. 2011, ch. 122, sec. 8, p. 345.]

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.

[41-5916, added 2009, ch. 87, sec. 1, p. 256; am. 2011, ch. 122, sec. 9, p. 345.]

41-5917. SEVERABILITY. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such

provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.

[41-5917, added 2009, ch. 87, sec. 1, p. 257.]