

State of South Dakota

SEVENTY-EIGHTH SESSION
LEGISLATIVE ASSEMBLY, 2003

400I0280

HOUSE BILL NO. 1047

Introduced by: The Committee on Commerce at the request of the Department of Commerce
and Regulation

1 FOR AN ACT ENTITLED, An Act to revise certain provisions concerning the requirements for
2 utilization review and grievances for health carriers.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

4 Section 1. That § 58-17C-1 be amended to read as follows:

5 58-17C-1. Terms used in this chapter mean:

6 (1) "Adverse determination," ~~a~~ any of the following:

7 (a) A determination by a health carrier or its designee utilization review
8 organization that ~~an admission, availability of care, continued stay, or other~~
9 ~~health care service has been reviewed and~~, based upon the information
10 provided, a request by a covered person for a benefit under the health carrier's
11 health benefit plan upon application of any utilization review technique does
12 not meet the health carrier's requirements for medical necessity,
13 appropriateness, health care setting, level of care or effectiveness; or is
14 determined to be experimental or investigational and the requested ~~service~~
15 benefit is therefore denied, reduced, or terminated or payment is not provided



1 or made, in whole or in part, for the benefit;

2 (b) The denial, reduction, termination, or failure to provide or make payment in
3 whole or in part, for a benefit based on a determination by a health carrier or
4 its designee utilization review organization of a covered person's eligibility to
5 participate in the health carrier's health benefit plan; or

6 (c) Any prospective review or retrospective review determination that denies,
7 reduces, terminates, or fails to provide or make payment, in whole or in part,
8 for a benefit;

9 (2) "Ambulatory review," utilization review of health care services performed or provided
10 in an outpatient setting;

11 (3) "Authorized representative," a person to whom a covered person has given express
12 written consent to represent the covered person for purposes of this Act, a person
13 authorized by law to provide substituted consent for a covered person, a family
14 member of the covered person or the covered person's treating health care
15 professional if the covered person is unable to provide consent, or a health care
16 professional if the covered person's health benefit plan requires that a request for a
17 benefit under the plan be initiated by the health care professional. For any urgent care
18 request, the term includes a health care professional with knowledge of the covered
19 person's medical condition;

20 (4) "Case management," a coordinated set of activities conducted for individual patient
21 management of serious, complicated, protracted, or other health conditions;

22 ~~(4)~~(5) "Certification," a determination by a health carrier or its designee utilization review
23 organization that ~~an admission, availability of care, continued stay, or other health~~
24 ~~care service~~ a request for a benefit under the health carrier's health benefit plan has

1 been reviewed and, based on the information provided, satisfies the health carrier's
2 requirements for medical necessity, appropriateness, health care setting, level of care,
3 and effectiveness;

4 ~~(5)~~(6) "Closed plan," a managed care plan or health carrier that requires covered persons to
5 use participating providers under the terms of the managed care plan or health carrier
6 and does not provide any benefits for out-of-network services except for emergency
7 services;

8 ~~(6)~~(7) "Concurrent review," utilization review conducted during a patient's hospital stay or
9 course of treatment in a facility, the office of a health care professional, or other
10 inpatient or outpatient health care setting;

11 ~~(7)~~(8) "Consumer," someone in the general public who may or may not be a covered person
12 or a purchaser of health care, including employers;

13 ~~(8)~~(9) "Covered benefits" or "benefits," those health care services to which a covered person
14 is entitled under the terms of a health benefit plan;

15 ~~(9)~~(10) "Covered person," a policyholder, subscriber, enrollee, or other individual
16 participating in a health benefit plan;

17 ~~(10)~~(11) "Director," the director of the Division of Insurance;

18 ~~(11)~~(12) "Discharge planning," the formal process for determining, prior to discharge
19 from a facility, the coordination and management of the care that a patient
20 receives following discharge from a facility;

21 ~~(12)~~(13) "Discounted fee for service," a contractual arrangement between a health
22 carrier and a provider or network of providers under which the provider is
23 compensated in a discounted fashion based upon each service performed and
24 under which there is no contractual responsibility on the part of the provider

1 to manage care, to serve as a gatekeeper or primary care provider, or to
2 provide or assure quality of care. A contract between a provider or network
3 of providers and a health maintenance organization is not a discounted fee for
4 service arrangement;

5 ~~(13)~~(14) "Emergency medical condition," the sudden and, at the time, unexpected onset
6 of a health condition that requires immediate medical attention, if failure to
7 provide medical attention would result in serious impairment to bodily
8 functions or serious dysfunction of a bodily organ or part, or would place the
9 person's health in serious jeopardy;

10 ~~(14)~~(15) "Emergency services," health care items and services furnished or required to
11 evaluate and treat an emergency medical condition;

12 ~~(15)~~(16) "Facility," an institution providing health care services or a health care setting,
13 including hospitals and other licensed inpatient centers, ambulatory surgical or
14 treatment centers, skilled nursing centers, residential treatment centers,
15 diagnostic, laboratory, and imaging centers, and rehabilitation, and other
16 therapeutic health settings;

17 ~~(16)~~(17) "Grievance," a written complaint, or oral complaint if the complaint involves
18 an urgent care request, submitted by or on behalf of a covered person
19 regarding:

- 20 (a) Availability, delivery, or quality of health care services;
- 21 (b) Claims payment, handling, or reimbursement for health care services;
- 22 (c) Any other matter pertaining to the contractual relationship between a covered
23 person and the health carrier.

24 A request for an expedited review need not be in writing;

1 any other entity providing coverage for health care services to operate a
2 managed care plan or health carrier;

3 ~~(25)~~(26) "Managed care entity," a licensed insurance company, hospital or medical
4 service plan, health maintenance organization, or an employer or employee
5 organization, ~~or a managed care contractor~~ that operates a managed care plan
6 ~~or health carrier~~ or a managed care contractor. The term does not include a
7 licensed insurance company unless it contracts with other entities to provide
8 a network of participating providers;

9 ~~(26)~~(27) "Managed care plan," a plan operated by a managed care entity that provides
10 for the financing or delivery of health care services, or both, to persons
11 enrolled in the plan through any of the following:

- 12 (a) Arrangements with selected providers to furnish health care services;
- 13 (b) Explicit standards for the selection of participating providers; or
- 14 (c) Financial incentives for persons enrolled in the plan to use the participating
15 providers and procedures provided for by the plan;

16 ~~(27)~~(28) "Necessary information," includes the results of any face-to-face clinical
17 evaluation or second opinion that may be required;

18 ~~(28)~~(29) "Network," the group of participating providers providing services to a health
19 carrier;

20 ~~(29)~~(30) "Open plan," a managed care plan or health carrier other than a closed plan that
21 provides incentives, including financial incentives, for covered persons to use
22 participating providers under the terms of the managed care plan or health
23 carrier;

24 ~~(30)~~(31) "Participating provider," a provider who, under a contract with the health

1 carrier or with its contractor or subcontractor, has agreed to provide health
2 care services to covered persons with an expectation of receiving payment,
3 other than coinsurance, copayments, or deductibles, directly or indirectly, from
4 the health carrier;

5 ~~(31)~~(32) "Prospective review," utilization review conducted prior to an admission or the
6 provision of a health care service or a course of treatment in accordance with
7 a health carrier's requirement that the health care service or course of
8 treatment, in whole or in part, be approved prior to its provision;

9 ~~(32)~~(33) "Quality assessment," the measurement and evaluation of the quality and
10 outcomes of medical care provided to individuals, groups, or populations;

11 ~~(33)~~(34) "Quality improvement," the effort to improve the processes and outcomes
12 related to the provision of care within the health plan;

13 ~~(34)~~(35) "Retrospective review," ~~utilization review of medical necessity that is~~
14 ~~conducted after services have been provided to a patient, but~~ any review of a
15 request for a benefit that is not a prospective review request, which does not
16 include the review of a claim that is limited to ~~an evaluation of reimbursement~~
17 ~~levels, veracity of documentation, or accuracy of coding, or adjudication for~~
18 ~~payment;~~

19 ~~(35)~~(36) "Second opinion," an opportunity or requirement to obtain a clinical evaluation
20 by a provider other than the one originally making a recommendation for a
21 proposed health care service to assess the ~~clinical~~ medical necessity and
22 appropriateness of the initial proposed health care service;

23 ~~(36)~~(37) "Secretary," the secretary of the Department of Health;

24 ~~(37)~~(38) "Stabilized," with respect to an emergency medical condition, that no material

1 deterioration of the condition is likely, with reasonable medical probability, to
2 result or occur before an individual can be transferred;

3 ~~(38)~~(39) "Utilization review," a set of formal techniques used by a managed care plan
4 or utilization review organization to monitor and evaluate the ~~clinical~~ medical
5 necessity, appropriateness, and efficiency of health care services and
6 procedures including techniques such as ambulatory review, prospective
7 review, second opinion, certification, concurrent review, case management,
8 discharge planning, and retrospective review; and

9 ~~(39)~~(40) "Utilization review organization," an entity that conducts utilization review
10 other than a health carrier performing utilization review for its own health
11 benefit plans.

12 Section 2. That § 58-17C-37 be amended to read as follows:

13 58-17C-37. A health carrier that ~~conducts~~ requires a request for benefits under the covered
14 person's health plan to be subjected to utilization review shall implement a written utilization
15 review program that describes all review activities, both delegated and nondelegated, ~~for covered~~
16 services provided for:

- 17 (1) The filing of benefit requests;
- 18 (2) The notification of utilization review and benefit determinations; and
- 19 (3) The review of adverse determinations in accordance with §§ 58-17C-58 to 58-17C-
20 63, inclusive.

21 The program document shall describe the following:

- 22 (1) Procedures to evaluate the ~~clinical~~ medical necessity, appropriateness, efficacy, or
23 efficiency of health care services;
- 24 (2) Data sources and clinical review criteria used in decision-making;

- 1 (3) ~~The process for conducting appeals of adverse determinations;~~
- 2 ~~(4)~~ Mechanisms to ensure consistent application of review criteria and compatible
- 3 decisions;
- 4 ~~(5)~~(4) Data collection processes and analytical methods used in assessing utilization of health
- 5 care services;
- 6 ~~(6)~~(5) Provisions for assuring confidentiality of clinical and proprietary information;
- 7 ~~(7)~~(6) The organizational structure that periodically assesses utilization review activities and
- 8 reports to the health carrier's governing body; and
- 9 ~~(8)~~(7) The staff position functionally responsible for day-to-day program management.

10 A health carrier shall prepare an annual summary report in the format specified of its
 11 utilization review program activities and file the report, if requested, with the director and the
 12 secretary of the Department of Health.

13 Section 3. That § 58-17C-40 be amended to read as follows:

14 58-17C-40. A health carrier shall issue utilization review ~~decisions~~ and benefit determinations
 15 in a timely manner pursuant to the requirements of §§ 58-17C-34 to 58-17C-57, inclusive. ~~A~~
 16 ~~health carrier shall obtain all information required to make a utilization review decision, including~~
 17 ~~pertinent clinical information.~~ A health carrier shall have a process to ensure that utilization
 18 reviewers apply clinical review criteria in conducting utilization review consistently.

19 Section 4. That § 58-17C-46 be amended to read as follows:

20 58-17C-46. When conducting utilization review, the health carrier shall collect only the
 21 information necessary, including pertinent clinical information, to ~~certify the admission,~~
 22 ~~procedure or treatment, length of stay, frequency, and duration of services~~ make the utilization
 23 review or benefit determination.

24 Section 5. That § 58-17C-48 be amended to read as follows:

1 58-17C-48. A health carrier shall maintain written procedures pursuant to this chapter for
2 making standard utilization review decisions and benefit determinations on requests submitted
3 to the health carrier by covered persons or their authorized representatives for benefits and for
4 notifying covered persons and providers acting on behalf of covered persons of its decisions their
5 authorized representatives of its determinations with respect to these requests within the
6 specified time frames required under this chapter.

7 Section 6. That § 58-17C-49 be amended to read as follows:

8 58-17C-49. For ~~initial~~ prospective review determinations, other than allowed by this section,
9 a health carrier shall make the determination and notify the covered person or, if applicable, the
10 covered person's authorized representative of the determination, whether the carrier certifies the
11 provision of the benefit or not, within two working a reasonable period of time appropriate to
12 the covered person's medical condition, but in no event later than fifteen days of obtaining all
13 necessary information regarding a proposed admission, procedure, or service requiring a review
14 determination: after the date the health carrier receives the request. If the determination is an
15 adverse determination, the health carrier shall make the notification of the adverse determination
16 in accordance with § 58-17C-52.

17 ~~(1) In the case of a determination to certify an admission, procedure, or service, the~~
18 ~~health carrier shall notify the provider rendering the service by telephone within~~
19 ~~twenty-four hours of making the initial certification. If the admission, procedure, or~~
20 ~~service is not certified or if a confirmation code or number is not provided upon~~
21 ~~certification of the admission, procedure, or service, the health carrier shall provide~~
22 ~~written or electronic confirmation of the telephone notification to the covered person~~
23 ~~and the provider within two working days of making the initial certification.~~

24 ~~(2) In the case of an adverse determination, the health carrier shall notify the provider~~

1 ~~rendering the service by telephone within twenty-four hours of making the adverse~~
2 ~~determination; and shall provide written or electronic confirmation of the telephone~~
3 ~~notification to the covered person and the provider within one working day of making~~
4 ~~the adverse determination.~~

5 The time period for making a determination and notifying the covered person or, if
6 applicable, the covered person's authorized representative of the determination pursuant to this
7 section may be extended once by the health carrier for up to fifteen days, if the health carrier:

8 (1) Determines that an extension is necessary due to matters beyond the health carrier's
9 control; and

10 (2) Notifies the covered person or, if applicable, the covered person's authorized
11 representative, prior to the expiration of the initial fifteen-day time period, of the
12 circumstances requiring the extension of time and the date by which the health carrier
13 expects to make a determination.

14 If the extension is necessary due to the failure of the covered person or the covered person's
15 authorized representative to submit information necessary to reach a determination on the
16 request, the notice of extension shall specifically describe the required information necessary to
17 complete the request; and give the covered person or, if applicable, the covered person's
18 authorized representative at least forty-five days from the date of receipt of the notice to provide
19 the specified information.

20 If the health carrier receives a prospective review request from a covered person or the
21 covered person's authorized representative that fails to meet the health carrier's filing procedures,
22 the health carrier shall notify the covered person or, if applicable, the covered person's authorized
23 representative of this failure and provide in the notice information on the proper procedures to
24 be followed for filing a request. This notice shall be provided as soon as possible, but in no event

1 later than five days following the date of the failure. The health carrier may provide the notice
2 orally or, if requested by the covered person or the covered person's authorized representative,
3 in writing. The provisions only apply in a case of failure that is a communication by a covered
4 person or the covered person's authorized representative that is received by a person or
5 organizational unit of the health carrier responsible for handling benefit matters and is a
6 communication that refers to a specific covered person, a specific medical condition or symptom,
7 and a specific health care service, treatment, or provider for which certification is being
8 requested.

9 Section 7. That § 58-17C-50 be amended to read as follows:

10 ~~58-17C-50. For concurrent review determinations, a health carrier shall make the~~
11 ~~determination within one working day of obtaining all necessary information:~~

12 ~~— (1) — In the case of a determination to certify an extended stay or additional services, the~~
13 ~~health carrier shall notify by telephone the provider rendering the service within one~~
14 ~~working day of making the certification; and the health carrier shall provide written~~
15 ~~or electronic confirmation to the covered person and the provider within one working~~
16 ~~day after the telephone notification. The written notification shall include the number~~
17 ~~of extended days or next review date, the new total number of days or services~~
18 ~~approved, and the date of admission or initiation of services:~~

19 ~~— (2) — In the case of an adverse determination, the health carrier shall notify by telephone the~~
20 ~~provider rendering the service within twenty-four hours of making the adverse~~
21 ~~determination; and the health carrier shall provide written or electronic notification~~
22 ~~to the covered person and the provider within one working day of the telephone~~
23 ~~notification:~~

24 ~~— For concurrent review determinations, if a health carrier has certified an ongoing course of~~

1 treatment to be provided over a period of time or number of treatments:

2 (1) Any reduction or termination by the health carrier during the course of treatment
3 before the end of the period or number treatments, other than by health benefit plan
4 amendment or termination of the health benefit plan, shall constitute an adverse
5 determination; and

6 (2) The health carrier shall notify the covered person of the adverse determination in
7 accordance with § 58-17C-52 at a time sufficiently in advance of the reduction or
8 termination to allow the covered person or, if applicable, the covered person's
9 authorized representative to file a grievance to request a review of the adverse
10 determination pursuant to sections 31 to 53, inclusive, of this Act and obtain a
11 determination with respect to that review of the adverse determination before the
12 benefit is reduced or terminated

13 The health care service or treatment that is the subject of the adverse determination shall be
14 continued without liability to the covered person until the covered person has been notified of
15 the determination by the health carrier with respect to the internal review request made pursuant
16 to sections 31 to 53, inclusive, of this Act.

17 Section 8. That § 58-17C-51 be amended to read as follows:

18 58-17C-51. For retrospective review determinations, a health carrier shall make the
19 determination within a reasonable period of time, but in no event later than thirty working days
20 of receiving all necessary information: after the date of receiving the benefit request.

21 ~~(1)~~In the case of a certification, the health carrier may notify in writing the covered person
22 and the provider rendering the service.

23 ~~(2)~~In the case of an adverse determination, the health carrier shall notify in writing the
24 ~~provider rendering the service and the covered person within five working days of making the~~

1 ~~adverse determination.~~ If the determination is an adverse determination, the health carrier shall
2 provide notice of the adverse determination to the covered person or, if applicable, the covered
3 person's authorized representative in accordance with § 58-17C-52. The time period for making
4 a determination and notifying the covered person or, if applicable, the covered person's
5 authorized representative of the determination pursuant to this section may be extended once by
6 the health carrier for up to fifteen days, provided the health carrier:

- 7 (1) Determines that an extension is necessary due to matters beyond the health carrier's
8 control; and
- 9 (2) Notifies the covered person or, if applicable, the covered person's authorized
10 representative, prior to the expiration of the initial thirty-day time period, of the
11 circumstances requiring the extension of time and the date by which the health carrier
12 expects to make a determination.

13 If the extension under this section is necessary due to the failure of the covered person or,
14 if applicable, the covered person's authorized representative to submit information necessary to
15 reach a determination on the request, the notice of extension shall specifically describe the
16 required information necessary to complete the request; and give the covered person or, if
17 applicable, the covered person's authorized representative at least forty-five days from the date
18 of receipt of the notice to provide the specified information.

19 Section 9. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
20 as follows:

21 For purposes of calculating the time periods within which a determination is required to be
22 made for prospective and retrospective reviews, the time period within which the determination
23 is required to be made begins on the date the request is received by the health carrier in
24 accordance with the health carrier's procedures established pursuant to § 58-17C-37. If the time

1 period for making the determination for a prospective or retrospective review is extended due
2 to the covered person or, if applicable, the covered person's authorized representative's failure
3 to submit the information necessary to make the determination, the time period for making the
4 determination shall be tolled from the date on which the health carrier sends the notification of
5 the extension to the covered person or, if applicable, the covered person's authorized
6 representative until the earlier of: the date on which the covered person or, if applicable, the
7 covered person's authorized representative responds to the request for additional information or
8 the date on which the specified information was to have been submitted. If the covered person
9 or the covered person's authorized representative fails to submit the information before the end
10 of the period of the extension, as specified in §§ 58-17C-49 and 58-17C-51, the health carrier
11 may deny the certification of the requested benefit.

12 Section 10. That § 58-17C-52 be amended to read as follows:

13 58-17C-52. Any ~~written~~ notification of an adverse determination under this section shall
14 ~~include the principal, in a manner which is designed to be understood by the covered person, set~~
15 forth:

16 (1) The specific reason or reasons for the adverse determination; ~~the instructions for~~
17 ~~initiating an appeal, grievance, or reconsideration of the determination, and the~~
18 ~~instructions;~~

19 (2) A reference to the specific plan provision on which the determination is based;

20 (3) A description of additional material or information necessary for the covered person
21 to complete the benefit request, including an explanation of why the material or
22 information is necessary to complete the request;

23 (4) A description of the health carrier's grievance procedures established pursuant to
24 sections 31 to 53, inclusive, of this Act, including time limits applicable to those

1 procedures;

2 (5) If the health carrier relied upon an internal rule, guideline, protocol, or other similar
3 criterion to make the adverse determination, either the specific rule, guideline,
4 protocol, or other similar criterion or a statement that a specific rule, guideline,
5 protocol, or other similar criterion was relied upon to make the adverse determination
6 and that a copy of the rule, guideline, protocol, or other similar criterion will be
7 provided free of charge to the covered person upon request;

8 (6) If the adverse determination is based on a medical necessity or experimental or
9 investigational treatment or similar exclusion or limit, either an explanation of the
10 scientific or clinical judgment for making the determination, applying the terms of the
11 health benefit plan to the covered person's medical circumstances or a statement that
12 an explanation will be provided to the covered person free of charge upon request;

13 (7) If applicable, instructions for requesting a:

14 (a) A copy of the rule, guideline, protocol, or other similar criterion relied upon
15 in making the adverse determination, as provided in subdivision (5) of this
16 section; or

17 (b) The written statement of the scientific or clinical rationale used to make for the
18 adverse determination, as provided in subdivision (6) of this section; and

19 (8) A statement explaining the right of the covered person, as appropriate, to contact the
20 Division of Insurance at any time for the assistance or, upon completion of the health
21 carrier's grievance procedure process as provided under sections 31 to 53, inclusive,
22 of this Act, to file a civil suit in a court of competent jurisdiction.

23 A health carrier shall ~~may~~ provide the ~~clinical rationale in writing for an adverse~~
24 ~~determination to any party who received notice of the adverse determination and who follows~~

1 ~~the procedures for a request. The clinical rationale shall contain sufficient specificity to allow the~~
2 ~~covered person to understand the basis of the adverse determination~~ notice required under this
3 section in writing or electronically.

4 Section 11. That § 58-17C-53 be repealed.

5 ~~— 58-17C-53. A health carrier shall have written procedures to address the failure or inability~~
6 ~~of a provider or a covered person to provide all necessary information for review. If the provider~~
7 ~~or a covered person will not release necessary information, the health carrier may deny~~
8 ~~certification.~~

9 Section 12. That § 58-17C-54 be amended to read as follows:

10 58-17C-54. In the certificate of coverage or member handbook provided to covered persons,
11 a health carrier shall include a clear and comprehensive description of its utilization review
12 procedures, including the procedures for obtaining review of adverse determinations, and a
13 statement of rights and responsibilities of covered persons with respect to those procedures. A
14 health carrier shall include a summary of its utilization review and benefit determination
15 procedures in materials intended for prospective covered persons. A health carrier shall print on
16 its membership cards a toll-free telephone number to call for utilization review and benefit
17 decisions.

18 Section 13. That § 58-17C-27 be amended to read as follows:

19 58-17C-27. A health carrier shall cover emergency services necessary to screen and stabilize
20 a covered person and may not require prior authorization of such services if a prudent layperson
21 ~~acting reasonably~~ would have reasonably believed that an emergency medical condition existed.
22 With respect to care obtained from a noncontracting provider within the service area of a
23 managed care plan, a health carrier shall cover emergency services necessary to screen and
24 stabilize a covered person and may not require prior authorization of such services if a prudent

1 layperson would have reasonably believed that use of a contracting provider would result in a
2 delay that would worsen the emergency, or if a provision of federal, state, or local law requires
3 the use of a specific provider. The coverage shall be at the same benefit level as if the service or
4 treatment had been rendered by a participating provider.

5 A health carrier shall cover emergency services if the plan, acting through a participating
6 provider or other ~~authorized~~ designated representative of the health carrier, has authorized the
7 provision of emergency services.

8 Section 14. That § 58-17C-28 be amended to read as follows:

9 58-17C-28. If a participating provider or other ~~authorized~~ designated representative of a
10 health carrier authorizes emergency services, the health carrier may not ~~retroactively deny~~
11 subsequently retract its authorization after the emergency services have been provided, or reduce
12 payment for a ~~covered expense~~ an item or service furnished in reliance on approval, unless the
13 approval was based on a material misrepresentation about the covered person's health condition
14 made by the provider of emergency services.

15 Section 15. That § 58-17C-30 be amended to read as follows:

16 58-17C-30. For immediately required post-evaluation or post-stabilization services, a health
17 carrier shall provide access to ~~an authorized~~ a designated representative twenty-four hours a day,
18 seven days a week, to facilitate review, or otherwise provide coverage with no financial penalty
19 to the covered person.

20 Section 16. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
21 as follows:

22 A health carrier shall establish written procedures in accordance with sections 16 to 24,
23 inclusive, of this Act, for receiving benefit requests from covered persons or their authorized
24 representatives and for making and notifying covered persons or their authorized representatives

1 of expedited utilization review and benefit determinations with respect to urgent care requests
2 and concurrent review urgent care requests.

3 Section 17. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
4 as follows:

5 For an urgent care request, unless the covered person or the covered person's authorized
6 representative has failed to provide sufficient information for the health carrier to determine
7 whether, or to what extent, the benefits requested are covered benefits or payable under the
8 health carrier's health benefit plan, the health carrier shall notify the covered person or, if
9 applicable, the covered person's authorized representative of the health carrier's determination
10 with respect to the request, whether or not the determination is an adverse determination, as
11 soon as possible, taking into account the medical condition of the covered person, but in no
12 event later than seventy-two hours after the date of the receipt of the request by the health
13 carrier. If the health carrier's determination is an adverse determination, the health carrier shall
14 provide notice of the adverse determination in accordance with section 24 of this Act.

15 Section 18. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
16 as follows:

17 If the covered person or, if applicable, the covered person's authorized representative has
18 failed to provide sufficient information for the health carrier to make a determination, the health
19 carrier shall notify the covered person or, if applicable, the covered person's authorized
20 representative either orally or, if requested by the covered person or the covered person's
21 authorized representative, in writing of this failure and state what specific information is needed
22 as soon as possible, but in no event later than twenty-four hours after receipt of the request.

23 Section 19. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
24 as follows:

1 If the benefit request involves a prospective review urgent care request, the provisions of
2 section 18 of this Act apply only in the case of a failure that:

3 (1) Is a communication by a covered person or, if applicable, the covered person's
4 authorized representative that is received by a person or organizational unit of the
5 health carrier responsible for handling benefit matters; and

6 (2) Is a communication that refers to a specific covered person, a specific medical
7 condition or symptom, and a specific health care service, treatment, or provider for
8 which approval is being requested.

9 Section 20. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
10 as follows:

11 The health carrier shall provide the covered person or, if applicable the covered person's
12 authorized representative a reasonable period of time to submit the necessary information, taking
13 into account the circumstances, but in no event less than forty-eight hours after the date of
14 notifying the covered person or the covered person's authorized representative of the failure to
15 submit sufficient information, as provided in sections 18 and 19 of this Act.

16 Section 21. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
17 as follows:

18 The health carrier shall notify the covered person or, if applicable, the covered person's
19 authorized representative of its determination with respect to the urgent care request as soon as
20 possible, but in no event more than forty-eight hours after the earlier of:

21 (1) The health carrier's receipt of the requested specified information; or

22 (2) The end of the period provided for the covered person or, if applicable, the covered
23 person's authorized representative to submit the requested specified information.

24 If the covered person or the covered person's authorized representative fails to submit the

1 information before the end of the period of the extension, as specified in section 20 of this Act,
2 the health carrier may deny the certification of the requested benefit. If the health carrier's
3 determination is an adverse determination, the health carrier shall provide notice of the adverse
4 determination in accordance with § 58-17C-52.

5 Section 22. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
6 as follows:

7 For concurrent review urgent care requests involving a request by the covered person or the
8 covered person's authorized representative to extend the course of treatment beyond the initial
9 period of time or the number of treatments, if the request is made at least twenty-four hours prior
10 to the expiration of the prescribed period of time or number of treatments, the health carrier shall
11 make a determination with respect to the request and notify the covered person or, if applicable,
12 the covered person's authorized representative of the determination, whether it is an adverse
13 determination or not, as soon as possible, taking into account the covered person's medical
14 condition but in no event more than twenty four hours after the date of the health carrier's receipt
15 of the request. If the health carrier's determination is an adverse determination, the health carrier
16 shall provide notice of the adverse determination in accordance with § 58-17C-52.

17 Section 23. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
18 as follows:

19 For purposes of calculating the time periods within which a determination is required to be
20 made under sections 17 to 22, inclusive, of this Act, the time period within which the
21 determination is required to be made shall begin on the date the request is filed with the health
22 carrier in accordance with the health carrier's procedures established pursuant to § 58-17C-37
23 for filing a request without regard to whether all of the information necessary to make the
24 determination accompanies the filing.

1 Section 24. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
2 as follows:

3 If a health carrier's determination with respect to sections 17 to 22, inclusive, of this Act is
4 an adverse determination, the health carrier shall provide notice of the adverse determination in
5 accordance with this section. A notification of an adverse determination under this section shall,
6 in a manner calculated to be understood by the covered person, set forth:

- 7 (1) The specific reason or reasons for the adverse determination;
- 8 (2) A reference to the specific plan provisions on which the determination is based;
- 9 (3) A description of any additional material or information necessary for the covered
10 person to complete the request, including an explanation of why the material or
11 information is necessary to complete the request;
- 12 (4) A description of the health carrier's internal review procedures established pursuant
13 to sections 31 to 53, inclusive, of this Act, including any time limits applicable to
14 those procedures;
- 15 (5) A description of the health carrier's expedited review procedures established pursuant
16 to sections 16 to 24, inclusive, of this Act;
- 17 (6) If the health carrier relied upon an internal rule, guideline, protocol, or other similar
18 criterion to make the adverse determination, either the specific rule, guideline,
19 protocol, or other similar criterion or a statement that a specific rule, guideline,
20 protocol, or other similar criterion was relied upon to make the adverse determination
21 and that a copy of the rule, guideline, protocol, or other similar criterion will be
22 provided free of charge to the covered person upon request;
- 23 (7) If the adverse determination is based on a medical necessity or experimental or
24 investigation treatment or similar exclusion or limit, either an explanation of the

1 scientific or clinical judgment for making the determination, applying the terms of the
2 health benefit plan to the covered person's medical circumstances or a statement that
3 an explanation will be provided to the covered person free of charge upon request;

4 (8) If applicable, instructions for requesting:

5 (a) A copy of the rule, guideline, protocol, or other similar criterion relied upon
6 in making the adverse determination in accordance with subdivision (6) of this
7 section; or

8 (b) The written statement of the scientific or clinical rationale for the adverse
9 determination in accordance with subdivision (7) of this section; and

10 (9) A statement explaining the right of the covered person, as appropriate, to contact the
11 Division of Insurance at any time for assistance or, upon completion of the health
12 carrier's grievance procedure process as provided under sections 31 to 53, inclusive,
13 of this Act, to file a civil suit in a court of competent jurisdiction.

14 A health carrier may provide the notice required under this section orally, in writing or
15 electronically. If notice of the adverse determination is provided orally, the health carrier shall
16 provide written or electronic notice of the adverse determination within three days following the
17 oral notification.

18 Section 25. That § 58-17C-58 be amended to read as follows:

19 58-17C-58. Each ~~managed care plan or utilization review organization~~ health carrier shall
20 establish and maintain a grievance system, approved by the director after consultation with the
21 secretary of the Department of Health, which may include an impartial mediation provision, to
22 provide reasonable procedures for the resolution of grievances initiated by any enrollee
23 concerning the provision of health care services. Mediation may be made available to enrollees
24 unless an enrollee elects to litigate a grievance prior to submission to mediation. No medical

1 malpractice damage claim is subject to arbitration under §§ 58-17C-58 to 58-17C-63, inclusive.
2 Each ~~managed care plan or utilization review organization~~ health carrier shall provide that if a
3 grievance is filed which requires a review of services authorized to be provided by a practitioner
4 or if a grievance is filed which requires a review of treatment which has been provided by a
5 practitioner, the review shall include a ~~similarly licensed peer whose scope of practice includes~~
6 ~~the services or treatment being reviewed~~ health care professional who has appropriate training
7 and experience in the field of medicine involved in the medical judgment.

8 Section 26. That § 58-17C-59 be amended to read as follows:

9 58-17C-59. The ~~managed care plan or utilization review organization~~ health carrier shall
10 maintain records of grievances filed with it and shall submit to the director a summary report at
11 such times and in such format as the director may require. The grievances involving other
12 persons shall be referred to such persons with a copy to the director.

13 Section 27. That § 58-17C-60 be amended to read as follows:

14 58-17C-60. The ~~managed care plan or utilization review organization~~ health carrier shall
15 maintain a record of each grievance filed with it for five years, and the director and the secretary
16 of health shall have access to the records.

17 Section 28. That § 58-17C-61 be repealed.

18 ~~58-17C-61. The director or the secretary may examine such grievance system provided for~~
19 ~~by § 58-17C-58.~~

20 Section 29. That § 58-17C-62 be repealed.

21 ~~58-17C-62. Each managed care plan or utilization review organization shall submit to the~~
22 ~~director and the secretary of health an annual report in a form prescribed by the director, after~~
23 ~~consultation with the secretary of health, which shall include:~~

24 ~~(1) A description of the procedures of the grievance system provided for by § 58-17C-58;~~

1 and

2 ~~(2) The total number of grievances handled through such grievance system and a~~
3 ~~compilation of causes underlying the grievances filed.~~

4 Section 30. That § 58-17C-20 be amended to read as follows:

5 58-17C-20. Each managed care entity contractor, as defined in § 58-17C-1, shall register
6 with the director prior to engaging in any managed care business in this state. The registration
7 ~~shall be~~ is subject to the provisions of §§ 58-17C-64 to 58-17C-68, inclusive, and any applicable
8 rules promulgated pursuant to those sections.

9 Section 31. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
10 as follows:

11 A health carrier shall maintain in a register written records to document all grievances
12 received during a calendar year. A request for a first level review of a grievance involving an
13 adverse determination shall be processed in compliance with sections 34 to 37, inclusive, of this
14 Act, but is not required to be included in the register. A request for an additional voluntary
15 review of a grievance involving an adverse determination that may be conducted pursuant to
16 sections 43 to 49, inclusive, of this Act, shall be included in the register. For each grievance the
17 register shall contain, at a minimum, the following information:

- 18 (1) A general description of the reason for the grievance;
- 19 (2) The date received;
- 20 (3) The date of each review or, if applicable, review meeting;
- 21 (4) Resolution at each level of the grievance, if applicable;
- 22 (5) Date of resolution at each level, if applicable; and
- 23 (6) Name of the covered person for whom the grievance was filed.

24 The register shall be maintained in a manner that is reasonably clear and accessible to the

1 director. A health carrier shall retain the register compiled for a calendar year for five years.

2 Section 32. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
3 as follows:

4 A health carrier shall submit to the director, at least annually, a report in the format specified
5 by the director. The report shall include for each type of health benefit plan offered by the health
6 carrier:

- 7 (1) The certificate of compliance required by section 33 of this Act;
- 8 (2) The number of covered lives;
- 9 (3) The total number of grievances;
- 10 (4) The number of grievances for which a covered person requested an additional
11 voluntary grievance review pursuant to sections 43 to 49, inclusive, of this Act;
- 12 (5) The number of grievances resolved at each level, if applicable, and their resolution;
- 13 (6) The number of grievances appealed to the director of which the health carrier has
14 been informed;
- 15 (7) The number of grievances referred to alternative dispute resolution procedures or
16 resulting in litigation; and
- 17 (8) A synopsis of actions being taken to correct problems identified.

18 Section 33. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
19 as follows:

20 Except as specified of this Act, a health carrier shall use written procedures for receiving and
21 resolving grievances from covered persons, as provided in sections 34 to 49, inclusive, of this
22 Act. A health carrier shall file with the director a copy of the procedures required under this
23 section, including all forms used to process requests made pursuant to sections 34 to 49,
24 inclusive, of this Act. Any subsequent material modifications to the documents also shall be filed.

1 The director may disapprove a filing received in accordance with this section that fails to comply
2 with this Act or applicable rules. In addition, a health carrier shall file annually with the director,
3 as part of its annual report required by sections 31 and 32 of this Act, a certificate of compliance
4 stating that the health carrier has established and maintains, for each of its health benefit plans,
5 grievance procedures that fully comply with the provisions of this Act. A description of the
6 grievance procedures required under this section shall be set forth in or attached to the policy,
7 certificate, membership booklet, outline of coverage, or other evidence of coverage provided to
8 covered persons. The grievance procedure documents shall include a statement of a covered
9 person's right to contact the Division of Insurance for assistance at any time. The statement shall
10 include the telephone number and address of the Division of Insurance.

11 Section 34. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
12 as follows:

13 Within one hundred eighty days after the date of receipt of a notice of an adverse
14 determination sent pursuant to sections 1 to 24, inclusive, of this Act, and to §§ 58-17C-35 to
15 58-17C-37, inclusive, a covered person or the covered person's authorized representative may
16 file a grievance with the health carrier requesting a first level review of the adverse
17 determination. The health carrier shall provide the covered person with the name, address, and
18 telephone number of a person or organizational unit designated to coordinate the first level
19 review on behalf of the health carrier. The health carrier shall designate a health care provider
20 or providers who have appropriate training and experience in the field of medicine involved in
21 the medical judgement to evaluate the adverse determination. No health care provider or
22 providers may have been involved in the initial adverse determination. In conducting the review,
23 the reviewer or reviewers shall take into consideration all comments, documents, records, and
24 other information regarding the request for services submitted by the covered person or the

1 covered person's authorized representative, without regard to whether the information was
2 submitted or considered in making the initial adverse determination.

3 Section 35. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
4 as follows:

5 No covered person has the right to attend, or to have a representative in attendance, at the
6 first level review, but the covered person or, if applicable, the covered person's authorized
7 representative is entitled to:

8 (1) Submit written comments, documents, records, and other material relating to the
9 request for benefits for the review or reviewers to consider when conducting the
10 review; and

11 (2) Receive from the health carrier, upon request and free of charge, reasonable access
12 to, and copies of all documents, records and other information relevant to the covered
13 person's request for benefits. A document, record, or other information shall be
14 considered relevant to a covered person's request for benefits if the document, record,
15 or other information:

16 (a) Was relied upon in making the benefit determination;

17 (b) Was submitted, considered, or generated in the course of making the adverse
18 determination, without regard to whether the document, record, or other
19 information was relied upon in making the benefit determination;

20 (c) Demonstrates that, in making the benefit determination, the health carrier, or
21 its designated representatives consistently applied required administrative
22 procedures and safeguards with respect to the covered person as other similarly
23 situated covered persons; or

24 (d) Constitutes a statement of policy or guidance with respect to the health benefit

1 plan concerning the denied health care service or treatment for the covered
2 person's diagnosis, without regard to whether the advice or statement was
3 relied upon in making the benefit determination.

4 The health carrier shall make the provisions of this section known to the covered person or,
5 if applicable, the covered person's authorized representative within three working days after the
6 date of receipt of the grievance.

7 Section 36. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
8 as follows:

9 A health carrier shall notify and issue a decision in writing or electronically to the covered
10 person or, if applicable, the covered person's authorized representative within the following time
11 frames:

12 (1) With respect to a grievance requesting a first level review of an adverse determination
13 involving a prospective review request, the health carrier shall notify and issue a
14 decision within a reasonable period of time that is appropriate given the covered
15 person's medical condition, but no later than thirty days after the date of the health
16 carrier's receipt of the grievance requesting the first level review made pursuant to
17 section 34 of this Act; or

18 (2) With respect to a grievance requesting a first level review of an adverse determination
19 involving a retrospective review request, the health carrier shall notify and issue a
20 decision within a reasonable period of time, but no later than sixty days after the date
21 of the health carrier's receipt of the grievance requesting the first level review made
22 pursuant to section 34 of this Act.

23 For purposes of calculating the time periods within which a determination is required to be
24 made and notice provided under this section, the time period shall begin on the date the

1 grievance requesting the review is filed with the health carrier in accordance with the health
2 carrier's procedures established pursuant to section 33 of this Act for filing a request without
3 regard to whether all of the information necessary to make the determination accompanies the
4 filing.

5 Section 37. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
6 as follows:

7 The decision issued pursuant to section 36 of this Act shall set forth in a manner calculated
8 to be understood by the covered person or, if applicable, the covered person's authorized
9 representative and include the following:

- 10 (1) The titles and qualifying credentials of the person or persons participating in the first
11 level review process (the reviewers);
- 12 (2) A statement of the reviewers' understanding of the covered person's grievance;
- 13 (3) The reviewers' decision in clear terms and the contract basis or medical rationale in
14 sufficient detail for the covered person to respond further to the health carrier's
15 position;
- 16 (4) A reference to the evidence or documentation used as the basis for the decision;
- 17 (5) For a decision involving an adverse determination:
 - 18 (a) The specific reason or reasons for the adverse determination;
 - 19 (b) A reference to the specific plan provisions on which the determination is based;
 - 20 (c) A statement that the covered person is entitled to receive, upon request and
21 free of charge, reasonable access to, and copies of, all documents, records, and
22 other information relevant, as the term, relevant, is defined in section 35 of this
23 Act, to the covered person's benefit request;
 - 24 (d) If the health carrier relied upon an internal rule, guideline, protocol, or other

1 similar criterion to make the adverse determination, either the specific rule,
2 guideline, protocol, or other similar criterion or a statement that a specific rule,
3 guideline, protocol, or other similar criterion was relied upon to make the
4 adverse determination and that a copy of the rule, guideline, protocol, or other
5 similar criterion will be provided free of charge to the covered person upon
6 request;

7 (e) If the adverse determination is based on a medical necessity or experimental or
8 investigational treatment or similar exclusion or limit, either an explanation of
9 the scientific or clinical judgment for making the determination, applying the
10 terms of the health benefit plan to the covered person's medical circumstances
11 or a statement that an explanation will be provided to the covered person free
12 of charge upon request; and

13 (f) If applicable, instructions for requesting:
14 (i) A copy of the rule, guideline, protocol, or other similar criterion relied
15 upon in making the adverse determination, as provided in subsection (d)
16 of this section; or
17 (ii) The written statement of the scientific or clinical rationale for the
18 determination, as provided in subsection (e) of this section;

19 (6) If applicable, a statement indicating:
20 (a) A description of the process to obtain an additional voluntary review of the
21 first level review decision involving an adverse determination, if the covered
22 person wishes to request a voluntary second level review pursuant to section
23 36 of this Act;

24 (b) The written procedures governing the voluntary review, including any required

1 time frame for the review; and

2 (c) The covered person's right to bring a civil action in a court of competent
3 jurisdiction;

4 (7) If applicable, the following statement: "You and your plan may have other voluntary
5 alternative dispute resolution options, such as mediation. One way to find out what
6 may be available is to contact your state insurance director."; and

7 (8) Notice of the covered person's right to contact the Division of Insurance for
8 assistance at any time, including the telephone number and address of the Division of
9 Insurance.

10 Section 38. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
11 as follows:

12 A health carrier shall establish written procedures for a standard review of a grievance that
13 does not involve an adverse determination. The procedures shall permit a covered person or the
14 covered person's authorized representative to file a grievance that does not involve an adverse
15 determination with the health carrier under sections 39 to 42, inclusive, of this Act.

16 Section 39. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
17 as follows:

18 No covered person has the right to attend, or to have a representative in attendance at the
19 standard review, but the covered person or the covered person's authorized representative is
20 entitled to submit written material for the person or persons designated by the carrier pursuant
21 to section 40 of this Act to consider when conducting the review. The health carrier shall make
22 the provisions of this section known to the covered person or, if applicable, the covered person's
23 authorized representative within three working days after the date of receiving the grievance.

24 Section 40. That chapter 58-17C be amended by adding thereto a NEW SECTION to read

1 as follows:

2 Upon receipt of the grievance, a health carrier shall designate a person or persons to conduct
3 the standard review of the grievance. The health carrier may not designate the same person or
4 persons to conduct the standard review of the grievance that denied the claim or handled the
5 matter that is the subject of the grievance. The health carrier shall provide the covered person
6 or, if applicable, the covered person's authorized representative with the name, address, and
7 telephone number of a person designated to coordinate the standard review on behalf of the
8 health carrier.

9 Section 41. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
10 as follows:

11 The health carrier shall notify in writing the covered person or, if applicable, the covered
12 person's authorized representative of the decision within twenty working days after the date of
13 receipt of the request for a standard review of a grievance filed pursuant to section 39 of this
14 Act. The time frame for notification may be varied subject to the following:

15 (1) Subject to subdivision (2) of this section, if, due to circumstances beyond the carrier's
16 control, the health carrier cannot make a decision and notifies the covered person or,
17 if applicable, the covered person's authorized representative pursuant to this section
18 within twenty working days, the health carrier may take up to an additional ten
19 working days to issue a written decision; and

20 (2) A health carrier may extend the time for making and notifying the covered person or,
21 if applicable, the covered person's authorized representative in accordance with
22 subdivision (1) of this section, if, on or before the twentieth working day after the
23 date of receiving the request for a standard review of a grievance, the health carrier
24 provides written notice to the covered person or, if applicable, the covered person's

1 authorized representative of the extension and the reasons for the delay.

2 Section 42. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
3 as follows:

4 The written decision issued pursuant to section 41 of this Act shall contain:

5 (1) The titles and qualifying credentials of the person or persons participating in the
6 standard review process (the reviewers);

7 (2) A statement of the reviewers' understanding of the covered person's grievance;

8 (3) The reviewers' decision in clear terms and the contract basis in sufficient detail for the
9 covered person to respond further to the health carrier's position;

10 (4) A reference to the evidence or documentation used as the basis for the decision;

11 (5) If applicable, a statement indicating:

12 (a) A description of the process to obtain an additional review of the standard
13 review decision if the covered person wishes to request a voluntary second
14 level review pursuant to section 36 of this Act; and

15 (b) The written procedures governing the voluntary review, including any required
16 time frame for the review; and

17 (6) Notice of the covered person's right, at any time, to contact the Division of Insurance,
18 including the telephone number and address of the Division of Insurance.

19 Section 43. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
20 as follows:

21 A health carrier that offers managed care plans shall establish a voluntary review process for
22 its managed care plans to give those covered persons who are dissatisfied with the first level
23 review decision made pursuant to sections 34 to 37, inclusive, of this Act, or who are dissatisfied
24 with the standard review decision made pursuant to sections 38 to 42, inclusive, of this Act, the

1 option to request an additional voluntary review, at which the covered person or the covered
2 person's authorized representative has the right to appear in person at the review meeting before
3 designated representatives of the health carrier. This section does not apply to health indemnity
4 plans.

5 A health carrier required by this section to establish a voluntary review process shall provide
6 covered persons or their authorized representatives with notice pursuant to subdivision (6) of
7 section 37 of this Act or subdivision (5) of section 42 of this Act, as appropriate, of the option
8 to file a request with the health carrier for an additional voluntary review of the first level review
9 decision received under sections 34 to 37, inclusive, of this Act, or the standard review decision
10 received under sections 38 to 42, inclusive, of this Act.

11 Section 44. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
12 as follows:

13 Upon receipt of a request for an additional voluntary review, the health carrier shall send
14 notice to the covered person or, if applicable, the covered person's authorized representative of
15 the covered person's right to:

- 16 (1) Request the opportunity to appear in person before a review panel of the health
17 carrier's designated representatives within five working days after the date of receipt
18 of the notice;
- 19 (2) Receive from the health carrier, upon request, copies of all documents, records, and
20 other information that is not confidential or privileged relevant to the covered person's
21 request for benefits;
- 22 (3) Present the covered person's case to the review panel;
- 23 (4) Submit written comments, documents, records, and other material relating to the
24 request for benefits for the review panel to consider when conducting the review both

1 before and, if applicable, at the review meeting;

2 (5) If applicable, ask questions of any representative of the health carrier on the review
3 panel; and

4 (6) Be assisted or represented by an individual of the covered person's choice.

5 The covered person's right to a fair review may not be made conditional on the covered
6 person's appearance at the review.

7 Section 45. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
8 as follows:

9 With respect to a voluntary review of a first level review decision made pursuant to sections
10 34 to 37, inclusive, of this Act, a health carrier shall appoint a review panel to review the request.
11 In conducting the review, the review panel shall take into consideration all comments,
12 documents, records, and other information regarding the request for benefits submitted by the
13 covered person or the covered person's authorized representative pursuant to section 44 of this
14 Act, without regard to whether the information was submitted or considered in reaching the first
15 level review decision. The decision of the panel is legally binding on the health carrier.

16 Except for an individual who was involved with the first level review decision who may be
17 a member of the panel or appear before the panel to present information or answer questions,
18 a majority of the panel shall be comprised of individuals who were not involved in the in the first
19 level review decision made pursuant to sections 34 to 37, inclusive, of this Act.

20 The health carrier shall ensure that a majority of the individuals conducting the additional
21 voluntary review of the first level review decision made pursuant to sections 34 to 37, inclusive,
22 of this Act, are health care professionals who have appropriate expertise. If a reviewing health
23 care professional without the expertise required by this section is not reasonably available and
24 there has been a denial of a health care service, the reviewing health care professional may not:

- 1 (1) Be a provider in the covered person's health benefit plan; and
- 2 (2) Have a financial interest in the outcome of the review.

3 Section 46. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
4 as follows:

5 With respect to a voluntary review of a standard review decision made pursuant to sections
6 38 to 42, inclusive, of this Act, a health carrier shall appoint a review panel to review the request.
7 The decision of the panel is legally binding on the health carrier.

8 An employee or representative of the health carrier who was involved with the standard
9 review decision may be a member of the panel or appear before the panel to present information
10 or answer questions. A majority of the panel shall be comprised of employees or representatives
11 of the health carrier who were not involved in the standard review decision made pursuant to
12 sections 38 to 42, inclusive, of this Act.

13 Section 47. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
14 as follows:

15 If a covered person or the covered person's authorized representative requests the
16 opportunity to appear in person before the review panel appointed pursuant to sections 45 and
17 46 of this Act, the procedures for conducting the review shall include the following provisions:

- 18 (1) The review panel shall schedule and hold a review meeting within forty-five working
19 days after the date of receipt of the request;
- 20 (2) The covered person or, if applicable, the covered person's authorized representative
21 shall be notified in writing at least fifteen working days in advance of the date of the
22 review meeting;
- 23 (3) The health carrier shall not unreasonably deny a request for postponement of the
24 review made by the covered person or the covered person's authorized representative;

1 and

2 (4) The review meeting shall be held during regular business hours at a location
3 reasonably accessible to the covered person or, if applicable, the covered person's
4 authorized representative.

5 In any case in which a face-to-face meeting is not practical for geographic reasons, a health
6 carrier shall offer the covered person or, if applicable, the covered person's authorized
7 representative the opportunity to communicate with the review panel, at the health carrier's
8 expense, by conference call, video conferencing, or other appropriate technology.

9 If the health carrier desires to have an attorney present to represent the interests of the health
10 carrier, the health carrier shall notify the covered person or, if applicable, the covered person's
11 authorized representative at least fifteen working days in advance of the date of the review
12 meeting that an attorney will be present and that the covered person may wish to obtain legal
13 representation of his or her own.

14 The review panel shall issue a written decision, as provided in section 49 of this Act, to the
15 covered person or, if applicable, the covered person's authorized representative within five
16 working days of completing the review meeting.

17 Section 48. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
18 as follows:

19 If the covered person or, if applicable, the covered person's authorized representative does
20 not request the opportunity to appear in person before the review panel within the specified
21 timeframe provided under subdivision (1) of section 44 of this Act, the review panel shall issue
22 a decision and notify the covered person or, if applicable, the covered person's authorized
23 representative of the decision, as provided in section 49 of this Act, in writing or electronically,
24 within forty-five working days after the earlier of:

- 1 (1) The date the covered person or the covered person's authorized representative notifies
- 2 the health carrier of the covered person's decision not to request the opportunity to
- 3 appear in person before the review panel; or
- 4 (2) The date on which the covered person's or the covered person's authorized
- 5 representative's opportunity to request to appear in person before the review panel
- 6 expires pursuant to subdivision (1) of section 44 of this Act.

7 For purposes of calculating the time periods within which a decision is required to be made

8 and notice provided under this section and section 47 of this Act and this section, the time period

9 shall begin on the date the request for additional voluntary review is filed with the health carrier

10 in accordance with the health carrier's procedures established pursuant to section 33 of this Act

11 for filing a request without regard to whether all of the information necessary to make the

12 determination accompanies the filing.

13 Section 49. That chapter 58-17C be amended by adding thereto a NEW SECTION to read

14 as follows:

15 A decision issued pursuant to sections 47 and 48 of this Act shall include:

- 16 (1) The titles and qualifying credentials of the members of the review panel;
- 17 (2) A statement of the review panel's understanding of the nature of the grievance and all
- 18 pertinent facts;
- 19 (3) The rationale for the review panel's decision;
- 20 (4) A reference to evidence or documentation considered by the review panel in making
- 21 that decision;
- 22 (5) In cases concerning a grievance involving an adverse determination, the instructions
- 23 for requesting a written statement of the clinical rationale, including the clinical review
- 24 criteria used to make the determination; and

1 (6) Notice of the covered person's right to contact the Division of Insurance for
2 assistance at any time, including the telephone number and address of the Division of
3 Insurance.

4 Section 50. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
5 as follows:

6 A health carrier shall establish written procedures for the expedited review of urgent care
7 requests of grievances involving an adverse determination. In addition, a health carrier shall
8 provide expedited review of a grievance involving an adverse determination with respect to
9 concurrent review urgent care requests involving an admission, availability of care, continued
10 stay, or health care service for a covered person who has received emergency services, but has
11 not been discharged from a facility. The procedures shall allow a covered person or the covered
12 person's authorized representative to request an expedited review under this section orally or in
13 writing.

14 A health carrier shall appoint an appropriate clinical peer or peers in the same or similar
15 specialty as would typically manage the case being reviewed to review the adverse determination.
16 The clinical peer or peers may not have been involved in making the initial adverse determination.

17 Section 51. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
18 as follows:

19 In an expedited review, all necessary information, including the health carrier's decision, shall
20 be transmitted between the health carrier and the covered person or, if applicable, the covered
21 person's authorized representative by telephone, facsimile, or the most expeditious method
22 available.

23 Section 52. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
24 as follows:

1 An expedited review decision shall be made and the covered person or, if applicable, the
2 covered person's authorized representative shall be notified of the decision in accordance with
3 section 53 of this Act as expeditiously as the covered person's medical condition requires, but
4 in no event more than seventy-two hours after the date of receipt of the request for the expedited
5 review. If the expedited review is of a grievance involving an adverse determination with respect
6 to a concurrent review urgent care request, the service shall be continued without liability to the
7 covered person until the covered person has been notified of the determination.

8 For purposes of calculating the time periods within which a decision is required to be made
9 under this section, the time period within which the decision is required to be made shall begin
10 on the date the request is filed with the health carrier in accordance with the health carrier's
11 procedures established pursuant to section 33 of this Act for filing a request without regard to
12 whether all of the information necessary to make the determination accompanies the filing.

13 Section 53. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
14 as follows:

15 A notification of a decision under sections 50 to 53, inclusive, of this Act shall, in a manner
16 calculated to be understood by the covered person or, if applicable, the covered person's
17 authorized representative, set forth the following:

- 18 (1) The titles and qualifying credentials of the person or persons participating in the
19 expedited review process (the reviewers);
- 20 (2) A statement of the reviewers' understanding of the covered person's grievance;
- 21 (3) The reviewers' decision in clear terms and the contract basis or medical rationale in
22 sufficient detail for the covered person to respond further to the health carrier's
23 position;
- 24 (4) A reference to the evidence or documentation used as the basis for the decision;

- 1 (5) If the decision involves an adverse determination, the notice shall provide:
- 2 (a) The reasons for the adverse determination;
- 3 (b) A reference to the specific plan provisions on which the determination is based;
- 4 (c) A description of any additional material or information necessary for the
- 5 covered person to complete the request, including an explanation of why the
- 6 material or information is necessary to complete the request;
- 7 (d) If the health carrier relied upon an internal rule, guideline, protocol, or other
- 8 similar criterion to make the adverse determination, either the specific rule,
- 9 guideline, protocol, or other similar criterion or a statement that a specific rule,
- 10 guideline, protocol, or other similar criterion was relied upon to make the
- 11 adverse determination and that a copy of the rule, guideline, protocol, or other
- 12 similar criterion will be provided free of charge to the covered person upon
- 13 request;
- 14 (e) If the adverse determination is based on a medical necessity or experimental or
- 15 investigational treatment or similar exclusion or limit, either an explanation of
- 16 the scientific or clinical judgment for making the determination, applying the
- 17 terms of the health benefit plan to the covered person's medical circumstances
- 18 or a statement that an explanation will be provided to the covered person free
- 19 of charge upon request;
- 20 (f) If applicable, instructions for requesting:
- 21 (i) A copy of the rule, guideline, protocol, or other similar criterion relied
- 22 upon in making the adverse determination as provided in subsection (d)
- 23 of this section; or
- 24 (ii) The written statement of the scientific or clinical rationale for the

1 adverse determination as provided in subsection (e) of this section;

2 (g) A statement indicating the covered person's right to bring a civil action in a
3 court of competent jurisdiction; and

4 (h) The following statement: "You and your plan may have other voluntary
5 alternative dispute resolution options, such as mediation. One way to find out
6 what may be available is to contact your state insurance director."; and

7 (i) A notice of the covered person's right to contact the Division of
8 Insurance for assistance at any time, including the telephone number and
9 address of the Division of Insurance.

10 A health carrier may provide the notice required under this section orally, in writing, or
11 electronically. If notice of the adverse determination is provided orally, the health carrier shall
12 provide written or electronic notice of the adverse determination within three days following the
13 date of the oral notification.

14 Section 54. The provisions of sections 2, 3, 5, and 33 of this Act apply to group disability
15 income policies as defined in § 58-17-108.

16 Section 55. That chapter 58-17C be amended by adding thereto a NEW SECTION to read
17 as follows:

18 For the purposes of this chapter, the term, urgent care request, means a request for a health
19 care service or course of treatment with respect to which the time periods for making a
20 nonurgent care request determination:

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

23 (2) In the opinion of a physician with knowledge of the covered person's medical
24 condition, would subject the covered person to severe pain that cannot be adequately

1 managed without the health care service or treatment that is the subject of the request.
2 Except as provided in subdivision (1), in determining whether a request is to be treated as
3 an urgent care request, an individual acting on behalf of the health carrier shall apply the
4 judgment of a prudent layperson who possesses an average knowledge of health and medicine.
5 Any request that a physician with knowledge of the covered person's medical condition
6 determines is an urgent care request within the meaning of subdivisions (1) and (2) shall be
7 treated as an urgent care request.