

SENATE SUBSTITUTE FOR
HOUSE BILL NO. 4933

A bill to amend 2000 PA 251, entitled
"Patient's right to independent review act,"
by amending sections 3, 5, 7, 9, 11, 13, 17, 19, 23, 25, and 27
(MCL 550.1903, 550.1905, 550.1907, 550.1909, 550.1911, 550.1913,
550.1917, 550.1919, 550.1923, 550.1925, and 550.1927), section 3 as
amended by 2006 PA 542 and sections 11, 13, and 23 as amended by
2000 PA 398.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 3. As used in this act:

2 (a) "Adverse determination" means a determination by a health
3 carrier or its designee utilization review organization that an
4 admission, availability of care, continued stay, or other health
5 care service **THAT IS A COVERED BENEFIT** has been reviewed and, ~~has~~
6 ~~been~~ **BASED ON THE INFORMATION PROVIDED, DOES NOT MEET THE HEALTH**
7 **CARRIER'S REQUIREMENTS FOR MEDICAL NECESSITY, APPROPRIATENESS,**

1 **HEALTH CARE SETTING, LEVEL OF CARE, OR EFFECTIVENESS, AND THE**
2 **REQUESTED SERVICE OR PAYMENT FOR THE SERVICE IS THEREFORE** denied,
3 reduced, or terminated. Failure to respond in a timely manner to a
4 request for a determination ~~constitutes~~ **IS** an adverse
5 determination.

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

8 (c) "Authorized representative" means any of the following:

9 (i) A person to whom a covered person has given express
10 written consent to represent the covered person in an external
11 review.

12 (ii) A person authorized by law to provide substituted consent
13 for a covered person.

14 (iii) If the covered person is unable to provide consent, a
15 family member of the covered person or the covered person's
16 treating health care professional.

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

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

27 (f) "Clinical review criteria" means the written screening

1 procedures, decision abstracts, clinical protocols, and practice
2 guidelines used by a health carrier to determine the necessity and
3 appropriateness of health care services.

4 ~~—— (g) "Commissioner" means the commissioner of the office of~~
5 ~~financial and insurance services.~~

6 (G) ~~(h)~~ "Concurrent review" means utilization review conducted
7 during a patient's hospital stay or course of treatment.

8 (H) ~~(i)~~ "Covered benefits" or "benefits" means those health
9 care services to which a covered person is entitled under the terms
10 of a health benefit plan.

11 (I) ~~(j)~~ "Covered person" means a policyholder, subscriber,
12 member, enrollee, or other individual participating in a health
13 benefit plan.

14 (J) "DEPARTMENT" MEANS THE DEPARTMENT OF INSURANCE AND
15 FINANCIAL SERVICES.

16 (K) "DIRECTOR" MEANS THE DIRECTOR OF THE DEPARTMENT.

17 (L) ~~(k)~~ "Discharge planning" means the formal process for
18 determining, ~~prior to~~ **BEFORE** discharge from a facility, the
19 coordination and management of the care that a patient receives
20 following discharge from ~~a~~ **THE** facility.

21 (M) ~~(l)~~ "Disclose" means to release, transfer, or otherwise
22 divulge protected health information to any person other than the
23 individual who is the subject of the protected health information.

24 (N) "EVIDENCE-BASED STANDARD" MEANS THE CONSCIENTIOUS,
25 EXPLICIT, AND JUDICIOUS USE OF THE CURRENT BEST EVIDENCE BASED ON
26 THE OVERALL SYSTEMATIC REVIEW OF THE RESEARCH IN MAKING DECISIONS
27 ABOUT THE CARE OF INDIVIDUAL PATIENTS.

(O) ~~(m)~~ "Expedited internal grievance" means an expedited grievance under section 2213(1) (l) of the insurance code of 1956, 1956 PA 218, MCL 500.2213, or section 404(4) of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1404.

(P) ~~(n)~~ "Facility" or "health facility" means:

(i) A facility or agency **OR A PART OF A FACILITY OR AGENCY THAT IS** licensed or authorized under parts 201 to 217 of the public health code, 1978 PA 368, MCL 333.20101 to 333.21799e. ~~or a licensed part thereof.~~

(ii) A psychiatric hospital, psychiatric unit, partial hospitalization psychiatric program, or center for persons with disabilities operated by the department of ~~community~~ health **AND HUMAN SERVICES** or certified or licensed under the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106.

(iii) A facility providing outpatient physical therapy services, including speech pathology services.

(iv) A kidney disease treatment center, including a freestanding hemodialysis unit.

(v) An ambulatory health care facility.

(vi) A tertiary health care service facility.

(vii) A substance ~~abuse treatment~~ **USE DISORDER SERVICES** program licensed under ~~parts 61 to 65~~ **PART 62** of the public health code, 1978 PA 368, MCL ~~333.6101 to 333.6523~~ **333.6230 TO 333.6251**.

(viii) An outpatient psychiatric clinic.

(ix) A home health agency.

(Q) **"FINAL ADVERSE DETERMINATION" MEANS AN ADVERSE DETERMINATION INVOLVING A COVERED BENEFIT THAT HAS BEEN UPHELD BY A**

1 HEALTH CARRIER, OR ITS DESIGNEE UTILIZATION REVIEW ORGANIZATION, AT
 2 THE COMPLETION OF THE HEALTH CARRIER'S INTERNAL GRIEVANCE PROCESS
 3 PROCEDURES AS SET FORTH IN SECTION 2213 OF THE INSURANCE CODE OF
 4 1956, 1956 PA 218, MCL 500.2213, OR SECTIONS 404 OR 407 OF THE
 5 NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL
 6 550.1404 AND MCL 550.1407.

7 (R) ~~(e)~~ "Health benefit plan" means a policy, contract,
 8 certificate, or agreement offered or issued by a health carrier to
 9 provide, deliver, arrange for, pay for, or reimburse any of the
 10 costs of covered health care services.

11 (S) ~~(p)~~ "Health care professional" means ~~a person~~ **AN**
 12 **INDIVIDUAL** licensed, certified, ~~or~~ registered, **OR OTHERWISE**
 13 **AUTHORIZED TO ENGAGE IN A HEALTH PROFESSION** under parts ~~61 to 65 or~~
 14 161 to 183 of the public health code, 1978 PA 368, MCL ~~333.6101 to~~
 15 ~~333.6523, and MCL 333.16101 to 333.18311.~~ **333.18315.**

16 (T) ~~(q)~~ "Health care provider" or "provider" means a health
 17 care professional or a health facility.

18 (U) ~~(r)~~ "Health care services" means services for the
 19 diagnosis, prevention, treatment, cure, or relief of a health
 20 condition, illness, injury, or disease.

21 (V) ~~(s)~~ "Health carrier" means ~~an entity~~ **A PERSON THAT IS**
 22 subject to the insurance laws and regulations of this state, or
 23 subject to the jurisdiction of the ~~commissioner,~~ **DIRECTOR**, that
 24 contracts or offers to contract to provide, deliver, arrange for,
 25 pay for, or reimburse any of the costs of health care services,
 26 including a sickness and accident insurance company, a health
 27 maintenance organization, a nonprofit health care corporation, **A**

1 **NONPROFIT DENTAL CARE CORPORATION OPERATING UNDER 1963 PA 125, MCL**
 2 **550.351 TO 550.373, or any other ~~entity~~-PERSON** providing a plan of
 3 health insurance, health benefits, or health services. Health
 4 carrier does not include a state department or agency administering
 5 a plan of medical assistance under the social welfare act, 1939 PA
 6 280, MCL 400.1 to 400.119b.

7 **(W) ~~(t)~~**"Health information" means information or data,
 8 whether oral or recorded in any form or medium, and personal facts
 9 or information about events or relationships that relates to 1 or
 10 more of the following:

11 (i) The past, present, or future physical, mental, or
 12 behavioral health or condition of an individual or a member of the
 13 individual's family.

14 (ii) The provision of health care services to an individual.

15 (iii) Payment for the provision of health care services to an
 16 individual.

17 **(X) ~~(u)~~**"Independent review organization" means ~~an entity~~ **A**
 18 **PERSON** that conducts independent external reviews of adverse
 19 determinations.

20 **(Y) "MEDICAL OR SCIENTIFIC EVIDENCE" MEANS EVIDENCE FOUND IN**
 21 **ANY OF THE FOLLOWING SOURCES:**

22 (i) **PEER-REVIEWED SCIENTIFIC STUDIES PUBLISHED IN OR ACCEPTED**
 23 **FOR PUBLICATION BY MEDICAL JOURNALS THAT MEET NATIONALLY RECOGNIZED**
 24 **REQUIREMENTS FOR SCIENTIFIC MANUSCRIPTS AND THAT SUBMIT MOST OF**
 25 **THEIR PUBLISHED ARTICLES FOR REVIEW BY EXPERTS WHO ARE NOT PART OF**
 26 **THE EDITORIAL STAFF.**

27 (ii) **PEER-REVIEWED MEDICAL LITERATURE, INCLUDING LITERATURE**

1 RELATING TO THERAPIES REVIEWED AND APPROVED BY A QUALIFIED
2 INSTITUTIONAL REVIEW BOARD, BIOMEDICAL COMPENDIA, AND OTHER MEDICAL
3 LITERATURE THAT MEET THE CRITERIA OF THE NATIONAL INSTITUTES OF
4 HEALTH'S UNITED STATES NATIONAL LIBRARY OF MEDICINE FOR INDEXING IN
5 THE FORMER INDEX MEDICUS OR ITS CURRENT ONLINE VERSION, MEDLINE,
6 AND ELSEVIER B. V. FOR INDEXING IN EMBASE.

7 (iii) MEDICAL JOURNALS RECOGNIZED BY THE SECRETARY OF THE
8 UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES UNDER 42 USC
9 1395X(T) (2) (B) (II) (I) .

10 (iv) THE FOLLOWING STANDARD REFERENCE COMPENDIA:

11 (A) THE AMERICAN HOSPITAL FORMULARY SERVICE DRUG INFORMATION.

12 (B) DRUG FACTS AND COMPARISONS.

13 (C) THE AMERICAN DENTAL ASSOCIATION'S ACCEPTED DENTAL
14 THERAPEUTICS.

15 (D) THE UNITED STATES PHARMACOPOEIA DRUG INFORMATION.

16 (v) FINDINGS, STUDIES, OR RESEARCH CONDUCTED BY OR UNDER THE
17 AUSPICES OF FEDERAL GOVERNMENT AGENCIES AND NATIONALLY RECOGNIZED
18 FEDERAL RESEARCH INSTITUTES, INCLUDING THE FOLLOWING:

19 (A) THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.

20 (B) THE NATIONAL INSTITUTES OF HEALTH.

21 (C) THE NATIONAL CANCER INSTITUTE.

22 (D) THE NATIONAL ACADEMY OF SCIENCES.

23 (E) THE CENTERS FOR MEDICARE AND MEDICAID SERVICES.

24 (F) THE UNITED STATES FOOD AND DRUG ADMINISTRATION.

25 (G) ANY NATIONAL BOARD RECOGNIZED BY THE NATIONAL INSTITUTES
26 OF HEALTH FOR THE PURPOSE OF EVALUATING THE MEDICAL VALUE OF HEALTH
27 CARE SERVICES.

1 (vi) ANY OTHER MEDICAL OR SCIENTIFIC EVIDENCE THAT IS
2 COMPARABLE TO THE SOURCES LISTED IN SUBPARAGRAPHS (i) TO (v) .

3 (Z) "PERSON" MEANS AN INDIVIDUAL OR A CORPORATION,
4 PARTNERSHIP, ASSOCIATION, JOINT VENTURE, JOINT STOCK COMPANY,
5 TRUST, UNINCORPORATED ORGANIZATION, OR SIMILAR ENTITY, OR ANY
6 COMBINATION OF THESE.

7 (AA) ~~(v)~~ "Prospective review" means utilization review
8 conducted ~~prior to~~ **BEFORE** an admission or a course of treatment.

9 (BB) ~~(w)~~ "Protected health information" means health
10 information that identifies an individual who is the subject of the
11 information or with respect to which there is a reasonable basis to
12 believe that the information could be used to identify an
13 individual.

14 (CC) ~~(x)~~ "Retrospective review" means a review of medical
15 necessity conducted after services have been provided to a patient,
16 but does not include the review of a claim that is limited to an
17 evaluation of reimbursement levels, veracity of documentation,
18 accuracy of coding, or adjudication for payment.

19 (DD) ~~(y)~~ "Second opinion" means an opportunity or requirement
20 to obtain a clinical evaluation by a provider other than the one
21 originally making a recommendation for a proposed health service to
22 assess the clinical necessity and appropriateness of the initial
23 proposed health service.

24 (EE) ~~(z)~~ "Utilization review" means a set of formal techniques
25 designed to monitor the use of, or evaluate the clinical necessity,
26 appropriateness, efficacy, or efficiency of, health care services,
27 procedures, or settings. Techniques may include ambulatory review,

1 prospective review, second opinion, certification, concurrent
 2 review, case management, discharge planning, or retrospective
 3 review.

4 (FF) ~~(aa)~~ "Utilization review organization" means ~~an entity~~ **A**
 5 **PERSON** that conducts utilization review, other than a health
 6 carrier performing a review for its own health plans.

7 Sec. 5. (1) Except as otherwise provided in subsection (2),
 8 this act applies to all health carriers. ~~that provide or perform~~
 9 ~~utilization review.~~

10 (2) This act does not apply to a policy or certificate that
 11 provides coverage only for specified accident or accident-only
 12 coverage, credit, disability income, hospital indemnity, long-term
 13 care insurance, **AS THAT TERM IS DEFINED IN SECTION 3901 OF THE**
 14 **INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.3901,** or any other
 15 limited supplemental benefit other than specified disease, dental,
 16 vision care, or care provided pursuant to a system of health care
 17 delivery and financing operating under section 3573 of the
 18 insurance code of 1956, 1956 PA 218, MCL 500.3573, ~~medicare~~
 19 **MEDICARE** supplement policy of insurance, coverage under a plan
 20 through ~~medicare,~~ **MEDICARE,** or the federal employees health
 21 benefits program, any coverage issued under ~~chapter 55 of title 10~~
 22 ~~of the United States Code, 10 U.S.C. USC 1071 to 1109,~~ **1110B,** and
 23 any coverage issued as supplement to that coverage, any coverage
 24 issued as supplemental to liability insurance, worker's **DISABILITY**
 25 compensation or similar insurance, automobile medical-payment
 26 insurance, or any insurance under which benefits are payable with
 27 or without regard to fault, whether written on a group blanket or

1 individual basis.

2 Sec. 7. (1) A health carrier shall provide written notice to a
3 covered person ~~in plain English~~ of the internal grievance and
4 external review processes at the time the health carrier sends
5 written notice of an adverse determination.

6 (2) Except as provided in subsection (3)(a), a request for an
7 external review under section 11 or 13 ~~shall~~ **MUST** not be made until
8 the covered person has exhausted the health carrier's internal
9 grievance process provided for by law.

10 (3) The written notice of the right to request an external
11 review for an adverse determination issued before the service is
12 provided to a covered person ~~shall be in plain English and shall~~
13 **MUST** include all of the following:

14 (a) A statement informing the covered person of all of the
15 following:

16 (i) If the covered person has a medical condition ~~where~~ **SUCH**
17 **THAT** the time frame for completion of an expedited internal
18 grievance would seriously jeopardize the life or health of the
19 covered person or would jeopardize the covered person's ability to
20 regain maximum function, as substantiated by a physician either
21 orally or in writing, the covered person or the covered person's
22 authorized representative may file a request for an expedited
23 external review under section 13 at the same time the covered
24 person or the covered person's authorized representative files a
25 request for an expedited internal grievance subject to section
26 13(3). **A COVERED PERSON WHO FILES A REQUEST UNDER THIS SUBPARAGRAPH**
27 **IS CONSIDERED TO HAVE EXHAUSTED THE HEALTH CARRIER'S INTERNAL**

1 GRIEVANCE PROCESS FOR PURPOSES OF SUBSECTION (2).

2 (ii) The covered person or the covered person's authorized
3 representative may file a grievance under the health carrier's
4 internal grievance process, but if the health carrier has not
5 issued a written decision to the covered person or the covered
6 person's authorized representative within the required time and
7 without the covered person or the covered person's authorized
8 representative requesting or agreeing to a delay, the covered
9 person or the covered person's authorized representative may file a
10 request for external review under section 9 and ~~shall be~~ IS
11 considered to have exhausted the health carrier's internal
12 grievance process for purposes of subsection (2).

13 (iii) A HEALTH CARRIER MAY WAIVE ITS INTERNAL GRIEVANCE
14 PROCESS AND THE REQUIREMENT FOR A COVERED PERSON TO EXHAUST THE
15 PROCESS BEFORE FILING A REQUEST FOR AN EXTERNAL REVIEW OR AN
16 EXPEDITED EXTERNAL REVIEW.

17 (iv) THE COVERED PERSON IS CONSIDERED TO HAVE EXHAUSTED A
18 HEALTH CARRIER'S INTERNAL GRIEVANCE PROCESS IF THE HEALTH CARRIER
19 HAS FAILED TO COMPLY WITH THE REQUIREMENTS OF THE INTERNAL
20 GRIEVANCE PROCESS UNLESS THE FAILURE OR FAILURES ARE BASED ON DE
21 MINIMIS VIOLATIONS THAT DO NOT CAUSE, AND ARE NOT LIKELY TO CAUSE,
22 PREJUDICE OR HARM TO THE COVERED PERSON.

23 (b) A copy of the description of both the standard and
24 expedited external review procedures the health carrier is required
25 to provide under section 25, highlighting the provisions in the
26 external review procedures that give the covered person or the
27 covered person's authorized representative the opportunity to

1 submit additional information and including any forms used to
2 process an external review.

3 (c) As part of any forms provided under subdivision (b),
4 ~~include~~ an authorization form, or other document approved by the
5 ~~commissioner~~, **DIRECTOR**, by which the covered person, for purposes
6 of conducting an external review under this act, authorizes the
7 health carrier and health care provider to disclose protected
8 health information, including medical records, concerning the
9 covered person that are pertinent to the external review.

10 (4) The written notice of the right to request an external
11 review for an adverse determination issued after the service was
12 provided to the covered person ~~shall be in plain English, shall~~
13 **MUST** include the standard external review procedures information
14 required ~~in~~ **UNDER** subsection (3) ~~, and shall be provided to the~~
15 covered person in the manner prescribed by the
16 ~~commissioner~~. **DIRECTOR**.

17 Sec. 9. (1) Except for a request for an expedited external
18 review under section 13, all requests for external review ~~shall~~
19 **MUST** be made in writing to the ~~commissioner~~. **DIRECTOR**.

20 (2) **A WRITTEN NOTICE REQUIRED TO BE PROVIDED UNDER THIS ACT**
21 **MUST BE PROVIDED IN A CULTURALLY AND LINGUISTICALLY APPROPRIATE**
22 **MANNER, AS REQUIRED UNDER 45 CFR 147.136 (B) (2) (ii) (E) .**

23 (3) **A HEALTH CARRIER MAY SATISFY A REQUIREMENT FOR THE**
24 **DELIVERY OF A NOTICE TO A COVERED PERSON UNDER THIS ACT BY**
25 **COMPLYING WITH 29 CFR 2520.104B-1(C) WITH RESPECT TO THE USE OF**
26 **ELECTRONIC COMMUNICATION.**

27 Sec. 11. (1) Not later than 60 days **OR, AFTER DECEMBER 31,**

1 **2016, 120 DAYS** after the date of receipt of a notice of an adverse
2 determination or final adverse determination under section 7, a
3 covered person or the covered person's authorized representative
4 may file a request for an external review with the ~~commissioner~~.
5 **DIRECTOR**. Upon receipt of a request for an external review, the
6 ~~commissioner~~**DIRECTOR** immediately shall notify and send a copy of
7 the request to the health carrier that made the adverse
8 determination or final adverse determination that is the subject of
9 the request.

10 (2) Not later than 5 business days after the date of receipt
11 of a request for an external review, the ~~commissioner~~**DIRECTOR**
12 shall complete a preliminary review of the request to determine all
13 of the following:

14 (a) Whether the individual is or was a covered person in the
15 health benefit plan at the time the health care service was
16 requested or, ~~in the case of~~ **FOR** a retrospective review, was a
17 covered person in the health benefit plan at the time the health
18 care service was provided.

19 (b) Whether the health care service that is the subject of the
20 adverse determination or final adverse determination reasonably
21 appears to be a covered service under the covered person's health
22 benefit plan.

23 (c) Whether the covered person has exhausted the health
24 carrier's internal grievance process, unless the covered person is
25 not required to exhaust the health carrier's internal grievance
26 process.

27 (d) ~~The~~ **WHETHER THE** covered person has provided all the

1 information and forms required by the ~~commissioner~~**DIRECTOR** that
2 are necessary to process an external review, including the health
3 information release form.

4 (e) Whether the health care service that is the subject of the
5 adverse determination or final adverse determination appears to
6 involve issues of medical necessity or clinical review criteria.

7 (3) IF A REQUEST FOR AN EXTERNAL REVIEW INVOLVES ISSUES OF
8 EXPERIMENTAL OR INVESTIGATIONAL SERVICE OR TREATMENT, NOT LATER
9 THAN 5 BUSINESS DAYS AFTER THE DATE OF RECEIPT OF A REQUEST FOR AN
10 EXTERNAL REVIEW, THE DIRECTOR SHALL COMPLETE A PRELIMINARY REVIEW
11 OF THE REQUEST TO DETERMINE ALL OF THE FOLLOWING:

12 (A) WHETHER THE INDIVIDUAL IS OR WAS A COVERED PERSON IN THE
13 HEALTH BENEFIT PLAN AT THE TIME THE HEALTH CARE SERVICE WAS
14 REQUESTED OR, FOR A RETROSPECTIVE REVIEW, WAS A COVERED PERSON IN
15 THE HEALTH BENEFIT PLAN AT THE TIME THE HEALTH CARE SERVICE WAS
16 PROVIDED.

17 (B) WHETHER THE RECOMMENDED OR REQUESTED HEALTH CARE SERVICE
18 OR TREATMENT THAT IS THE SUBJECT OF THE ADVERSE DETERMINATION OR
19 FINAL ADVERSE DETERMINATION IS BOTH OF THE FOLLOWING:

20 (i) A COVERED BENEFIT UNDER THE COVERED PERSON'S HEALTH
21 BENEFIT PLAN EXCEPT FOR THE HEALTH CARRIER'S DETERMINATION THAT THE
22 SERVICE OR TREATMENT IS EXPERIMENTAL OR INVESTIGATIONAL FOR A
23 PARTICULAR MEDICAL CONDITION.

24 (ii) NOT EXPLICITLY LISTED AS AN EXCLUDED BENEFIT UNDER THE
25 COVERED PERSON'S HEALTH BENEFIT PLAN WITH THE HEALTH CARRIER.

26 (C) WHETHER THE COVERED PERSON'S TREATING PROVIDER WITH THE
27 AUTHORITY TO DIAGNOSE UNDER THE PUBLIC HEALTH CODE, 1978 PA 368,

1 MCL 333.1101 TO 333.25211, HAS CERTIFIED THAT 1 OR MORE OF THE
2 FOLLOWING SITUATIONS ARE APPLICABLE:

3 (i) STANDARD HEALTH CARE SERVICES OR TREATMENTS HAVE NOT BEEN
4 EFFECTIVE IN IMPROVING THE CONDITION OF THE COVERED PERSON.

5 (ii) STANDARD HEALTH CARE SERVICES OR TREATMENTS ARE NOT
6 MEDICALLY APPROPRIATE FOR THE COVERED PERSON.

7 (iii) THERE IS NO AVAILABLE STANDARD HEALTH CARE SERVICE OR
8 TREATMENT COVERED BY THE HEALTH CARRIER THAT IS MORE BENEFICIAL
9 THAN THE RECOMMENDED OR REQUESTED HEALTH CARE SERVICE OR TREATMENT
10 DESCRIBED IN SUBDIVISION (D).

11 (D) WHETHER THE COVERED PERSON'S TREATING PROVIDER WITH THE
12 AUTHORITY TO DIAGNOSE UNDER THE PUBLIC HEALTH CODE, 1978 PA 368,
13 MCL 333.1101 TO 333.25211, HAS DONE EITHER OF THE FOLLOWING:

14 (i) RECOMMENDED A HEALTH CARE SERVICE OR TREATMENT THAT THE
15 TREATING PROVIDER CERTIFIES, IN WRITING, IS LIKELY TO BE MORE
16 BENEFICIAL TO THE COVERED PERSON, IN THE TREATING PROVIDER'S
17 OPINION, THAN ANY AVAILABLE STANDARD HEALTH CARE SERVICES OR
18 TREATMENTS.

19 (ii) IF THE TREATING PROVIDER IS A LICENSED, BOARD CERTIFIED
20 OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRACTICE IN THE AREA OF
21 MEDICINE APPROPRIATE TO TREAT THE COVERED PERSON'S CONDITION,
22 CERTIFIED IN WRITING THAT SCIENTIFICALLY VALID STUDIES USING
23 ACCEPTED PROTOCOLS DEMONSTRATE THAT THE HEALTH CARE SERVICE OR
24 TREATMENT REQUESTED BY THE COVERED PERSON THAT IS THE SUBJECT OF
25 THE ADVERSE DETERMINATION OR FINAL ADVERSE DETERMINATION IS LIKELY
26 TO BE MORE BENEFICIAL TO THE COVERED PERSON THAN ANY AVAILABLE
27 STANDARD HEALTH CARE SERVICES OR TREATMENTS.

1 (E) WHETHER THE COVERED PERSON HAS EXHAUSTED THE HEALTH
2 CARRIER'S INTERNAL GRIEVANCE PROCESS, UNLESS THE COVERED PERSON IS
3 NOT REQUIRED TO EXHAUST THE HEALTH CARRIER'S INTERNAL GRIEVANCE
4 PROCESS UNDER THIS ACT.

5 (F) WHETHER THE COVERED PERSON HAS PROVIDED ALL THE
6 INFORMATION AND FORMS REQUIRED BY THE DIRECTOR THAT ARE NECESSARY
7 TO PROCESS AN EXTERNAL REVIEW, INCLUDING THE HEALTH INFORMATION
8 RELEASE FORM.

9 (4) ~~(3)~~ Upon completion of the ~~A~~ preliminary review under
10 subsection (2) OR (3), the ~~commissioner~~ DIRECTOR immediately shall
11 provide a written notice ~~in plain English~~ to the covered person
12 and, if applicable, the covered person's authorized representative
13 as to whether the request is complete and whether it has been
14 accepted for external review.

15 (5) ~~(4)~~ If **ON ACCEPTING** a request ~~is accepted~~ for external
16 review, the ~~commissioner~~ DIRECTOR shall do both of the following:

17 (a) Include in the written notice under subsection ~~(3)~~ (4) a
18 statement that the covered person or the covered person's
19 authorized representative may submit to the ~~commissioner~~ DIRECTOR
20 in writing within 7 business days following the date of the notice
21 additional information and supporting documentation that the
22 reviewing entity ~~shall~~ **WILL** consider when conducting the external
23 review.

24 (b) Immediately notify the health carrier in writing of the
25 acceptance of the request for external review.

26 (6) ~~(5)~~ If a request is not accepted for external review
27 because the request is not complete, the ~~commissioner~~ DIRECTOR

1 shall inform the covered person and, if applicable, the covered
2 person's authorized representative what information or materials
3 are needed to make the request complete. **THE COVERED PERSON OR, IF**
4 **APPLICABLE, THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE SHALL**
5 **PROVIDE THE INFORMATION OR MATERIALS IDENTIFIED BY THE DIRECTOR**
6 **WITHIN 30 DAYS AFTER RECEIVING THE NOTIFICATION.** If a request is
7 not accepted for external review, the ~~commissioner~~**DIRECTOR** shall
8 provide written notice ~~in plain English~~ to the covered person, if
9 applicable, the covered person's authorized representative, and the
10 health carrier of the reasons for its nonacceptance.

11 (7) ~~(6)~~—If a request is accepted for external review and
12 appears to involve issues of medical necessity or clinical review
13 criteria, the ~~commissioner~~**DIRECTOR** shall assign an independent
14 review organization at the time the request is accepted for
15 external review. The assigned independent review organization ~~shall~~
16 **MUST** be approved under this act to conduct external reviews. ~~and~~
17 **THE ASSIGNED INDEPENDENT REVIEW ORGANIZATION** shall provide a
18 written recommendation to the ~~commissioner~~**DIRECTOR** on whether to
19 uphold or reverse the adverse determination or the final adverse
20 determination.

21 (8) ~~(7)~~—If a request is accepted for external review, does not
22 appear to involve issues of medical necessity or clinical review
23 criteria, and appears to only involve purely contractual provisions
24 of a health benefit plan, such as covered benefits or accuracy of
25 coding, the ~~commissioner~~**DIRECTOR** may keep the request and conduct
26 his or her own external review or may assign an independent review
27 organization as provided in subsection ~~(6)~~**(7)** at the time the

request is accepted for external review. Except as otherwise provided in subsection ~~(16)~~, **(18)**, if the ~~commissioner~~**DIRECTOR** keeps a request, he or she shall review the request and issue a decision upholding or reversing the adverse determination or final adverse determination within the same time limits and subject to all other requirements of this act for requests assigned to an independent review organization. If at any time during the ~~commissioner's~~**DIRECTOR'S** review of a request it is determined that a request does appear to involve issues of medical necessity or clinical review criteria, the ~~commissioner~~**DIRECTOR** shall immediately assign the request to an independent review organization approved under this act to conduct external reviews.

(9) ~~(8)~~—In reaching a recommendation, the reviewing entity is not bound by any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal grievance process.

(10) ~~(9)~~—Not later than 7 business days after the date of the notice under subsection ~~(4)(b)~~, **(5)(B)**, the health carrier or its designee utilization review organization shall provide to the reviewing entity the documents and any information considered in making the adverse determination or the final adverse determination. Except as provided in subsection ~~(10)~~, **(11)**, **THE REVIEWING ENTITY SHALL NOT DELAY THE EXTERNAL REVIEW BECAUSE OF** failure by the health carrier or its designee utilization review organization to provide the documents and information within 7 business days. ~~shall not delay the conduct of the external review.~~

(11) ~~(10)~~—Upon receipt of a notice from the assigned

1 independent review organization that the health carrier or its
2 designee utilization review organization has failed to provide the
3 documents and information within 7 business days, the ~~commissioner~~
4 **DIRECTOR** may terminate the external review and make a decision to
5 reverse the adverse determination or final adverse determination
6 and shall immediately notify the assigned independent review
7 organization, the covered person, if applicable, the covered
8 person's authorized representative, and the health carrier of his
9 or her decision.

10 (12) ~~(11)~~ The reviewing entity shall review all of the
11 information and documents received under subsection ~~(9)~~ (10) and
12 any other information submitted in writing by the covered person or
13 the covered person's authorized representative under subsection
14 ~~(4)(a)~~ (5) (A) that has been forwarded by the ~~commissioner~~.
15 **DIRECTOR**. Upon receipt of any information submitted by the covered
16 person or the covered person's authorized representative under
17 subsection ~~(4)(a)~~, (5) (A), at the same time the ~~commissioner~~
18 **DIRECTOR** forwards the information to the independent review
19 organization, the ~~commissioner~~ **DIRECTOR** shall forward the
20 information to the health carrier.

21 (13) ~~(12)~~ The health carrier may reconsider its adverse
22 determination or final adverse determination that is the subject of
23 the external review. Reconsideration by the health carrier of its
24 adverse determination or final adverse determination does not delay
25 or terminate the external review. The external review may only be
26 terminated if the health carrier decides, upon completion of its
27 reconsideration, to reverse its adverse determination or final

1 adverse determination and provide coverage or payment for the
2 health care service that is the subject of the adverse
3 determination or final adverse determination. Immediately upon
4 making the decision to reverse its adverse determination or final
5 adverse determination, the health carrier shall notify the covered
6 person, if applicable the covered person's authorized
7 representative, if applicable the assigned independent review
8 organization, and the ~~commissioner~~**DIRECTOR** in writing of its
9 decision. The reviewing entity shall terminate the external review
10 upon receipt of the notice from the health carrier.

11 (14) ~~(13)~~—In addition to the documents and information
12 provided under subsection ~~(9)~~, **(10)**, the reviewing entity, to the
13 extent the information or documents are available and the reviewing
14 entity considers them appropriate, shall consider the following in
15 reaching a recommendation:

16 (a) The covered person's pertinent medical records.

17 (b) The attending health care professional's recommendation.

18 (c) Consulting reports from appropriate health care
19 professionals and other documents submitted by the health carrier,
20 the covered person, the covered person's authorized representative,
21 or the covered person's treating provider.

22 (d) The terms of coverage under the covered person's health
23 benefit plan with the health carrier.

24 (e) The most appropriate practice guidelines, which may
25 include generally accepted practice guidelines, evidence-based
26 practice guidelines, or any other practice guidelines developed by
27 the federal government or national or professional medical

1 societies, boards, and associations.

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

5 (15) IF A REQUEST FOR AN EXTERNAL REVIEW INVOLVES ISSUES OF
6 EXPERIMENTAL OR INVESTIGATIONAL SERVICE OR TREATMENT, IN ADDITION
7 TO THE DOCUMENTS AND INFORMATION PROVIDED UNDER SUBSECTIONS (10)
8 AND (14), THE REVIEWING ENTITY, IN REACHING A RECOMMENDATION, SHALL
9 CONSIDER WHETHER EITHER OF THE FOLLOWING APPLIES:

10 (A) THE RECOMMENDED OR REQUESTED HEALTH CARE SERVICE OR
11 TREATMENT HAS BEEN APPROVED BY THE UNITED STATES FOOD AND DRUG
12 ADMINISTRATION, IF APPLICABLE, FOR THE CONDITION.

13 (B) MEDICAL OR SCIENTIFIC EVIDENCE OR EVIDENCE-BASED STANDARDS
14 DEMONSTRATE THAT THE EXPECTED BENEFITS OF THE RECOMMENDED OR
15 REQUESTED HEALTH CARE SERVICE OR TREATMENT ARE MORE LIKELY THAN NOT
16 TO BE MORE BENEFICIAL TO THE COVERED PERSON THAN THE BENEFITS OF
17 ANY AVAILABLE STANDARD HEALTH CARE SERVICE OR TREATMENT AND THE
18 ADVERSE RISKS OF THE RECOMMENDED OR REQUESTED HEALTH CARE SERVICE
19 OR TREATMENT WOULD NOT BE SUBSTANTIALLY INCREASED OVER THOSE OF
20 AVAILABLE STANDARD HEALTH CARE SERVICES OR TREATMENTS.

21 (16) ~~(14)~~—The assigned independent review organization shall
22 provide its recommendation to the ~~commissioner not later than~~
23 **DIRECTOR WITHIN** 14 days after the assignment by the ~~commissioner~~
24 **DIRECTOR** of the request for an external review. The independent
25 review organization shall include in its recommendation all of the
26 following:

27 (a) A general description of the reason for the request for

1 external review.

2 (b) The date the independent review organization received the
3 assignment from the ~~commissioner~~**DIRECTOR** to conduct the external
4 review.

5 (c) The date the external review was conducted.

6 (d) The date of its recommendation.

7 (e) The principal reason or reasons for its recommendation.

8 (f) The rationale for its recommendation.

9 (g) References to the evidence or documentation, including the
10 practice guidelines, considered in reaching its recommendation.

11 (17) ~~(15)~~ Upon receipt of the assigned independent review
12 organization's recommendation under subsection ~~(14)~~, **(16)**, the
13 ~~commissioner~~**DIRECTOR** immediately shall review the recommendation
14 to ensure that it is not contrary to the terms of coverage under
15 the covered person's health benefit plan with the health carrier.

16 (18) ~~(16)~~ The ~~commissioner~~**DIRECTOR** shall provide written
17 notice ~~in plain English~~ to the covered person, if applicable the
18 covered person's authorized representative, and the health carrier
19 of the decision to uphold or reverse the adverse determination or
20 the final adverse determination ~~not later than~~ **WITHIN** 7 business
21 days after the date of receipt of the selected independent review
22 organization's recommendation. If the ~~commissioner~~**DIRECTOR** has
23 kept a request for review, the ~~commissioner~~**DIRECTOR** shall provide
24 written notice ~~in plain English~~ to the covered person, if
25 applicable the covered person's authorized representative, and the
26 health carrier of his or her decision ~~not later than~~ **WITHIN** 14 days
27 after the decision to keep the request. The ~~commissioner~~**DIRECTOR**

1 shall include in a notice under this subsection all of the
2 following:

3 (a) The principal reason or reasons for the decision,
4 including, as an attachment to the notice or in any other manner
5 the ~~commissioner~~**DIRECTOR** considers appropriate, the information
6 provided as determined by the reviewing entity under subsection
7 ~~(14)~~**(16)**.

8 (b) If appropriate, the principal reason or reasons why the
9 ~~commissioner~~**DIRECTOR** did not follow the assigned independent
10 review organization's recommendation.

11 **(19)** ~~(17)~~ Upon receipt of a notice of a decision under
12 subsection ~~(16)~~**(18)** reversing the adverse determination or final
13 adverse determination, the health carrier immediately shall approve
14 the coverage that was the subject of the adverse determination or
15 final adverse determination.

16 Sec. 13. (1) Except as provided in subsection ~~(11)~~**(12)**, a
17 covered person or the covered person's authorized representative
18 may make a request for an expedited external review with the
19 ~~commissioner~~**DIRECTOR** within 10 days after the covered person
20 receives an adverse determination if both of the following ~~are~~
21 ~~met~~**APPLY:**

22 (a) The adverse determination involves a medical condition of
23 the covered person for which the time frame for completion of an
24 expedited internal grievance would seriously jeopardize the life or
25 health of the covered person or would jeopardize the covered
26 person's ability to regain maximum function as substantiated by a
27 physician either orally or in writing.

1 (b) The covered person or the covered person's authorized
2 representative has filed a request for an expedited internal
3 grievance.

4 (2) ~~At the time~~ **WHEN** the ~~commissioner~~ **DIRECTOR** receives a
5 request for an expedited external review, the ~~commissioner~~ **DIRECTOR**
6 immediately shall notify and provide a copy of the request to the
7 health carrier that made the adverse determination or final adverse
8 determination. If the ~~commissioner~~ **DIRECTOR** determines the request
9 meets the reviewability requirements under section 11(2) **OR (3)**,
10 the ~~commissioner~~ **DIRECTOR** shall assign an independent review
11 organization that has been approved under this act to conduct the
12 expedited external review and to provide a written recommendation
13 to the ~~commissioner~~ **DIRECTOR** on whether to uphold or reverse the
14 adverse determination or final adverse determination.

15 (3) If a covered person has not completed the health carrier's
16 expedited internal grievance process, the independent review
17 organization shall determine immediately after receipt of the
18 assignment to conduct the expedited external review whether the
19 covered person will be required to complete the expedited internal
20 grievance ~~prior to~~ **BEFORE** conducting the expedited external review.
21 If the independent review organization determines that the covered
22 person must first complete the expedited internal grievance
23 process, the independent review organization immediately shall
24 notify the covered person and, if applicable, the covered person's
25 authorized representative of this determination and that it will
26 not proceed with the expedited external review until the covered
27 person completes the expedited internal grievance.

1 (4) In reaching a recommendation, ~~the~~~~AN~~ assigned independent
2 review organization is not bound by any decisions or conclusions
3 reached during the health carrier's utilization review process or
4 the health carrier's internal grievance process.

5 (5) Not later than 12 hours after ~~the~~~~A~~ health carrier
6 receives ~~the~~~~A~~ notice under subsection (2), the health carrier or
7 its designee utilization review organization shall provide or
8 transmit all necessary documents and information considered in
9 making the adverse determination or final adverse determination to
10 the assigned independent review organization electronically or by
11 telephone, ~~or~~ facsimile, or any other available expeditious method.

12 (6) In addition to the documents and information provided or
13 transmitted under subsection (5), the assigned independent review
14 organization, to the extent the information or documents are
15 available and the independent review organization considers them
16 appropriate, shall consider the following in reaching a
17 recommendation:

18 (a) The covered person's pertinent medical records.

19 (b) The attending health care professional's recommendation.

20 (c) Consulting reports from appropriate health care
21 professionals and other documents submitted by the health carrier,
22 covered person, the covered person's authorized representative, or
23 the covered person's treating provider.

24 (d) The terms of coverage under the covered person's health
25 benefit plan with the health carrier.

26 (e) The most appropriate practice guidelines, which may
27 include generally accepted practice guidelines, evidence-based

1 practice guidelines, or any other practice guidelines developed by
2 the federal government or national or professional medical
3 societies, boards, and associations.

4 (f) Any applicable clinical review criteria developed and used
5 by the health carrier or its designee utilization review
6 organization in making adverse determinations.

7 (7) IF A REQUEST FOR AN EXTERNAL REVIEW INVOLVES ISSUES OF
8 EXPERIMENTAL OR INVESTIGATIONAL SERVICE OR TREATMENT, IN ADDITION
9 TO THE DOCUMENTS AND INFORMATION PROVIDED UNDER SUBSECTIONS (5) AND
10 (6), THE ASSIGNED INDEPENDENT REVIEW ORGANIZATION, IN REACHING A
11 RECOMMENDATION, SHALL CONSIDER WHETHER EITHER OF THE FOLLOWING
12 APPLIES:

13 (A) THE RECOMMENDED OR REQUESTED HEALTH CARE SERVICE OR
14 TREATMENT HAS BEEN APPROVED BY THE UNITED STATES FOOD AND DRUG
15 ADMINISTRATION, IF APPLICABLE, FOR THE CONDITION.

16 (B) MEDICAL OR SCIENTIFIC EVIDENCE OR EVIDENCE-BASED STANDARDS
17 DEMONSTRATE THAT THE EXPECTED BENEFITS OF THE RECOMMENDED OR
18 REQUESTED HEALTH CARE SERVICE OR TREATMENT ARE MORE LIKELY THAN NOT
19 TO BE MORE BENEFICIAL TO THE COVERED PERSON THAN THE BENEFITS OF
20 ANY AVAILABLE STANDARD HEALTH CARE SERVICE OR TREATMENT AND THE
21 ADVERSE RISKS OF THE RECOMMENDED OR REQUESTED HEALTH CARE SERVICE
22 OR TREATMENT WOULD NOT BE SUBSTANTIALLY INCREASED OVER THOSE OF
23 AVAILABLE STANDARD HEALTH CARE SERVICES OR TREATMENTS.

24 (8) ~~(7) The~~ ~~AN~~ assigned independent review organization shall
25 provide its recommendation to the ~~commissioner~~ ~~DIRECTOR~~ as
26 expeditiously as the covered person's medical condition or
27 circumstances require, but ~~in no event~~ ~~NOT~~ more than 36 hours after

1 the date the ~~commissioner~~**DIRECTOR** received the request for an
2 expedited external review.

3 (9) ~~(8)~~ Upon receipt of the ~~an~~ assigned independent review
4 organization's recommendation, the ~~commissioner~~**DIRECTOR**
5 immediately shall review the recommendation to ensure that it is
6 not contrary to the terms of coverage under the covered person's
7 health benefit plan with the health carrier.

8 (10) ~~(9)~~ As expeditiously as the covered person's medical
9 condition or circumstances require, but ~~in no event~~ **NOT** more than
10 24 hours after receiving the recommendation of the assigned
11 independent review organization, the ~~commissioner~~**DIRECTOR** shall
12 complete the review of the independent review organization's
13 recommendation and notify the covered person, if applicable, the
14 covered person's authorized representative, and the health carrier
15 of the decision to uphold or reverse the adverse determination or
16 final adverse determination. If ~~this~~ **THE** notice ~~was~~ **UNDER THIS**
17 **SUBSECTION IS** not in writing, within 2 days after the date of
18 providing ~~that~~ **THE** notice, the ~~commissioner~~**DIRECTOR** shall provide
19 written confirmation of the decision to the covered person, if
20 applicable, the covered person's authorized representative, and the
21 health carrier and include the information required in section
22 ~~11(16)~~ **11(18)**.

23 (11) ~~(10)~~ Upon receipt of a notice of a decision under
24 subsection ~~(9)~~ **(10)** reversing the adverse determination or final
25 adverse determination, the health carrier immediately shall approve
26 the coverage that was the subject of the adverse determination or
27 final adverse determination.

1 (12) ~~(11)~~ An expedited external review ~~shall~~ **MUST** not be
2 provided for retrospective adverse determinations or retrospective
3 final adverse determinations.

4 Sec. 17. (1) The ~~commissioner~~ **DIRECTOR** shall approve
5 independent review organizations eligible to be assigned to conduct
6 external reviews under this act to ensure that an independent
7 review organization satisfies the minimum standards established
8 under section 19.

9 (2) The ~~commissioner~~ **DIRECTOR** shall develop an application
10 form for initially approving and for reapproving independent review
11 organizations to conduct external reviews.

12 (3) Any independent review organization wishing to be approved
13 to conduct external reviews under this act shall submit the
14 application form developed under subsection (2) and include with
15 the form all documentation and information necessary for the
16 ~~commissioner~~ **DIRECTOR** to determine if the independent review
17 organization satisfies the minimum qualifications established under
18 section 19. The ~~commissioner~~ **DIRECTOR** may charge an application fee
19 that independent review organizations shall submit to the
20 ~~commissioner~~ **DIRECTOR** with an application for approval ~~and~~ **OR**
21 reapproval.

22 (4) An approval under this section is effective for 2 years,
23 unless the ~~commissioner~~ **DIRECTOR** determines before expiration of
24 the approval that the independent review organization is not
25 satisfying the minimum standards established under section 19. If
26 the ~~commissioner~~ **DIRECTOR** determines that an independent review
27 organization no longer satisfies the minimum standards established

1 under section 19, the ~~commissioner~~**DIRECTOR** shall terminate the
2 approval of the independent review organization and remove the
3 independent review organization from the list of independent review
4 organizations approved to conduct external reviews under this act
5 that is maintained by the ~~commissioner~~**DIRECTOR** under subsection
6 (5).

7 (5) The ~~commissioner~~**DIRECTOR** shall maintain and periodically
8 update a list of approved independent review organizations.

9 Sec. 19. (1) To be approved under section 17 to conduct
10 external reviews, an independent review organization ~~shall~~**MUST** do
11 ~~both~~**ALL** of the following:

12 (a) Have and maintain written policies and procedures that
13 govern all aspects of both the standard external review process and
14 the expedited external review process under sections 11 and 13 that
15 include, at a minimum, a quality assurance mechanism in place that
16 does all of the following:

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

20 (ii) Ensures the selection of qualified and impartial clinical
21 peer reviewers to conduct external reviews on behalf of the
22 independent review organization and suitable matching of reviewers
23 to specific cases.

24 (iii) Ensures the confidentiality of medical and treatment
25 records and clinical review criteria.

26 (iv) Ensures that any person employed by or under contract
27 with the independent review organization adheres to the

1 requirements of this act.

2 (b) Agree to maintain and provide to the ~~commissioner~~**DIRECTOR**
3 the information required in section 23.

4 **(C) BE ACCREDITED BY A NATIONALLY RECOGNIZED PRIVATE**
5 **ACCREDITING ORGANIZATION APPROVED BY THE DIRECTOR.**

6 (2) A clinical peer reviewer assigned by an independent review
7 organization to conduct external reviews ~~shall~~**MUST** be a physician
8 or other appropriate health care professional who meets all of the
9 following minimum qualifications:

10 (a) Is an expert in the treatment of the covered person's
11 medical condition that is the subject of the external review.

12 (b) Is knowledgeable about the recommended health care service
13 or treatment because he or she devoted in the immediately preceding
14 year a majority of his or her time in an active clinical practice
15 within the medical specialty most relevant to the subject of the
16 review.

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

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

27 (3) An independent review organization may not own or control,

1 be a subsidiary of or in any way be owned or controlled by, or
2 exercise control with a health benefit plan, a national, state, or
3 local trade association of health benefit plans, or a national,
4 state, or local trade association of health care providers.

5 (4) An independent review organization selected to conduct the
6 external review and any clinical peer reviewer assigned by the
7 independent organization to conduct the external review ~~shall~~**MUST**
8 not have a material professional, familial, or financial conflict
9 of interest with any of the following:

10 (a) The health carrier that is the subject of the external
11 review.

12 (b) The covered person whose treatment is the subject of the
13 external review or the covered person's authorized representative.

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

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

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

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

26 (5) In determining whether an independent review organization
27 or a clinical peer reviewer of the independent review organization

1 has a material professional, familial, or financial conflict of
2 interest for purposes of subsection (4), the ~~commissioner~~**DIRECTOR**
3 shall take into consideration situations ~~where~~**IN WHICH** the
4 independent review organization to be assigned to conduct an
5 external review of a specified case or a clinical peer reviewer to
6 be assigned by the independent review organization to conduct an
7 external review of a specified case may have an apparent
8 professional, familial, or financial relationship or connection
9 with a person described in subsection (4), but that the
10 characteristics of that relationship or connection are such that
11 they are not a material professional, familial, or financial
12 conflict of interest that results in the disapproval of the
13 independent review organization or the clinical peer reviewer from
14 conducting the external review.

15 Sec. 23. (1) An independent review organization assigned to
16 conduct an external review under section 11 or 13 shall maintain
17 for 3 years written records in the aggregate and by health carrier
18 on all requests for external review for which it conducted an
19 external review during a calendar year. Each independent review
20 organization required to maintain written records on all requests
21 for external review for which it was assigned to conduct an
22 external review shall submit to the ~~commissioner~~**DIRECTOR**, at
23 least annually, a report in the format specified by the
24 ~~commissioner~~**DIRECTOR**.

25 (2) The report to the ~~commissioner~~**DIRECTOR** under subsection
26 (1) ~~shall~~**MUST** include in the aggregate and for each health carrier
27 all of the following:

1 (a) The total number of requests for external review.

2 (b) The number of requests for external review resolved and,
3 of those resolved, the number resolved upholding the adverse
4 determination or final adverse determination and the number
5 resolved reversing the adverse determination or final adverse
6 determination.

7 (c) The average length of time for resolution.

8 (d) A summary of the types of coverages or cases for which an
9 external review was sought, as provided in the format required by
10 the ~~commissioner~~-DIRECTOR.

11 (e) The number of external reviews under section ~~11(12)~~-11(13)
12 that were terminated as the result of a reconsideration by the
13 health carrier of its adverse determination or final adverse
14 determination after the receipt of additional information from the
15 covered person or the covered person's authorized representative.

16 (f) Any other information the ~~commissioner~~-DIRECTOR may
17 request or require.

18 (3) ~~Each~~-A health carrier shall maintain for 3 years written
19 records in the aggregate and for each type of health benefit plan
20 offered by the health carrier on all requests for external review
21 that are filed with the health carrier or that the health carrier
22 receives notice of from the ~~commissioner~~-DIRECTOR under this act.
23 ~~Each~~-A health carrier required to maintain written records on all
24 requests for external review shall submit to the ~~commissioner~~,
25 DIRECTOR, at least annually, a report in the format specified by
26 the ~~commissioner~~-DIRECTOR.

27 (4) The report to the ~~commissioner~~-DIRECTOR under subsection

1 (3) ~~shall~~**MUST** include in the aggregate and by type of health
2 benefit plan all of the following:

3 (a) The total number of requests for external review.

4 (b) From the number of requests for external review that are
5 filed directly with the health carrier, the number of requests
6 accepted for a full external review.

7 (c) The number of requests for external review resolved and,
8 of those resolved, the number resolved upholding the adverse
9 determination or final adverse determination and the number
10 resolved reversing the adverse determination or final adverse
11 determination.

12 (d) The average length of time for resolution.

13 (e) A summary of the types of coverages or cases for which an
14 external review was sought, as provided in the format required by
15 the ~~commissioner~~**DIRECTOR**.

16 (f) The number of external reviews under section ~~11(12)~~**11(13)**
17 that were terminated as the result of a reconsideration by the
18 health carrier of its adverse determination or final adverse
19 determination after the receipt of additional information from the
20 covered person or the covered person's authorized representative.

21 (g) Any other information the ~~commissioner~~**DIRECTOR** may
22 request or require.

23 Sec. 25. (1) ~~Each~~**A** health carrier shall include a description
24 of the internal grievance and external review procedures in or
25 attached to the policy, certificate, membership booklet, outline of
26 coverage, or other evidence of coverage it provides to covered
27 persons.

1 (2) The description under subsection (1) ~~shall be in plain~~
2 ~~English and shall~~ **MUST** include all of the following:

3 (a) A statement informing the covered person of his or her
4 right to file a request for an internal grievance and external
5 review of an adverse determination.

6 (b) The ~~commissioner's~~ **DIRECTOR'S** toll-free telephone number
7 and address.

8 (c) A statement informing the covered person that, when filing
9 a request for an external review, the covered person will be
10 required to authorize the release of any medical records that may
11 be required to be reviewed ~~for the purpose of reaching~~ **TO REACH** a
12 decision on the external review.

13 Sec. 27. The ~~commissioner~~ **DIRECTOR** may promulgate rules
14 ~~pursuant to~~ **UNDER** the administrative procedures act of 1969, 1969
15 PA 306, MCL 24.201 to 24.328, necessary to carry out ~~the provisions~~
16 ~~of this act.~~

17 Enacting section 1. This amendatory act takes effect 90 days
18 after the date it is enacted into law.

19 Enacting section 2. This amendatory act does not take effect
20 unless House Bill No. 4935 of the 98th Legislature is enacted into
21 law.