

**REPRINT
SUBSTITUTE FOR
HOUSE BILL NO. 5576**

(As passed the House, May 24, 2000)

A bill to provide review of certain health care coverage adverse determinations made by health carriers; to prescribe eligibility, powers, and duties of certain independent review organizations; to prescribe the powers and duties of certain health carriers; to prescribe the powers and duties of certain persons; to prescribe the powers and duties of certain state officials; to provide for the reporting of certain information; to provide fees; and to provide penalties for violations of this act.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 1. This act shall be known and may be cited as the
2 "patient's right to independent review act".

3 Sec. 3. As used in this act:

4 (a) "Adverse determination" means a determination by a
5 health carrier or its designee utilization review organization
6 that an admission, availability of care, continued stay, or other

1 health care service has been reviewed and has been denied,
2 reduced, or terminated. Failure to respond in a timely manner to
3 a request for a determination constitutes an adverse
4 determination.

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

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

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

11 (ii) A person authorized by law to provide substituted con-
12 sent for a covered person.

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

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

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

26 (f) "Clinical review criteria" means the written screening
27 procedures, decision abstracts, clinical protocols, and practice

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1 guidelines used by a health carrier to determine the necessity
2 and appropriateness of health care services.

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

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

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

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

13 (k) "Discharge planning" means the formal process for deter-
14 mining, prior to discharge from a facility, the coordination and
15 management of the care that a patient receives following dis-
16 charge from a facility.

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

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

25 (n) "Facility" or "health facility" means:

- 1 (i) A facility or agency licensed or authorized under
2 parts 201 to 217 of the public health code, 1978 PA 368,
3 MCL 333.20101 to 333.21799e, or a licensed part thereof.
- 4 (ii) A psychiatric hospital, psychiatric unit, partial hos-
5 pitalization psychiatric program, or center for persons with dis-
6 abilities operated by the department of community health or cer-
7 tified or licensed under the mental health code, 1974 PA 258,
8 MCL 330.1001 to 330.2106.
- 9 (iii) A facility providing outpatient physical therapy serv-
10 ices, including speech pathology services.
- 11 (iv) A kidney disease treatment center, including a free-
12 standing hemodialysis unit.
- 13 (v) An ambulatory health care facility.
- 14 (vi) A tertiary health care service facility.
- 15 (vii) A substance abuse treatment program licensed under
16 parts 61 to 65 of the public health code, 1978 PA 368,
17 MCL 333.6101 to 333.6523.
- 18 (viii) An outpatient psychiatric clinic.
- 19 (ix) A home health agency.
- 20 (o) "Health benefit plan" means a policy, contract, certifi-
21 cate, or agreement offered or issued by a health carrier to pro-
22 vide, deliver, arrange for, pay for, or reimburse any of the
23 costs of covered health care services.
- 24 (p) "Health care professional" means a person licensed, cer-
25 tified, or registered under parts 61 to 65 or 161 to 183 of the
26 public health code, 1978 PA 368, MCL 333.6101 to 333.6523, and
27 MCL 333.16101 to 333.18311.

1 (q) "Health care provider" or "provider" means a health care
2 professional or a health facility.

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

6 (s) "Health carrier" means an entity subject to the insur-
7 ance laws and regulations of this state, or subject to the juris-
8 diction of the commissioner, that contracts or offers to contract
9 to provide, deliver, arrange for, pay for, or reimburse any of
10 the costs of health care services, including a sickness and acci-
11 dent insurance company, a health maintenance organization, a non-
12 profit health care corporation, or any other entity providing a
13 plan of health insurance, health benefits, or health services.
14 Health carrier does not include a state department or agency.

15 (t) "Health information" means information or data, whether
16 oral or recorded in any form or medium, and personal facts or
17 information about events or relationships that relates to 1 or
18 more of the following:

19 (i) The past, present, or future physical, mental, or behav-
20 ioral health or condition of an individual or a member of the
21 individual's family.

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

24 (iii) Payment for the provision of health care services to
25 an individual.

26 (u) "Independent review organization" means an entity that
27 conducts independent external reviews of adverse determinations.

1 (v) "Prospective review" means utilization review conducted
2 prior to an admission or a course of treatment.

3 (w) "Protected health information" means health information
4 that identifies an individual who is the subject of the informa-
5 tion or with respect to which there is a reasonable basis to
6 believe that the information could be used to identify an
7 individual.

8 (x) "Retrospective review" means a review of medical neces-
9 sity conducted after services have been provided to a patient,
10 but does not include the review of a claim that is limited to an
11 evaluation of reimbursement levels, veracity of documentation,
12 accuracy of coding, or adjudication for payment.

13 (y) "Second opinion" means an opportunity or requirement to
14 obtain a clinical evaluation by a provider other than the one
15 originally making a recommendation for a proposed health service
16 to assess the clinical necessity and appropriateness of the ini-
17 tial proposed health service.

18 (z) "Utilization review" means a set of formal techniques
19 designed to monitor the use of, or evaluate the clinical necessi-
20 ty, appropriateness, efficacy, or efficiency of, health care
21 services, procedures, or settings. Techniques may include ambu-
22 latory review, prospective review, second opinion, certification,
23 concurrent review, case management, discharge planning, or retro-
24 spective review.

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

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

4 (2) This act does not apply to a policy or certificate that
5 provides coverage only for specified accident or accident-only
6 coverage, credit, disability income, hospital indemnity,
7 long-term care insurance, or any other limited supplemental bene-
8 fit other than specified disease, dental, vision care, or care
9 provided pursuant to a system of health care delivery and financ-
10 ing operating under section 3573 of the insurance code of 1956,
11 1956 PA 218, MCL 500.3573, medicare supplement policy of insur-
12 ance, coverage under a plan through medicare, or the federal
13 employees health benefits program, any coverage issued under
14 chapter 55 of title 10 of the United States Code, 10 U.S.C. 1071
15 to 1109, and any coverage issued as supplement to that coverage,
16 any coverage issued as supplemental to liability insurance,
17 worker's compensation or similar insurance, automobile
18 medical-payment insurance, or any insurance under which benefits
19 are payable with or without regard to fault, whether written on a
20 group blanket or individual basis.

21 Sec. 7. (1) A health carrier shall provide written notice
22 to a covered person in plain English of the internal grievance
23 and external review processes at the time the health carrier
24 sends written notice of an adverse determination.

25 (2) Except as provided in subsection (3)(a), a request for
26 an external review under section 11 or 13 shall not be made until

1 the covered person has exhausted the health carrier's internal
2 grievance process provided for by law.

3 (3) The written notice of the right to request an external
4 review for an adverse determination issued before the service is
provided to a covered person shall be in plain English and shall
5 include all of the following:

6 (a) A
7 statement informing the covered person of all of the following:

8 (i) If the covered person has a medical condition where the
9 time frame for completion of an expedited internal grievance
10 would seriously jeopardize the life or health of the covered
11 person or would jeopardize the covered person's ability to regain
12 maximum function, as substantiated by a physician either orally
13 or in writing, the covered person or the covered person's autho-
14 rized representative may file a request for an expedited external
15 review under section 13 at the same time the covered person or
16 the covered person's authorized representative files a request
17 for an expedited internal grievance subject to section 13(3).

18 (ii) The covered person or the covered person's authorized
19 representative may file a grievance under the health carrier's
20 internal grievance process but if the health carrier has not
21 issued a written decision to the covered person or the covered
22 person's authorized representative within the required time and
23 without the covered person or the covered person's authorized
24 representative requesting or agreeing

25
26 to a delay, the covered person or the
27 covered person's authorized representative may file a request for

1 external review under section 9 and shall be considered to have
2 exhausted the health carrier's internal grievance process for
3 purposes of subsection (2).

4 (b) A copy of the description of both the standard and expe-
5 dited external review procedures the health carrier is required
6 to provide under section 25, highlighting the provisions in the
7 external review procedures that give the covered person or the
8 covered person's authorized representative the opportunity to
9 submit additional information and including any forms used to
10 process an external review.

11 (c) As part of any forms provided under subdivision (b),
12 include an authorization form, or other document approved by the
13 commissioner, by which the covered person, for purposes of con-
14 ducting an external review under this act, authorizes the health
15 carrier and health care provider to disclose protected health
16 information, including medical records, concerning the covered
17 person that are pertinent to the external review.

(4) The written notice of the right to request an external
review for an adverse determination issued after the service was
provided to the covered person shall be in plain English, shall
include the standard external review procedures information required
in subsection (3), and shall be provided to the covered person in
the manner prescribed by the commissioner.

18 Sec. 9. Except for a request for an expedited external
19 review under section 13, all requests for external review shall
20 be made in writing to the commissioner.

21 Sec. 11. (1) Not later than 60 days after the date of
22 receipt of a notice of an adverse determination or final adverse
23 determination under section 7, a covered person or the covered
24 person's authorized representative may file a request for an
25 external review with the commissioner. Upon receipt of a request
26 for an external review, the commissioner immediately shall notify
27 and send a copy of the request to the health carrier that made

1 the adverse determination or final adverse determination that is
2 the subject of the request.

3 (2) Not later than 5 business days after the date of receipt
4 of a request for an external review, the commissioner shall com-
5 plete a preliminary review of the request to determine all of the
6 following:

7 (a) Whether the individual is or was a covered person in the
8 health benefit plan at the time the health care service was
9 requested or, in the case of a retrospective review, was a cov-
10 ered person in the health benefit plan at the time the health
11 care service was provided.

12 (b) Whether the health care service that is the subject of
13 the adverse determination or final adverse determination reason-
14 ably appears to be a covered service under the covered person's
15 health benefit plan.

16 (c) Whether the covered person has exhausted the health
17 carrier's internal grievance process unless the covered person is
18 not required to exhaust the health carrier's internal grievance
19 process.

20 (d) The covered person has provided all the information and
21 forms required by the commissioner that are necessary to process
22 an external review, including the health information release
23 form.

24 (3) Upon completion of the preliminary review under subsec-
25 tion (2), the commissioner immediately shall provide a written
26 notice in plain English to the covered person and, if applicable,
27 the covered person's authorized representative as to whether the

1 request is complete and whether it has been accepted for external
2 review.

3 (4) If a request is accepted for external review, the com-
4 missioner shall do both of the following:

5 (a) Include in the written notice under subsection (3) a
6 statement that the covered person or the covered person's autho-
7 rized representative may submit to the commissioner in writing
8 within 7 days following the date of receipt of the notice addi-
9 tional information and supporting documentation that the assigned
10 independent review organization shall consider when conducting
11 the external review.

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

14 (5) If a request is not accepted for external review because
15 the request is not complete, the commissioner shall inform the
16 covered person and, if applicable, the covered person's autho-
17 rized representative what information or materials are needed to
18 make the request complete. If a request is not accepted for
19 external review, the commissioner shall provide written notice in
20 plain English to the covered person, if applicable, the covered
21 person's authorized representative, and the health carrier of the
22 reasons for its nonacceptance.

23 (6) At the time a request is accepted for external review,
24 the commissioner shall assign an independent review organization
25 that has been approved under this act to conduct the external
26 review and to provide a written recommendation to the

1 commissioner on whether to uphold or reverse the adverse
2 determination or the final adverse determination.

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

7 (8) Not later than 7 business days after the date of receipt
8 of the notice under subsection (4)(b), the health carrier or its
9 designee utilization review organization shall provide to the
10 assigned independent review organization the documents and any
11 information considered in making the adverse determination or the
12 final adverse determination. Except as provided in subsection
13 (9), failure by the health carrier or its designee utilization
14 review organization to provide the documents and information
15 within 7 business days shall not delay the conduct of the exter-
16 nal review.

17 (9) Upon receipt of a notice from the assigned independent
18 review organization that the health carrier or its designee util-
19 ization review organization has failed to provide the documents
20 and information within 7 business days, the commissioner may ter-
21 minate the external review and make a decision to reverse the
22 adverse determination or final adverse determination and shall
23 immediately notify the assigned independent review organization,
24 the covered person, if applicable, the covered person's autho-
25 rized representative, and the health carrier of his or her
26 decision.

1 (10) The assigned independent review organization shall
2 review all of the information and documents received under
3 subsection (8) and any other information submitted in writing by
4 the covered person or the covered person's authorized representa-
5 tive under subsection (4)(a) that has been forwarded to the inde-
6 pendent review organization by the commissioner. Upon receipt of
7 any information submitted by the covered person or the covered
8 person's authorized representative under subsection (4)(a), at
9 the same time the commissioner forwards the information to the
10 independent review organization, the commissioner shall forward
11 the information to the health carrier.

12 (11) The health carrier may reconsider its adverse determi-
13 nation or final adverse determination that is the subject of the
14 external review. Reconsideration by the health carrier of its
15 adverse determination or final adverse determination does not
16 delay or terminate the external review. The external review may
17 only be terminated if the health carrier decides, upon completion
18 of its reconsideration, to reverse its adverse determination or
19 final adverse determination and provide coverage or payment for
20 the health care service that is the subject of the adverse deter-
21 mination or final adverse determination. Immediately upon making
22 the decision to reverse its adverse determination or final
23 adverse determination, the health carrier shall notify the cov-
24 ered person, if applicable, the covered person's authorized rep-
25 resentative, the assigned independent review organization, and
26 the commissioner in writing of its decision. The assigned

1 independent review organization shall terminate the external
2 review upon receipt of the notice from the health carrier.

3 (12) In addition to the documents and information provided
4 under subsection (8), the assigned independent review organiza-
5 tion, to the extent the information or documents are available
6 and the independent review organization considers them appropri-
7 ate, shall consider the following in reaching a recommendation:

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

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

11 (c) Consulting reports from appropriate health care profes-
12 sionals and other documents submitted by the health carrier, the
13 covered person, the covered person's authorized representative,
14 or the covered person's treating provider.

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

17 (e) The most appropriate practice guidelines, which may
18 include generally accepted practice guidelines, evidence-based
19 practice guidelines, or any other practice guidelines developed
20 by the federal government or national or professional medical
21 societies, boards, and associations.

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

25 (13) The assigned independent review organization shall pro-
26 vide its recommendation to the commissioner not later than
27 14 days after acceptance by the commissioner of the request for

1 an external review. The independent review organization shall
2 include in its recommendation all of the following:

3 (a) A general description of the reason for the request for
4 external review.

5 (b) The date the independent review organization received
6 the assignment from the commissioner to conduct the external
7 review.

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

9 (d) The date of its recommendation.

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

11 (f) The rationale for its recommendation.

12 (g) References to the evidence or documentation, including
13 the practice guidelines, considered in reaching its
14 recommendation.

15 (14) Upon receipt of the assigned independent review
16 organization's recommendation under subsection (13), the commis-
17 sioner immediately shall review the recommendation to ensure that
18 it is not contrary to the terms of coverage under the covered
19 person's health benefit plan with the health carrier.

20 (15) The commissioner shall provide written notice in plain
21 English to the covered person, if applicable, the covered
22 person's authorized representative, and the health carrier of the
23 decision to uphold or reverse the adverse determination or the
24 final adverse determination not later than 7 business days after the
25 date of receipt of the selected independent review organization's
26 recommendation. The commissioner shall include in this notice
27 all of the following:

1 (a) The principal reason or reasons for the decision,
2 including, as an attachment to the notice or in any other manner
3 the commissioner considers appropriate, the information provided
4 by the selected independent review organization under subsection
5 (13).

6 (b) If appropriate, the principal reason or reasons why the
7 commissioner did not follow the assigned independent review
8 organization's recommendation.

9 (16) Upon receipt of a notice of a decision under subsection
10 (15) reversing the adverse determination or final adverse deter-
11 mination, the health carrier immediately shall approve the cover-
12 age that was the subject of the adverse determination or final
13 adverse determination.

14 Sec. 13. (1) Except as provided in subsection (11), a cov-
15 ered person or the covered person's authorized representative may
16 make a request for an expedited external review with the commis-
17 sioner within 10 days after the covered person receives an
18 adverse determination if both of the following are met:

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

25 (b) The covered person or the covered person's authorized
26 representative has filed a request for an expedited internal
27 grievance.

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

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

26 (4) In reaching a recommendation, the assigned independent
27 review organization is not bound by any decisions or conclusions

1 reached during the health carrier's utilization review process or
2 the health carrier's internal grievance process.

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

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

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

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

20 (c) Consulting reports from appropriate health care profes-
21 sionals and other documents submitted by the health carrier, cov-
22 ered 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
2 by the federal government or national or professional medical
3 societies, boards, and associations.

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

7 (7) The assigned independent review organization shall pro-
8 vide its recommendation to the commissioner as expeditiously as
9 the covered person's medical condition or circumstances require,
10 but in no event more than 36 hours after the date the commis-
11 sioner received the request for an expedited external review.

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

17 (9) As expeditiously as the covered person's medical condi-
18 tion or circumstances require, but in no event more than 24 hours
19 after receiving the recommendation of the assigned independent
20 review organization, the commissioner shall complete the review
21 of the independent review organization's recommendation and
22 notify the covered person, if applicable, the covered person's
23 authorized representative, and the health carrier of the decision
24 to uphold or reverse the adverse determination or final adverse
25 determination. If this notice was not in writing, within 2 days
26 after the date of providing that notice, the commissioner shall
27 provide written confirmation of the decision to the covered

1 person, if applicable, the covered person's authorized
2 representative, and the health carrier and include the informa-
3 tion required in section 11(15).

4 (10) Upon receipt of a notice of a decision under subsection
5 (9) reversing the adverse determination or final adverse determi-
6 nation, the health carrier immediately shall approve the coverage
7 that was the subject of the adverse determination or final
8 adverse determination.

9 (11) An expedited external review shall not be provided for
10 retrospective adverse determinations or retrospective final
11 adverse determinations.

12 Sec. 15. (1) An external review decision and an expedited
13 external review decision are the final administrative remedies
14 available under this act.

15 (2) Subsection (1) does not preclude a health carrier from
16 seeking other remedies available under applicable state law.

17 (3) Subsection (1) does not preclude a covered person from
18 seeking other remedies available under applicable federal or
19 state law.

20 (4) A covered person or the covered person's authorized rep-
21 resentative may not file a subsequent request for external review
22 involving the same adverse determination or final adverse deter-
23 mination for which the covered person has already received an
24 external review decision under this act.

25 Sec. 17. (1) The commissioner shall approve independent
26 review organizations eligible to be assigned to conduct external
27 reviews under this act to ensure that an independent review

1 organization satisfies the minimum standards established under
2 section 19.

3 (2) The commissioner shall develop an application form for
4 initially approving and for reapproving independent review organ-
5 izations to conduct external reviews.

6 (3) Any independent review organization wishing to be
7 approved to conduct external reviews under this act shall submit
8 the application form developed under subsection (2) and include
9 with the form all documentation and information necessary for the
10 commissioner to determine if the independent review organization
11 satisfies the minimum qualifications established under section
12 19. The commissioner may charge an application fee that indepen-
13 dent review organizations shall submit to the commissioner with
14 an application for approval and reapproval.

15 (4) An approval under this section is effective for 2 years,
16 unless the commissioner determines before expiration of the
17 approval that the independent review organization is not satisfy-
18 ing the minimum standards established under section 19. If the
19 commissioner determines that an independent review organization
20 no longer satisfies the minimum standards established under sec-
21 tion 19, the commissioner shall terminate the approval of the
22 independent review organization and remove the independent review
23 organization from the list of independent review organizations
24 approved to conduct external reviews under this act that is main-
25 tained by the commissioner under subsection (5).

26 (5) The commissioner shall maintain and periodically update
27 a list of approved independent review organizations.

1 Sec. 19. (1) To be approved under section 17 to conduct
2 external reviews, an independent review organization shall do
3 both of the following:

4 (a) Have and maintain written policies and procedures that
5 govern all aspects of both the standard external review process
6 and the expedited external review process under sections 11 and
7 13 that include, at a minimum, a quality assurance mechanism in
8 place that does all of the following:

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

12 (ii) Ensures the selection of qualified and impartial clini-
13 cal peer reviewers to conduct external reviews on behalf of the
14 independent review organization and suitable matching of review-
15 ers to specific cases.

16 (iii) Ensures the confidentiality of medical and treatment
17 records and clinical review criteria.

18 (iv) Ensures that any person employed by or under contract
19 with the independent review organization adheres to the require-
20 ments of this act.

21 (b) Agree to maintain and provide to the commissioner the
22 information required in section 23.

23 (2) A clinical peer reviewer assigned by an independent
24 review organization to conduct external reviews shall be a physi-
25 cian or other appropriate health care professional who meets all
26 of the following minimum qualifications:

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

3 (b) Is knowledgeable about the recommended health care serv-
4 ice or treatment because he or she devoted in the immediately
5 preceding year a majority of his or her time in an active clini-
6 cal practice within the medical specialty most relevant to the
7 subject of the review.

8 (c) Holds a nonrestricted license in a state of the United
9 States and, for physicians, a current certification by a recog-
10 nized American medical specialty board in the area or areas
11 appropriate to the subject of the external review.

12 (d) Has no history of disciplinary actions or sanctions,
13 including loss of staff privileges or participation restrictions,
14 that have been taken or are pending by any hospital, governmental
15 agency or unit, or regulatory body that raise a substantial ques-
16 tion as to the clinical peer reviewer's physical, mental, or pro-
17 fessional competence or moral character.

18 (3) An independent review organization may not own or con-
19 trol, be a subsidiary of or in any way be owned or controlled by,
20 or exercise control with a health benefit plan, a national,
21 state, or local trade association of health benefit plans, or a
22 national, state, or local trade association of health care
23 providers.

24 (4) An independent review organization selected to conduct
25 the external review and any clinical peer reviewer assigned by
26 the independent organization to conduct the external review shall

1 not have a material professional, familial, or financial conflict
2 of interest with any of the following:

3 (a) The health carrier that is the subject of the external
4 review.

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

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

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

14 (e) The facility at which the recommended health care serv-
15 ice or treatment would be provided.

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

20 (5) In determining whether an independent review organiza-
21 tion or a clinical peer reviewer of the independent review organ-
22 ization has a material professional, familial, or financial con-
23 flict of interest for purposes of subsection (4), the commis-
24 sioner shall take into consideration situations where the inde-
25 pendent review organization to be assigned to conduct an external
26 review of a specified case or a clinical peer reviewer to be
27 assigned by the independent review organization to conduct an

1 external review of a specified case may have an apparent
2 professional, familial, or financial relationship or connection
3 with a person described in subsection (4), but that the charac-
4 teristics of that relationship or connection are such that they
5 are not a material professional, familial, or financial conflict
6 of interest that results in the disapproval of the independent
7 review organization or the clinical peer reviewer from conducting
8 the external review.

9 Sec. 21. An independent review organization or clinical
10 peer reviewer working on behalf of an independent review organi-
11 zation is not liable in damages to any person for any opinions
12 rendered during or upon completion of an external review con-
13 ducted under this act, unless the opinion was rendered in bad
14 faith or involved gross negligence.

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 car-
18 rier on all requests for external review for which it conducted
19 an external review during a calendar year. Each independent
20 review organization required to maintain written records on all
21 requests for external review for which it was assigned to conduct
22 an external review shall submit to the commissioner, at least
23 annually, a report in the format specified by the commissioner.

24 (2) The report to the commissioner under subsection (1)
25 shall include in the aggregate and for each health carrier all of
26 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
9 an external review was sought, as provided in the format required
10 by the commissioner.

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

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

18 (3) Each 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 under this act. Each
23 health carrier required to maintain written records on all
24 requests for external review shall submit to the commissioner, at
25 least annually, a report in the format specified by the
26 commissioner.

1 (4) The report to the commissioner under subsection (3)
2 shall include in the aggregate and by type of health benefit plan
3 all of the following:

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

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

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

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

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

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

22 (g) Any other information the commissioner may request or
23 require.

24 Sec. 25. (1) Each health carrier shall include a descrip-
25 tion of the internal grievance and external review procedures in
26 or attached to the policy, certificate, membership booklet,

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1 outline of coverage, or other evidence of coverage it provides to
2 covered persons.

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

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

8 (b) The commissioner's toll-free telephone number and
9 address.

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

15 Sec. 27. The commissioner may promulgate rules pursuant to
16 the administrative procedures act of 1969, 1969 PA 306,
17 MCL 24.201 to 24.328, necessary to carry out the provisions of
18 this act.

19 Sec. 29. (1) If the commissioner finds that a violation of
20 this act has occurred, the commissioner shall reduce the findings
21 and decision to writing and shall issue and cause to be served
22 upon the person charged with the violation a copy of the findings
23 and an order requiring the person to cease and desist from the
24 violation. In addition, the commissioner may order any of the
25 following:

26 (a) Payment of a civil fine of not more than \$1,000.00 for
27 each violation. However, if the person knew or reasonably should

1 have known that he or she was in violation of this act, the
2 commissioner may order the payment of a civil fine of not more
3 than \$5,000.00 for each violation.

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8 (b) The suspension, limitation, or revocation of the
9 person's license or certificate of authority.

(2) If the commissioner finds that a health carrier has
deliberately refused to pay for a covered benefit, the commissioner
may order any of the following:

(a) For a first offense, payment of a civil fine of not more
than \$25,000.00 and recovery of the cost of the investigation.

(b) For a second offense, payment of a civil fine of not more
than \$50,000.00 and recovery of the cost of the investigation.

(c) For a third or subsequent offense or if the commissioner
determines that the health carrier has deliberately engaged in a
pattern of refusing to pay for a covered benefit, both of the
following:

(i) The greater of the following:

(A) Payment of a civil fine of not more than \$280,000.00.

(B) Payment of a civil fine which shall be the amount of the
health carrier's total liability for the covered benefits denied.

(ii) Recovery of the cost of the investigation.

(3) A fine collected under this section shall be placed in
the cancer clinical trials fund created in subsection (7).

10 (3) A person who violates any provision of this act shall be
11 afforded an opportunity for a hearing before the commissioner
12 pursuant to the administrative procedures act of 1969, 1969 PA
13 306, MCL 24.201 to 24.328. After notice and opportunity for
14 hearing, the commissioner may by order reopen and alter, modify,
15 or set aside, in whole or in part, an order issued under this
16 section if, in the commissioner's opinion, conditions of fact or
17 law have changed to require that action or the public interest
18 requires that action.

19 (4) If a person knowingly violates a cease and desist order
20 under this section and has been given notice and an opportunity
21 for a hearing held pursuant to the administrative procedures act
22 of 1969, 1969 PA 306, MCL 24.201 to 24.328, the commissioner may
23 order a civil fine of \$10,000.00 for each violation, or a suspen-
24 sion, limitation, or revocation of a person's license, or both.

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1 (5) The commissioner may apply to the Ingham county circuit
2 court for an order of the court enjoining a violation of this
3 act.

(6) The cancer clinical trials fund is created as a separate fund in the state treasury. The money in the fund shall be used as provided in this subsection. The state treasurer shall credit to the cancer clinical trials fund all fines collected under this section. The state treasurer may invest money in the fund in any manner authorized by law for the investment of state money, and earnings shall be credited to the fund. Money may be appropriated from the fund to hospitals, outpatient oncology centers, and other facilities located in this state involved in national institutes of health phase III or IV cancer clinical trials that apply for fund money to partially defray costs of patient participation in cancer clinical trials not covered by pharmaceutical manufacturers or health carriers. Money may be appropriated from the fund in amounts that shall not exceed \$5,000.00 per facility per year. Money in the cancer clinical trials fund at the close of the fiscal year shall remain in the fund and shall not lapse to the general fund.

4 Enacting section 1. This act takes effect October 1, 2000.