

**HOUSE SUBSTITUTE FOR
SENATE BILL NO. 1208**

A bill to amend 2000 PA 251, entitled
"Patient's right to independent review act,"
by amending sections 11, 13, 15, and 23 (MCL 550.1911, 550.1913,
550.1915, and 550.1923).

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 11. (1) Not later than 60 days after the date of
2 receipt of a notice of an adverse determination or final adverse
3 determination under section 7, a covered person or the covered
4 person's authorized representative may file a request for an
5 external review with the commissioner. Upon receipt of a request
6 for an external review, the commissioner immediately shall notify
7 and send a copy of the request to the health carrier that made
8 the adverse determination or final adverse determination that is
9 the subject of the request.

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

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

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

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

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

22 (E) WHETHER THE HEALTH CARE SERVICE THAT IS THE SUBJECT OF
23 THE ADVERSE DETERMINATION OR FINAL ADVERSE DETERMINATION APPEARS
24 TO INVOLVE ISSUES OF MEDICAL NECESSITY OR CLINICAL REVIEW
25 CRITERIA.

26 (3) Upon completion of the preliminary review under
27 subsection (2), the commissioner immediately shall provide a

1 written notice in plain English to the covered person and, if
2 applicable, the covered person's authorized representative as to
3 whether the request is complete and whether it has been accepted
4 for external review.

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

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

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

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

25 (6) ~~At the time~~ IF a request is accepted for external
26 review AND APPEARS TO INVOLVE ISSUES OF MEDICAL NECESSITY OR
27 CLINICAL REVIEW CRITERIA, the commissioner shall assign an

1 independent review organization ~~that has been~~ AT THE TIME THE
2 REQUEST IS ACCEPTED FOR EXTERNAL REVIEW. THE ASSIGNED INDEPEN-
3 DENT REVIEW ORGANIZATION SHALL BE approved under this act to con-
4 duct ~~the~~ external ~~review~~ REVIEWS and ~~to~~ SHALL provide a
5 written recommendation to the commissioner on whether to uphold
6 or reverse the adverse determination or the final adverse
7 determination.

8 (7) IF A REQUEST IS ACCEPTED FOR EXTERNAL REVIEW, DOES NOT
9 APPEAR TO INVOLVE ISSUES OF MEDICAL NECESSITY OR CLINICAL REVIEW
10 CRITERIA, AND APPEARS TO ONLY INVOLVE PURELY CONTRACTUAL PROVI-
11 SIONS OF A HEALTH BENEFIT PLAN, SUCH AS COVERED BENEFITS OR ACCU-
12 RACY OF CODING, THE COMMISSIONER MAY KEEP THE REQUEST AND CONDUCT
13 HIS OR HER OWN EXTERNAL REVIEW OR MAY ASSIGN AN INDEPENDENT
14 REVIEW ORGANIZATION AS PROVIDED IN SUBSECTION (6) AT THE TIME THE
15 REQUEST IS ACCEPTED FOR EXTERNAL REVIEW. EXCEPT AS OTHERWISE
16 PROVIDED IN SUBSECTION (16), IF THE COMMISSIONER KEEPS A REQUEST,
17 HE OR SHE SHALL REVIEW THE REQUEST AND ISSUE A DECISION UPHOLDING
18 OR REVERSING THE ADVERSE DETERMINATION OR FINAL ADVERSE DETERMI-
19 NATION WITHIN THE SAME TIME LIMITS AND SUBJECT TO ALL OTHER
20 REQUIREMENTS OF THIS ACT FOR REQUESTS ASSIGNED TO AN INDEPENDENT
21 REVIEW ORGANIZATION. IF AT ANY TIME DURING THE COMMISSIONER'S
22 REVIEW OF A REQUEST IT IS DETERMINED THAT A REQUEST DOES APPEAR
23 TO INVOLVE ISSUES OF MEDICAL NECESSITY OR CLINICAL REVIEW CRI-
24 TERIA, THE COMMISSIONER SHALL IMMEDIATELY ASSIGN THE REQUEST TO
25 AN INDEPENDENT REVIEW ORGANIZATION APPROVED UNDER THIS ACT TO
26 CONDUCT EXTERNAL REVIEWS.

1 (8) ~~-(7)-~~ In reaching a recommendation, the ~~assigned~~
2 ~~independent review organization~~ REVIEWING ENTITY is not bound by
3 any decisions or conclusions reached during the health carrier's
4 utilization review process or the health carrier's internal
5 grievance process.

6 (9) ~~-(8)-~~ Not later than 7 business days after the date of
7 ~~receipt of~~ the notice under subsection (4)(b), the health car-
8 rier or its designee utilization review organization shall pro-
9 vide to the ~~assigned independent review organization~~ REVIEWING
10 ENTITY the documents and any information considered in making the
11 adverse determination or the final adverse determination. Except
12 as provided in subsection ~~-(9)-~~ (10), failure by the health car-
13 rier or its designee utilization review organization to provide
14 the documents and information within 7 business days shall not
15 delay the conduct of the external review.

16 (10) ~~-(9)-~~ Upon receipt of a notice from the assigned inde-
17 pendent review organization that the health carrier or its desig-
18 nee utilization review organization has failed to provide the
19 documents and information within 7 business days, the commis-
20 sioner may terminate the external review and make a decision to
21 reverse the adverse determination or final adverse determination
22 and shall immediately notify the assigned independent review
23 organization, the covered person, if applicable, the covered
24 person's authorized representative, and the health carrier of his
25 or her decision.

26 (11) ~~-(10)-~~ The ~~assigned independent review organization~~
27 REVIEWING ENTITY shall review all of the information and

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

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

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

3 (13) ~~—(12)—~~ In addition to the documents and information
4 provided under subsection ~~—(8)—~~ (9), the ~~assigned independent~~
5 ~~review organization~~ REVIEWING ENTITY, to the extent the informa-
6 tion or documents are available and the ~~independent review~~
7 ~~organization~~ REVIEWING ENTITY considers them appropriate, shall
8 consider the following in reaching a recommendation:

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

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

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

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

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

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

26 (14) ~~—(13)—~~ The assigned independent review organization
27 shall provide its recommendation to the commissioner not later

1 than 14 days after ~~acceptance~~ THE ASSIGNMENT by the
2 commissioner of the request for an external review. The indepen-
3 dent review organization shall include in its recommendation all
4 of the following:

5 (a) A general description of the reason for the request for
6 external review.

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

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

11 (d) The date of its recommendation.

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

13 (f) The rationale for its recommendation.

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

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

22 (16) ~~-(15)-~~ The commissioner shall provide written notice in
23 plain English to the covered person, if applicable ~~—~~ the cov-
24 ered person's authorized representative, and the health carrier
25 of the decision to uphold or reverse the adverse determination or
26 the final adverse determination not later than 7 business days
27 after the date of receipt of the selected independent review

1 organization's recommendation. IF THE COMMISSIONER HAS KEPT A
2 REQUEST FOR REVIEW, THE COMMISSIONER SHALL PROVIDE WRITTEN NOTICE
3 IN PLAIN ENGLISH TO THE COVERED PERSON, IF APPLICABLE THE COVERED
4 PERSON'S AUTHORIZED REPRESENTATIVE, AND THE HEALTH CARRIER OF HIS
5 OR HER DECISION NOT LATER THAN 14 DAYS AFTER THE DECISION TO KEEP
6 THE REQUEST. The commissioner shall include in ~~this~~ A notice
7 UNDER THIS SUBSECTION all of the following:

8 (a) The principal reason or reasons for the decision,
9 including, as an attachment to the notice or in any other manner
10 the commissioner considers appropriate, the information provided
11 AS DETERMINED by the ~~selected independent review organization~~
12 REVIEWING ENTITY under subsection ~~(13)~~ (14).

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

16 (17) ~~(16)~~ Upon receipt of a notice of a decision under
17 subsection ~~(15)~~ (16) reversing the adverse determination or
18 final adverse determination, the health carrier immediately shall
19 approve the coverage that was the subject of the adverse determi-
20 nation or final adverse determination.

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

26 (a) The adverse determination involves a medical condition
27 of the covered person for which the time frame for completion of

1 an expedited internal grievance would seriously jeopardize the
2 life or health of the covered person or would jeopardize the cov-
3 ered person's ability to regain maximum function as substantiated
4 by a physician either orally or in writing.

5 (b) The covered person or the covered person's authorized
6 representative has filed a request for an expedited internal
7 grievance.

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

19 (3) If a covered person has not completed the health
20 carrier's expedited internal grievance process, the independent
21 review organization shall determine immediately after receipt of
22 the assignment to conduct the expedited external review whether
23 the covered person will be required to complete the expedited
24 internal grievance prior to conducting the expedited external
25 review. If the independent review organization determines that
26 the covered person must first complete the expedited internal
27 grievance process, the independent review organization

1 immediately shall notify the covered person and, if applicable,
2 the covered person's authorized representative of this determina-
3 tion and that it will not proceed with the expedited external
4 review until the covered person completes the expedited internal
5 grievance.

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

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

18 (6) In addition to the documents and information provided or
19 transmitted under subsection (5), the assigned independent review
20 organization, to the extent the information or documents are
21 available and the independent review organization considers them
22 appropriate, shall consider the following in reaching a
23 recommendation:

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

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

1 (c) Consulting reports from appropriate health care
2 professionals and other documents submitted by the health
3 carrier, covered person, the covered person's authorized repre-
4 sentative, or the covered person's treating provider.

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

7 (e) The most appropriate practice guidelines, which may
8 include generally accepted practice guidelines, evidence-based
9 practice guidelines, or any other practice guidelines developed
10 by the federal government or national or professional medical
11 societies, boards, and associations.

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

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

20 (8) Upon receipt of the assigned independent review
21 organization's recommendation, the commissioner immediately shall
22 review the recommendation to ensure that it is not contrary to
23 the terms of coverage under the covered person's health benefit
24 plan with the health carrier.

25 (9) As expeditiously as the covered person's medical condi-
26 tion or circumstances require, but in no event more than 24 hours
27 after receiving the recommendation of the assigned independent

SB1208, As Passed House, December 14, 2000

Senate Bill No. 1208

13

1 review organization, the commissioner shall complete the review
2 of the independent review organization's recommendation and
3 notify the covered person, if applicable, the covered person's
4 authorized representative, and the health carrier of the decision
5 to uphold or reverse the adverse determination or final adverse
6 determination. If this notice was not in writing, within 2 days
7 after the date of providing that notice, the commissioner shall
8 provide written confirmation of the decision to the covered
9 person, if applicable, the covered person's authorized represen-
10 tative, and the health carrier and include the information
11 required in section ~~11(15)~~ 11(16).

12 (10) Upon receipt of a notice of a decision under subsection
13 (9) reversing the adverse determination or final adverse determi-
14 nation, the health carrier immediately shall approve the coverage
15 that was the subject of the adverse determination or final
16 adverse determination.

17 (11) An expedited external review shall not be provided for
18 retrospective adverse determinations or retrospective final
19 adverse determinations.

20 Sec. 15. (1) An external review decision and an expedited
21 external review decision are the final administrative remedies
22 available under this act. A PERSON AGGRIEVED BY AN EXTERNAL
23 REVIEW DECISION OR AN EXPEDITED EXTERNAL REVIEW DECISION MAY SEEK
24 JUDICIAL REVIEW NO LATER THAN 60 DAYS FROM THE DATE OF THE DECI-
25 SION IN THE CIRCUIT COURT FOR THE COUNTY WHERE THE COVERED PERSON
26 RESIDES OR IN THE CIRCUIT COURT OF INGHAM COUNTY.

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

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

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

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

20 (2) The report to the commissioner under subsection (1)
21 shall include in the aggregate and for each health carrier all of
22 the following:

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

24 (b) The number of requests for external review resolved and,
25 of those resolved, the number resolved upholding the adverse
26 determination or final adverse determination and the number

1 resolved reversing the adverse determination or final adverse
2 determination.

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

4 (d) A summary of the types of coverages or cases for which
5 an external review was sought, as provided in the format required
6 by the commissioner.

7 (e) The number of external reviews under section ~~11(11)~~
8 11(12) that were terminated as the result of a reconsideration by
9 the health carrier of its adverse determination or final adverse
10 determination after the receipt of additional information from
11 the covered person or the covered person's authorized
12 representative.

13 (f) Any other information the commissioner may request or
14 require.

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

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

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

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

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

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

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

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

20 (g) Any other information the commissioner may request or
21 require.