SUBSTITUTE FOR

HOUSE BILL NO. 6494

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), as amended by 2000 PA 398.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

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

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

(a) Whether the individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided.

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

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

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

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

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

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

(4) If a request is accepted for external review, the commissioner shall do both of the following:

(a) Include in the written notice under subsection (3) a statement that the covered person or the covered person's authorized representative may submit to the commissioner in writing within 7 business days following the date of the notice additional information and supporting documentation that the reviewing entity shall consider when conducting the external review.

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

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

(6) If a request is accepted for external review and appears to involve issues of medical necessity or clinical review criteria, the commissioner shall assign an independent review organization at the time the request is accepted for external

review. The assigned independent review organization shall be approved under this act to conduct external reviews and shall provide a written recommendation to the commissioner on whether to uphold or reverse the adverse determination or the final adverse determination.

(7) If a request ~~is~~ accepted for external review ~~,~~ does not appear to involve issues of medical necessity or clinical review criteria ~~,~~ and appears to only involve purely contractual provisions of a health benefit plan, such as covered benefits or accuracy of coding, the commissioner may keep the request and conduct his or her own external review or may assign an independent review organization as provided in subsection (6) at the time the request is accepted for external review. Except as otherwise provided in subsection (16), if the commissioner 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 review of a request it is determined that a request does appear to involve issues of medical necessity or clinical review criteria, the commissioner shall immediately assign the request to an independent review organization approved under this act to conduct external reviews.

(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.

(9) Not later than 7 business days after the date of the notice under subsection (4)(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), 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.

(10) Upon receipt of a notice from the assigned independent review organization that the health carrier or its designee utilization review organization has failed to provide the documents and information within 7 business days, the commissioner may terminate the external review and make a decision to reverse the adverse determination or final adverse determination and shall immediately notify the assigned independent review organization, the covered person, if applicable, the covered person's authorized representative, and the health carrier of his or her decision.

(11) The reviewing entity shall review all of the information and documents received under subsection (9) and any other information submitted in writing by the covered person or the covered person's authorized representative under subsection (4)(a) that has been forwarded by the commissioner. Upon receipt of any information submitted by the covered person or the covered

person's authorized representative under subsection (4)(a), at the same time the commissioner forwards the information to the independent review organization, the commissioner shall forward the information to the health carrier.

(12) The health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review. Reconsideration by the health carrier of its adverse determination or final adverse determination does not delay or terminate the external review. The external review may ~~only~~ be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination, EITHER IN WHOLE OR IN PART, and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination. IF THE HEALTH CARRIER MAKES A PARTIAL REVERSAL OF ITS ADVERSE DETERMINATION OR FINAL ADVERSE DETERMINATION AND THE COVERED PERSON ACCEPTS THE HEALTH CARRIER'S DECISION, THE COVERED PERSON MAY WITHDRAW HIS OR HER REQUEST FOR AN EXTERNAL REVIEW. Immediately upon making the decision to reverse its adverse determination or final adverse determination, the health carrier shall notify the covered person, if applicable the covered person's authorized representative, if applicable the assigned independent review organization, and the commissioner in writing of its decision. The reviewing entity shall terminate the external review upon receipt of the notice from the health carrier.

(13) In addition to the documents and information provided under subsection (9), the reviewing entity, to the extent the

information or documents are available and the reviewing entity considers them appropriate, shall consider the following in reaching a recommendation:

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

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

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

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

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

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

(14) The assigned independent review organization shall provide its recommendation to the commissioner not later than ~~14~~ 10 BUSINESS days after the assignment by the commissioner of the request for an external review OR 5 BUSINESS DAYS AFTER RECEIPT OF COMPLETE INFORMATION UNDER SUBSECTION (4)(A) OR (9), WHICHEVER IS LATER. The independent review organization shall include in its recommendation all of the following:

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

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

(c) The date the external review was conducted.

(d) The date of its recommendation.

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

(f) The rationale for its recommendation.

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

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

(16) The commissioner shall provide written notice in plain English to the covered person, if applicable the covered person's authorized representative, and the health carrier of the decision to uphold or reverse the adverse determination or the final adverse determination not later than 7 business days after the date of receipt of the selected independent review organization's recommendation. If the commissioner has kept a request for review, the commissioner shall provide written notice in plain English to the covered person, if applicable the covered person's authorized representative, and the health carrier of his or her

decision not later than ~~14~~ 10 BUSINESS days after the decision to keep the request. The commissioner shall include in a notice under this subsection all of the following:

(a) The principal reason or reasons for the decision, including, as an attachment to the notice or in any other manner the commissioner considers appropriate, the information provided as determined by the reviewing entity under subsection (14).

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

(17) Upon receipt of a notice of a decision under subsection (16) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

(18) IF THE COMMISSIONER DETERMINES THAT ADDITIONAL INFORMATION OR MEDICAL RECORDS NOT IN THE POSSESSION OF THE HEALTH CARRIER OR COVERED PERSON ARE NEEDED TO COMPLETE A REVIEW KEPT BY THE COMMISSIONER UNDER SUBSECTION (7) OR THAT ADDITIONAL INFORMATION OR MEDICAL RECORDS NOT IN THE POSSESSION OF THE HEALTH CARRIER OR COVERED PERSON OR THAT ADDITIONAL REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION IS NEEDED, THE COMMISSIONER MAY ISSUE AN ORDER TO PRODUCE THE ADDITIONAL INFORMATION OR MEDICAL RECORDS OR MAY ISSUE AN ORDER FOR ADDITIONAL INDEPENDENT REVIEW RECOMMENDATIONS. THE ORDER SHALL CONTAIN SPECIFIC TIME FRAMES IN WHICH THE INFORMATION OR RECORDS SHALL BE PROVIDED. THE COMMISSIONER MAY ALSO ISSUE ANY ORDER NECESSARY TO ADMINISTER A

REVIEW. TIME REQUIREMENTS UNDER SUBSECTION (16) SHALL BE TOLLED UNTIL THE COMMISSIONER RECEIVES THE ADDITIONAL INFORMATION OR MEDICAL RECORDS, ADDITIONAL INDEPENDENT REVIEW RECOMMENDATIONS, OR CONFIRMATION OF COMPLIANCE WITH HIS OR HER ORDER. THE COMMISSIONER MAY PROCEED UNDER SUBSECTION (9) IF THE TIME PERIODS IN THE ORDER ARE NOT COMPLIED WITH.

(19) AS USED IN THIS SECTION, "BUSINESS DAY" MEANS ANY DAY ON WHICH THE OFFICE OF FINANCIAL AND INSURANCE SERVICES IS OPEN AND EXCLUDES SATURDAYS, SUNDAYS, LEGAL HOLIDAYS, AND ANY OTHER DAY ON WHICH THE OFFICE OF FINANCIAL AND INSURANCE SERVICES IS CLOSED. FOR THE PURPOSE OF COMPUTING TIME, THE DAY OF THE ACT OR EVENT AFTER WHICH THE DESIGNATED PERIOD OF TIME BEGINS TO RUN IS NOT INCLUDED. THE LAST DAY OF THE PERIOD IS INCLUDED, UNLESS IT IS A SATURDAY, SUNDAY, LEGAL HOLIDAY, OR OTHER DAY ON WHICH THE OFFICE OF FINANCIAL AND INSURANCE SERVICES IS NOT OPEN, IN WHICH CASE THE PERIOD RUNS UNTIL THE END OF THE NEXT DAY THAT IS NOT A SATURDAY, SUNDAY, LEGAL HOLIDAY, OR OTHER DAY ON WHICH THE OFFICE OF FINANCIAL AND INSURANCE SERVICES IS CLOSED.

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

(a) The adverse determination involves a medical condition of the covered person for which the time frame for completion of an expedited internal grievance would seriously jeopardize the life or health of the covered person or would jeopardize the

covered person's ability to regain maximum function as substantiated by a physician either orally or in writing.

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

(2) ~~At~~ NOT LATER THAN 2 HOURS AFTER the time the commissioner receives a request for an expedited external review, the commissioner ~~immediately shall notify and provide a copy of the request to the health carrier that made the adverse determination or final adverse determination~~ SHALL DETERMINE WHETHER THE REQUEST MEETS THE REQUIREMENTS OF SUBSECTION (1) AND THE REVIEWABILITY REQUIREMENTS OF SECTION 11(2). If the commissioner determines the request meets the REQUIREMENTS OF SUBSECTION (1) AND THE reviewability requirements under section 11(2), the commissioner IMMEDIATELY shall ~~assign~~ DO BOTH OF THE FOLLOWING:

(A) NOTIFY AND PROVIDE A COPY OF THE REQUEST TO THE HEALTH CARRIER THAT MADE THE ADVERSE DETERMINATION OR FINAL ADVERSE DETERMINATION.

(B) ASSIGN an independent review organization that has been approved under this act to conduct the expedited external review and to provide a written recommendation to the commissioner on whether to uphold or reverse the adverse determination or final adverse determination.

(3) If a covered person has not completed the health carrier's expedited internal grievance process, the independent review organization shall determine immediately after receipt of the assignment to conduct the expedited external review whether

the covered person will be required to complete the expedited internal grievance prior to conducting the expedited external review. If the independent review organization determines that the covered person must first complete the expedited internal grievance process, the independent review organization immediately shall notify the covered person and, if applicable, the covered person's authorized representative of this determination and that it will not proceed with the expedited external review until the covered person completes the expedited internal grievance.

(4) In reaching a recommendation, the assigned independent review organization 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.

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

(6) In addition to the documents and information provided or transmitted under subsection (5), the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them

appropriate, shall consider the following in reaching a recommendation:

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

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

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

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

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

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

(7) The assigned independent review organization shall provide its recommendation to the commissioner as expeditiously as the covered person's medical condition or circumstances require, but in no event more than 36 hours after ~~the date~~ the commissioner ~~received~~ TRANSMITS TO THE INDEPENDENT REVIEW ORGANIZATION NOTICE OF ASSIGNMENT OF the request for an expedited external review.

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

(9) As expeditiously as the covered person's medical condition or circumstances require, but in no event more than 24 hours after receiving the recommendation of the assigned independent review organization, the commissioner shall complete the review of the independent review organization's recommendation and notify the covered person, if applicable, the covered person's authorized representative, and the health carrier of the decision to uphold or reverse the adverse determination or final adverse determination. If this notice was not in writing, within 2 days after the date of providing that notice, the commissioner shall provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, and the health carrier and include the information required in section 11(16).

(10) Upon receipt of a notice of a decision under subsection (9) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

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

Sec. 15. (1) An external review decision and an expedited external review decision are the final administrative remedies available under this act. A person aggrieved by an external review decision or an expedited external review decision may seek judicial review no later than 60 days from the date of the decision in the circuit court for the county where the covered person resides or in the circuit court of Ingham county AND SHALL SERVE UPON THE COMMISSIONER A COPY OF THE PETITION FOR REVIEW. THE COMMISSIONER MAY BECOME A PARTY TO ANY JUDICIAL REVIEW OF AN EXTERNAL REVIEW DECISION BY FILING AN APPEARANCE IN THE CASE. THE HEALTH CARRIER IN ANY JUDICIAL REVIEW NOT INVOLVING THE COMMISSIONER SHALL SERVE UPON THE COMMISSIONER A COPY OF THE CIRCUIT COURT FINAL ORDER IN THE REVIEW.

(2) ~~Subsection (1)~~ THE AVAILABILITY OF REVIEW UNDER THIS ACT does not preclude a health carrier from seeking other remedies available under applicable state law.

(3) ~~Subsection (1)~~ THE AVAILABILITY OF REVIEW UNDER THIS ACT does not preclude a covered person from seeking other remedies available under applicable federal or state law.

(4) A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision under this act.

Sec. 23. (1) An independent review organization assigned to conduct an external review under section 11 or 13 shall maintain for 3 years written records in the aggregate and by health

carrier on all requests for external review for which it conducted an external review during a calendar year. Each independent review organization required to maintain written records on all requests for external review for which it was assigned to conduct an external review shall submit to the commissioner, at least annually, a report in the format specified by the commissioner.

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

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

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

(c) The average length of time for resolution.

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

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

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

(3) Each health carrier shall maintain for 3 years written records in the aggregate and for each type of health benefit plan offered by the health carrier on all requests for external review ~~that are filed with the health carrier or~~ that the health carrier receives notice of from the commissioner under this act AND SHALL PRODUCE THESE RECORDS UPON THE COMMISSIONER'S REQUEST. ~~Each health carrier required to maintain written records on all requests for external review shall submit to the commissioner, at least annually, a report in the format specified by the commissioner.~~

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

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

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

~~(c) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination.~~

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

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

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

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