

**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:

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.

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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

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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 the notice addi-
11 tional information and supporting documentation that the review-
12 ing entity shall consider when conducting the external review.

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

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

24 (6) If a request is accepted for external review and appears
25 to involve issues of medical necessity or clinical review cri-
26 teria, the commissioner shall assign an independent review
27 organization at the time the request is accepted for external

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

6 (7) If a request ~~is~~ accepted for external review ~~,~~ does
7 not appear to involve issues of medical necessity or clinical
8 review criteria ~~,~~ and appears to only involve purely contrac-
9 tual provisions of a health benefit plan, such as covered bene-
10 fits or accuracy of coding, the commissioner may keep the request
11 and conduct his or her own external review or may assign an inde-
12 pendent review organization as provided in subsection (6) at the
13 time the request is accepted for external review. Except as oth-
14 erwise provided in subsection (16), if the commissioner keeps a
15 request, he or she shall review the request and issue a decision
16 upholding or reversing the adverse determination or final adverse
17 determination within the same time limits and subject to all
18 other requirements of this act for requests assigned to an inde-
19 pendent review organization. If at any time during the
20 commissioner's review of a request it is determined that a
21 request does appear to involve issues of medical necessity or
22 clinical review criteria, the commissioner shall immediately
23 assign the request to an independent review organization approved
24 under this act to conduct external reviews.

25 (8) In reaching a recommendation, the reviewing entity is
26 not bound by any decisions or conclusions reached during the

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

3 (9) Not later than 7 business days after the date of the
4 notice under subsection (4)(b), the health carrier or its desig-
5 nee utilization review organization shall provide to the review-
6 ing entity the documents and any information considered in making
7 the adverse determination or the final adverse determination.
8 Except as provided in subsection (10), failure by the health car-
9 rier or its designee utilization review organization to provide
10 the documents and information within 7 business days shall not
11 delay the conduct of the external review.

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

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

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

5 (12) The health carrier may reconsider its adverse determi-
6 nation or final adverse determination that is the subject of the
7 external review. Reconsideration by the health carrier of its
8 adverse determination or final adverse determination does not
9 delay or terminate the external review. The external review may
10 ~~only~~ be terminated if the health carrier decides, upon comple-
11 tion of its reconsideration, to reverse its adverse determination
12 or final adverse determination, EITHER IN WHOLE OR IN PART, and
13 provide coverage or payment for the health care service that is
14 the subject of the adverse determination or final adverse
15 determination. IF THE HEALTH CARRIER MAKES A PARTIAL REVERSAL OF
16 ITS ADVERSE DETERMINATION OR FINAL ADVERSE DETERMINATION AND THE
17 COVERED PERSON ACCEPTS THE HEALTH CARRIER'S DECISION, THE COVERED
18 PERSON MAY WITHDRAW HIS OR HER REQUEST FOR AN EXTERNAL REVIEW.
19 Immediately upon making the decision to reverse its adverse
20 determination or final adverse determination, the health carrier
21 shall notify the covered person, if applicable the covered
22 person's authorized representative, if applicable the assigned
23 independent review organization, and the commissioner in writing
24 of its decision. The reviewing entity shall terminate the exter-
25 nal review upon receipt of the notice from the health carrier.

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

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

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

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

7 (c) Consulting reports from appropriate health care profes-
8 sionals and other documents submitted by the health carrier, the
9 covered person, the covered person's authorized representative,
10 or the covered person's treating provider.

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

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

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

21 (14) The assigned independent review organization shall pro-
22 vide its recommendation to the commissioner not later than ~~14~~
23 10 BUSINESS days after the assignment by the commissioner of the
24 request for an external review OR 5 BUSINESS DAYS AFTER RECEIPT
25 OF COMPLETE INFORMATION UNDER SUBSECTION (4)(A) OR (9), WHICHEVER
26 IS LATER. The independent review organization shall include in
27 its recommendation all of the following:

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

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

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

7 (d) The date of its recommendation.

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

9 (f) The rationale for its recommendation.

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

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

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

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

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

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

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

16 (18) IF THE COMMISSIONER DETERMINES THAT ADDITIONAL INFORMA-
17 TION OR MEDICAL RECORDS NOT IN THE POSSESSION OF THE HEALTH CAR-
18 RIER OR COVERED PERSON ARE NEEDED TO COMPLETE A REVIEW KEPT BY
19 THE COMMISSIONER UNDER SUBSECTION (7) OR THAT ADDITIONAL INFORMA-
20 TION OR MEDICAL RECORDS NOT IN THE POSSESSION OF THE HEALTH CAR-
21 RIER OR COVERED PERSON OR THAT ADDITIONAL REVIEW BY AN INDEPEN-
22 DENT REVIEW ORGANIZATION IS NEEDED, THE COMMISSIONER MAY ISSUE AN
23 ORDER TO PRODUCE THE ADDITIONAL INFORMATION OR MEDICAL RECORDS OR
24 MAY ISSUE AN ORDER FOR ADDITIONAL INDEPENDENT REVIEW
25 RECOMMENDATIONS. THE ORDER SHALL CONTAIN SPECIFIC TIME FRAMES IN
26 WHICH THE INFORMATION OR RECORDS SHALL BE PROVIDED. THE
27 COMMISSIONER MAY ALSO ISSUE ANY ORDER NECESSARY TO ADMINISTER A

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

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

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

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

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

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

6 (2) ~~At~~ NOT LATER THAN 2 HOURS AFTER the time the commis-
7 sioner receives a request for an expedited external review, the
8 commissioner ~~immediately shall notify and provide a copy of the~~
9 ~~request to the health carrier that made the adverse determination~~
10 ~~or final adverse determination~~ SHALL DETERMINE WHETHER THE
11 REQUEST MEETS THE REQUIREMENTS OF SUBSECTION (1) AND THE REVIEWA-
12 BILITY REQUIREMENTS OF SECTION 11(2). If the commissioner deter-
13 mines the request meets the REQUIREMENTS OF SUBSECTION (1) AND
14 THE reviewability requirements under section 11(2), the commis-
15 sioner IMMEDIATELY shall ~~assign~~ DO BOTH OF THE FOLLOWING:

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

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

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

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1 the covered person will be required to complete the expedited
2 internal grievance prior to conducting the expedited external
3 review. If the independent review organization determines that
4 the covered person must first complete the expedited internal
5 grievance process, the independent review organization immedi-
6 ately shall notify the covered person and, if applicable, the
7 covered person's authorized representative of this determination
8 and that it will not proceed with the expedited external review
9 until the covered person completes the expedited internal
10 grievance.

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

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

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

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1 appropriate, shall consider the following in reaching a
2 recommendation:

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

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

6 (c) Consulting reports from appropriate health care profes-
7 sionals and other documents submitted by the health carrier, cov-
8 ered person, the covered person's authorized representative, or
9 the covered person's treating provider.

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

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

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

20 (7) The assigned independent review organization shall pro-
21 vide its recommendation to the commissioner as expeditiously as
22 the covered person's medical condition or circumstances require,
23 but in no event more than 36 hours after ~~the date~~ the commis-
24 sioner ~~received~~ TRANSMITS TO THE INDEPENDENT REVIEW ORGANIZA-
25 TION NOTICE OF ASSIGNMENT OF the request for an expedited exter-
26 nal review.

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

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

20 (10) Upon receipt of a notice of a decision under subsection
21 (9) reversing the adverse determination or final adverse determi-
22 nation, the health carrier immediately shall approve the coverage
23 that was the subject of the adverse determination or final
24 adverse determination.

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

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

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

17 (3) ~~Subsection (1)~~ THE AVAILABILITY OF REVIEW UNDER THIS
18 ACT does not preclude a covered person from seeking other reme-
19 dies available under applicable federal or 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. 23. (1) An independent review organization assigned to
26 conduct an external review under section 11 or 13 shall maintain
27 for 3 years written records in the aggregate and by health

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1 carrier on all requests for external review for which it
2 conducted an external review during a calendar year. Each inde-
3 pendent review organization required to maintain written records
4 on all requests for external review for which it was assigned to
5 conduct an external review shall submit to the commissioner, at
6 least annually, a report in the format specified by the
7 commissioner.

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

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

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

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

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

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

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

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(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.~~

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

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