PATIENT'S RIGHT TO INDEPENDENT REVIEW ACT (EXCERPT)
Act 251 of 2000

550.1911 Request for external review; commencement; preliminary review; notice of acceptance; duties of director; incomplete request; nonacceptance; assignment of independent review organization; duty of health carrier to provide documents; reconsideration by health carrier of its adverse determination; recommendation; considerations; review by director; notice of decision.

Sec. 11. (1) Not later than 60 days or, after December 31, 2016, 120 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 director. Upon receipt of a request for an external review, the director 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 director 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, for 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) Whether the covered person has provided all the information and forms required by the director 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) If a request for an external review involves issues of experimental or investigational service or treatment, not later than 5 business days after the date of receipt of a request for an external review, the director 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, for a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided.

(b) Whether the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination is both of the following:

(*i*) A covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition.

(*ii*) Not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier.

(c) Whether the covered person's treating provider with the authority to treat under the public health code, 1978 PA 368, MCL 333.1101 to 333.25211, has certified that 1 or more of the following situations are applicable:

(*i*) Standard health care services or treatments have not been effective in improving the condition of the covered person.

(*ii*) Standard health care services or treatments are not medically appropriate for the covered person.

(*iii*) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment described in subdivision (d).

(d) Whether the covered person's treating provider with the authority to treat under the public health code, 1978 PA 368, MCL 333.1101 to 333.25211, has done either of the following:

(*i*) Recommended a health care service or treatment that the treating provider certifies, in writing, is likely to be more beneficial to the covered person, in the treating provider's opinion, than any available standard health care services or treatments.

(*ii*) If the treating provider is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be

more beneficial to the covered person than any available standard health care services or treatments.

(e) 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 under this act.

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

(4) Upon completion of a preliminary review under subsection (2) or (3), the director immediately shall provide a written notice 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.

(5) On accepting a request for external review, the director shall do both of the following:

(a) Include in the written notice under subsection (4) a statement that the covered person or the covered person's authorized representative may submit to the director in writing within 7 business days following the date of the notice additional information and supporting documentation that the reviewing entity will consider when conducting the external review.

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

(6) If a request is not accepted for external review because the request is not complete, the director 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. The covered person or, if applicable, the covered person's authorized representative shall provide the information or materials identified by the director within 30 days after receiving the notification. If a request is not accepted for external review, the director shall provide written notice to the covered person, if applicable, the covered person's authorized representative, and the health carrier of the reasons for its nonacceptance.

(7) If a request is accepted for external review and appears to involve issues of medical necessity or clinical review criteria, the director shall assign an independent review organization at the time the request is accepted for external review. The assigned independent review organization must be approved under this act to conduct external reviews. The assigned independent review organization shall provide a written recommendation to the director on whether to uphold or reverse the adverse determination or the final adverse determination.

(8) 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 director may keep the request and conduct his or her own external review or may assign an independent review organization as provided in subsection (7) at the time the request is accepted for external review. Except as otherwise provided in subsection (18), if the director keeps a request, he or she shall review the request and issue a decision upholding or reversing the adverse determination or final adverse determination within the same time limits and subject to all other requirements of this act for requests assigned to an independent review organization. If at any time during the director's review of a request it is determined that a request does appear to involve issues of medical necessity or clinical review criteria, the director shall immediately assign the request to an independent review organization approved under this act to conduct external reviews.

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

(10) Not later than 7 business days after the date of the notice under subsection (5)(b), the health carrier or its designee utilization review organization shall provide to the reviewing entity the documents and any information considered in making the adverse determination or the final adverse determination. Except as provided in subsection (11), the reviewing entity shall not delay the external review because of failure by the health carrier or its designee utilization review organization to provide the documents and information within 7 business days.

(11) 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 director 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.

(12) The reviewing entity shall review all of the information and documents received under subsection (10) and any other information submitted in writing by the covered person or the covered person's authorized representative under subsection (5)(a) that has been forwarded by the director. Upon receipt of any information submitted by the covered person or the covered person's authorized representative under subsection (5)(a), at the same time the director forwards the information to the independent review organization, the director shall forward the information to the health carrier.

(13) 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 and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination. 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 director in writing of its decision. The reviewing entity shall terminate the external review upon receipt of the notice from the health carrier.

(14) In addition to the documents and information provided under subsection (10), 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.

(15) If a request for an external review involves issues of experimental or investigational service or treatment, in addition to the documents and information provided under subsections (10) and (14), the reviewing entity, in reaching a recommendation, shall consider whether either of the following applies:

(a) The recommended or requested health care service or treatment has been approved by the United States Food and Drug Administration, if applicable, for the condition.

(b) Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment are more likely than not to be more beneficial to the covered person than the benefits of any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

(16) The assigned independent review organization shall provide its recommendation to the director within 14 days after the assignment by the director of the request for an external review. 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 director 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.

(17) Upon receipt of the assigned independent review organization's recommendation under subsection (16), the director 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.

(18) The director shall provide written notice 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 within 7 business days after the date of receipt of the selected independent review organization's recommendation. If the director has kept a request for review, the director shall provide written notice to the covered person, if applicable the covered person's authorized representative, and the health carrier of his or her decision within 14 days after the decision to keep the request. The director 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 director considers appropriate, the information provided as determined by the reviewing

entity under subsection (16).

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

(19) Upon receipt of a notice of a decision under subsection (18) 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.

History: 2000, Act 251, Eff. Oct. 1, 2000;—Am. 2000, Act 398, Imd. Eff. Jan. 8, 2001;—Am. 2016, Act 274, Eff. Sept. 29, 2016.