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

550.1913 Expedited external review.

Sec. 13. (1) Except as provided in subsection (12), a covered person or the covered person's authorized representative may make a request for an expedited external review with the director within 10 days after the covered person receives an adverse determination if both of the following apply:

(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) When the director receives a request for an expedited external review, the director immediately shall notify and provide a copy of the request to the health carrier that made the adverse determination or final adverse determination. If the director determines the request meets the reviewability requirements under section 11(2) or (3), the director shall 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 director 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 before 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, an 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 a health carrier receives a 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, 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) 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 (5) and (6), the assigned independent review organization, 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.

(8) An assigned independent review organization shall provide its recommendation to the director as expeditiously as the covered person's medical condition or circumstances require, but not more than 36 hours after the date the director received the request for an expedited external review.

(9) Upon receipt of an assigned independent review organization's recommendation, 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.

(10) As expeditiously as the covered person's medical condition or circumstances require, but not more than 24 hours after receiving the recommendation of the assigned independent review organization, the director 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 the notice under this subsection is not in writing, within 2 days after the date of providing the notice, the director 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(18).

(11) Upon receipt of a notice of a decision under subsection (10) 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.

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

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.