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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2019

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A N A C T

RELATING TO INSURANCE -- BENEFIT DETERMINATION AND UTILIZATION
REVIEW ACT

Introduced By: Representatives Ajello, Casimiro, Kazarian, Shekarchi, and Jacquard

Date Introduced: February 08, 2019

Referred To: House Health, Education & Welfare

It is enacted by the General Assembly as follows:

1 SECTION 1. Sections 27-18.9-7 and 27-18.9-8 of the General Laws in Chapter 27-18.9
2 entitled "Benefit Determination and Utilization Review Act" are hereby amended to read as
3 follows:

4 **27-18.9-7. Internal appeal procedural requirements.**

5 (a) Administrative and non-administrative appeals. The review agent shall conform to the
6 following for the internal appeal of administrative or non-administrative, adverse benefit
7 determinations:

8 (1) The review agent shall maintain and make available a written description of its appeal
9 procedures by which either the beneficiary or the provider of record may seek review of
10 determinations not to authorize health-care services.

11 (2) The process established by each review agent may include a reasonable period within
12 which an appeal must be filed to be considered and that period shall not be less than one hundred
13 eighty (180) calendar days after receipt of the adverse benefit determination notice.

14 (3) During the appeal, a review agent may utilize a reconsideration process in assessing
15 an adverse benefit determination. If utilized, the review agent shall develop a reasonable
16 reconsideration and appeal process, in accordance with this section. For non-administrative,
17 adverse benefit determinations, the period for the reconsideration may not exceed fifteen (15)
18 days from the date the request for reconsideration or appeal is received. The review agent shall

1 notify the beneficiary and/or provider of the reconsideration determination with the form and
2 content described in § 27-18.9-6(b), as appropriate. Following the decision on reconsideration,
3 the beneficiary and/or provider shall have a period of forty-five (45) calendar days during which
4 the beneficiary and/or provider may request an appeal of the reconsideration decision and/or
5 submit additional information.

6 (4) Prior to a final internal appeal decision, the review agent must allow the claimant to
7 review the entire adverse determination and appeal file and allow the claimant to present evidence
8 and/or additional testimony as part of the internal appeal process.

9 (5) A review agent is only entitled to request and review information or data relevant to
10 the benefit determination and utilization review processes.

11 (6) The review agent shall maintain records of written adverse benefit determinations,
12 reconsiderations, appeals and their resolution, and shall provide reports as requested by the office.

13 (7)(i) The review agent shall notify, in writing, the beneficiary and/or provider of record
14 of its decision on the administrative appeal in no case later than thirty (30) calendar days after
15 receipt of the request for the review of an adverse benefit determination for pre-service claims,
16 and sixty (60) days for post-service claims, commensurate with 29 C.F.R. § 2560.503-1(i)(2)(ii)
17 and (iii).

18 (ii) The review agent shall notify, in writing, the beneficiary and provider of record of its
19 decision on the non-administrative appeal as soon as practical considering medical circumstances,
20 but in no case later than thirty (30) calendar days after receipt of the request for the review of an
21 adverse benefit determination, inclusive of the period to conduct the reconsideration, if any. The
22 timeline for decision on appeal is paused from the date on which the determination on
23 reconsideration is sent to the beneficiary and/or provider and restarted when the beneficiary
24 and/or provider submits additional information and/or a request for appeal of the reconsideration
25 decision.

26 (8) The review agent shall also provide for an expedited appeal process for urgent and
27 emergent situations taking into consideration medical exigencies. Notwithstanding any other
28 provision of this chapter, each review agent shall complete the adjudication of expedited appeals,
29 including notification of the beneficiary and provider of record of its decision on the appeal, not
30 later than seventy-two (72) hours after receipt of the claimant's request for the appeal of an
31 adverse benefit determination.

32 (9) Benefits for an ongoing course of treatment cannot be reduced or terminated without
33 providing advance notice and an opportunity for advance review. The review agent or health-care
34 entity is required to continue coverage pending the outcome of an appeal.

1 (10) A review agent may not disclose or publish individual medical records or any
2 confidential information obtained in the performance of benefit determination or utilization
3 review activities. A review agent shall be considered a third-party health insurer for the purposes
4 of § 5-37.3-6(b)(6) and shall be required to maintain the security procedures mandated in § 5-
5 37.3-4(c).

6 (b) Non-administrative appeals. In addition to subsection (a) of this section the utilization
7 review agent shall conform to the following for its internal appeals adverse benefit
8 determinations:

9 (1) A claimant is deemed to have exhausted the internal claims appeal process when the
10 utilization review agent or health-care entity fails to strictly adhere to all benefit determination
11 and appeal processes with respect to a claim. In this case the claimant may initiate an external
12 appeal or remedies under section 502(a) of the Employee Retirement Income Security Act of
13 1974, 29 U.S.C. § 1001 et seq., or other state and federal law, as applicable.

14 (2) No reviewer under this section, who has been involved in prior reviews or in the
15 adverse benefit determination under appeal or who has participated in the direct care of the
16 beneficiary, may participate in reviewing the case under appeal.

17 (3) All internal-level appeals of utilization review determinations not to authorize a
18 health-care service that had been ordered by a physician, dentist, or other provider shall be made
19 according to the following:

20 (i) The reconsideration decision of a non-administrative, adverse benefit determination
21 shall not be made until the utilization review agent's professional provider with the same
22 licensure status as typically manages the condition, procedure, treatment, or requested service
23 under discussion, and which professional is a physician or dentist who is licensed, certified, or
24 otherwise formally recognized as a specialist in the field of health care services or problem being
25 reviewed, has spoken to, or otherwise provided for, an equivalent two-way, direct communication
26 with the beneficiary's attending physician, dentist, other professional provider, or other qualified
27 professional provider responsible for treatment of the beneficiary concerning the services under
28 review.

29 (ii) A review agent who does not utilize a reconsideration process must comply with the
30 peer-review obligation described in subsection (b)(3)(i) of this section as part of the appeal
31 process.

32 (iii) When the appeal of any adverse benefit determination, including an appeal of a
33 reconsideration decision, is based in whole or in part on medical judgment, including
34 determinations with regard to whether a particular service, treatment, drug, or other item is

1 experimental, investigational or not medically necessary or appropriate, the reviewer making the
2 appeal decision must be ~~appropriately trained having the same licensure status as the ordering~~
3 ~~provider or be~~ a physician or dentist and be in the same or similar specialty as typically manages
4 the condition, and be licensed, certified, or otherwise formally recognized as a specialist in the
5 field of health care services or problem being reviewed. These qualifications must be provided to
6 the claimant upon request.

7 (iv) The utilization review agency reviewer must document and sign their decisions.

8 (4) The review agent must ensure that an appropriately licensed practitioner or licensed
9 physician is reasonably available to review the case as required under this subsection (b) and shall
10 conform to the following:

11 (i) Each agency peer reviewer shall have access to and review all necessary information
12 as requested by the agency and/or submitted by the provider(s) and/or beneficiaries;

13 (ii) Each agency shall provide accurate peer review contact information to the provider at
14 the time of service, if requested, and/or prior to such service, if requested. This contact
15 information must provide a mechanism for direct communication with the agency's peer
16 reviewer; and

17 (iii) Agency peer reviewers shall respond to the provider's request for a two-way, direct
18 communication defined in this subsection (b) as follows:

19 (A) For a prospective review of non-urgent and non-emergent health-care services, a
20 response within one business day of the request for a peer discussion;

21 (B) For concurrent and prospective reviews of urgent and emergent health-care services,
22 a response within a reasonable period of time of the request for a peer discussion; and

23 (C) For retrospective reviews, prior to the internal-level appeal decision.

24 (5) The review agency will have met the requirements of a two-way, direct
25 communication, when requested and/or as required prior to the internal level of appeal, when it
26 has made two (2) reasonable attempts to contact the attending provider directly. Repeated
27 violations of this section shall be deemed to be substantial violations pursuant to § 27-18.9-9 and
28 shall be cause for the imposition of penalties under that section.

29 (6) For the appeal of an adverse benefit determination decision that a drug is not covered,
30 the review agent shall complete the internal-appeal determination and notify the claimant of its
31 determination:

32 (i) No later than seventy-two (72) hours following receipt of the appeal request; or

33 (ii) No later than twenty-four (24) hours following the receipt of the appeal request in
34 cases where the beneficiary is suffering from a health condition that may seriously jeopardize the

1 beneficiary's life, health, or ability to regain maximum function or when an beneficiary is
2 undergoing a current course of treatment using a non-formulary drug.

3 (iii) And if approved on appeal, coverage of the non-formulary drug must be provided for
4 the duration of the prescription, including refills unless expedited then for the duration of the
5 exigency.

6 (7) The review agents using clinical criteria and medical judgment in making utilization
7 review decisions shall comply with the following:

8 (i) The requirement that each review agent shall provide its clinical criteria to OHIC upon
9 request;

10 (ii) Provide and use written clinical criteria and review procedures established according
11 to nationally accepted standards, evidence-based medicine and protocols that are periodically
12 evaluated and updated or other reasonable standards required by the commissioner;

13 (iii) Establish and employ a process to incorporate and consider local variations to
14 national standards and criteria identified herein including without limitation, a process to
15 incorporate input from local participating providers; and

16 (iv) Updated description of clinical decision criteria to be available to beneficiaries,
17 providers, and the office upon request and readily available and accessible on the health-care
18 entity or the review agent's website.

19 (8) The review agent shall maintain records of written, adverse benefit determination
20 reconsiderations and appeals to include their resolution, and shall provide reports and other
21 information as requested by the office.

22 **27-18.9-8. External appeal procedural requirements.**

23 (a) General requirements.

24 (1) In cases where the non-administrative, adverse benefit determination or the final
25 internal level of appeal to reverse a non-administrative, adverse benefit determination is
26 unsuccessful, the health care entity or review agent shall provide for an external appeal by an
27 independent review organization (IRO) approved by the commissioner and ensure that the
28 external appeal complies with all applicable laws and regulations. Provided, the independent
29 review must be conducted by a licensed physician or dentist who is licensed , certified, or
30 otherwise formally recognized as a specialist in the field of the health care services or the
31 problem being reviewed.

32 (2) In order to seek an external appeal, claimant must have exhausted the internal claims
33 and appeal process unless the utilization review agent or health care entity has waived the internal
34 appeal process by failing to comply with the internal appeal process or the claimant has applied

1 for expedited external review at the same time as applying for expedited internal review.

2 (3) A claimant shall have at least four (4) months after receipt of a notice of the decision
3 on a final internal appeal to request an external appeal by an IRO.

4 (4) Health care entities and review agents must use a rotational IRO registry system
5 specified by the commissioner, and must select an IRO in the rotational manner described in the
6 IRO registry system.

7 (5) A claimant requesting an external appeal may be charged no more than a twenty-five
8 dollar (\$25.00) external appeal fee by the review agent. The external appeal fee, if charged, must
9 be refunded to the claimant if the adverse benefit determination is reversed through external
10 review. The external appeal fee must be waived if payment of the fee would impose an undue
11 financial hardship on the beneficiary. In addition, the annual limit on external appeal fees for any
12 beneficiary within a single plan year (in the individual market, within a policy year) must not
13 exceed seventy-five dollars (\$75.00). Notwithstanding the aforementioned, this subsection shall
14 not apply to excepted benefits as defined in 42 U.S.C. § 300gg-91(c).

15 (6) IRO and/or the review agent and/or the health care entity may not impose a minimum
16 dollar amount of a claim for a claim to be eligible for external review by an IRO.

17 (7) The decision of the external appeal by the IRO shall be binding on the health care
18 entity and/or review agent; however, any person who is aggrieved by a final decision of the
19 external appeal agency is entitled to judicial review in a court of competent jurisdiction.

20 (8) The health care entity must provide benefits (including making payment on the claim)
21 pursuant to an external review decision without delay regardless whether the health care entity or
22 review agent intends to seek judicial review of the IRO decision.

23 (9) The commissioner shall promulgate rules and regulations including, but not limited
24 to, criteria for designation, operation, policy, oversight, and termination of designation as an IRO.
25 The IRO shall not be required to be certified under this chapter for activities conducted pursuant
26 to its designation.

27 (b) The external appeal process shall include, but not be limited to, the following
28 characteristics:

29 (1) The claimant must be noticed that he/she shall have at least five (5) business days
30 from receipt of the external appeal notice to submit additional information to the IRO.

31 (2) The IRO must notice the claimant of its external appeal decision to uphold or overturn
32 the review agency decision:

33 (i) No more than ten (10) calendar days from receipt of all the information necessary to
34 complete the external review and not greater than forty-five (45) calendar days after the receipt of

1 the request for external review; and

2 (ii) In the event of an expedited external appeal by the IRO for urgent or emergent care,
3 as expeditiously as possible and no more than seventy-two (72) hours after the receipt of the
4 request for the external appeal by the IRO. Notwithstanding provisions in this section to the
5 contrary, this notice may be made orally but must be followed by a written decision within forty-
6 eight (48) hours after oral notice is given.

7 (3) For an external appeal of an internal appeal decision that a drug is not covered, the
8 IRO shall complete the external appeal determination and notify the claimant of its determination:

9 (i) No later than seventy-two (72) hours following receipt of the external appeal request;
10 or

11 (ii) No later than twenty-four (24) hours following the receipt of the external appeal
12 request if the original request was an expedited request; and

13 (iii) If approved on external appeal, coverage of the non-formulary drug must be provided
14 for the duration of the prescription, including refills, unless expedited then for the duration of the
15 exigencies.

16 (c) External appeal decision notifications. The health care entity and review agent must
17 ensure that the IRO adheres to the following relative to decision notifications:

18 (1) May be written or electronic with reasonable assurance of receipt by claimant unless
19 urgent or emergent. If urgent or emergent, oral notification is acceptable followed by written or
20 electronic notification within three (3) calendar days;

21 (2) Must be culturally and linguistically appropriate;

22 (3) The details of claim that is being denied to include the date of service, provider name,
23 amount of claim, diagnostic code, and treatment costs with corresponding meanings;

24 (4) Must include the specific reason or reasons for the external appeal decision;

25 (5) Must include information for claimant as to procedure to obtain copies of any and all
26 information relevant to the external appeal which copies must be provided to the claimant free of
27 charge; and

28 (6) Must not be written in a manner that could reasonably be expected to negatively
29 impact the beneficiary.

30 SECTION 2. This act shall take effect upon passage.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

RELATING TO INSURANCE -- BENEFIT DETERMINATION AND UTILIZATION
REVIEW ACT

1 This act would provide that both internal and external reviews of health insurance benefit
2 determinations as to insurance coverage would be conducted by a licensed physician or dentist
3 who is licensed, certified, or otherwise formally recognized as a specialist in the field of the
4 health care services or the problems being reviewed.

5 This act would take effect upon passage.

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