

HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

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Section 1. Title

This Act shall be known and may be cited as the Health Carrier External Review Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act as a regulation. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as a regulation.

Section 2. Purpose and Intent

The purpose of this Act is to provide standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in this Act.

Drafting Note: This Act governs the processes relating to external review procedures only. For processes related to a health carrier's internal grievance procedures, see the NAIC Health Carrier Grievance Procedure Model Act.

Drafting Note: States are strongly encouraged to adopt both this Act and the NAIC's Health Carrier Grievance Procedure Model Act, which sets out an internal grievance process for the review of written grievances stemming from adverse determinations, as defined in that Act. The external review procedures of this Act assume the existence of the internal grievance process outlined in the NAIC Health Carrier Grievance Procedure Model Act. This Act also assumes that any adverse determination that remains in dispute after the health carrier's internal grievance process has been exhausted and for which a request for an external review is made under this Act, will be considered a "final adverse determination," as that term is defined by this Act. Further, this Act assumes that, in a case in which the health carrier's internal grievance process has not been exhausted prior to a request for external review under this Act, the subject of the request for external review will be the adverse determination made by the health carrier or its designee utilization review organization pursuant to the NAIC's Utilization Review and Benefit Determination Model Act.

Section 3. Definitions

For purposes of this Act:

- A. "Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

Drafting Note: The definition of “adverse determination” should be interpreted broadly to ensure that all adverse determinations where the covered person believes the treatment or service is medically necessary are eligible for external review in accordance with the provisions of this Act. It includes, for example, adverse determinations regarding cosmetic procedures, when the covered person requests the health care service on medical necessity grounds rather than for cosmetic reasons. It also includes adverse determinations related to out-of-network services, when the covered person requests health care services from a provider that does not participate in the health carrier’s provider network because the clinical expertise of the provider may be medically necessary for treatment of the covered person’s medical condition and that expertise is not available in the health carrier’s provider network. States may wish to consider carving out adverse determinations related to out-of-network services depending on their regulatory structure relating to utilization review and out-of-network treatment decisions, including any concurrent jurisdiction among state agencies that may be applicable, in determining the scope of the external review process.

Denials of coverage based on a determination that a recommended or requested health care service or treatment is experimental also are adverse determinations. The NAIC believes, however, that the review of these denials should be subject to separate external review standards and procedures. Section 10 of this Act sets out external review standards and procedures for reviewing coverage denials based on a determination that a recommended or requested health care service or treatment is experimental.

- B. “Ambulatory review” means utilization review of health care services performed or provided in an outpatient setting.
- C. “Authorized representative” means:
 - (1) A person to whom a covered person has given express written consent to represent the covered person in an external review;
 - (2) A person authorized by law to provide substituted consent for a covered person; or
 - (3) A family member of the covered person or the covered person’s treating health care professional when the covered person is unable to provide consent.
- D. “Case management” means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.
- E. “Certification” means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.
- F. “Clinical review criteria” means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.
- G. “Commissioner” means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

- H. “Concurrent review” means utilization review conducted during a patient’s hospital stay or course of treatment.
- I. “Covered benefits” or “benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.
- J. “Covered person” means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.
- K. “Discharge planning” means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.
- L. “Disclose” means to release, transfer or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

- M. “Emergency medical condition” means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.
- N. “Emergency services” means health care items and services furnished or required to evaluate and treat an emergency medical condition.
- O. “Facility” means an institution providing health care services or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.
- P. “Final adverse determination” means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier’s internal grievance process procedures as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

Drafting Note: States that do not require covered persons to exhaust a health carrier’s internal grievance process procedures before filing a request for an external review should not adopt the definition of “final adverse determination” in Subsection P and should not use the term in the rest of the law.

- Q. “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
- R. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate “persons.”

- S. “Health care provider” or “provider” means a health care professional or a facility.
- T. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.
- U. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

- V. “Health information” means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:
 - (1) The past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual’s family;
 - (2) The provision of health care services to an individual; or
 - (3) Payment for the provision of health care services to an individual.
- W. “Independent review organization” means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.
- X. “Medical or scientific evidence” means evidence found in the following sources:

- (1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
 - (2) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);
 - (3) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act
 - (4) The following standard reference compendia:
 - (a) The American Hospital Formulary Service–Drug Information;
 - (b) Drug Facts and Comparisons;
 - (c) The American Dental Association Accepted Dental Therapeutics; and
 - (d) The United States Pharmacopoeia–Drug Information;
 - (5) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:
 - (a) The federal Agency for Healthcare Research and Quality;
 - (b) The National Institutes of Health;
 - (c) The National Cancer Institute;
 - (d) The National Academy of Sciences;
 - (e) The Centers for Medicare & Medicaid Services;
 - (f) The federal Food and Drug Administration; and
 - (g) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or
 - (6) Any other medical or scientific evidence that is comparable to the sources listed in Paragraphs (1) through (5).
- Y. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.
- Z. "Prospective review" means utilization review conducted prior to an admission or a course of treatment.
- AA. "Protected health information" means health information:
 - (1) That identifies an individual who is the subject of the information; or
 - (2) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.
- BB. "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

- CC. “Second opinion” means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.
- DD. “Utilization review” means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.
- EE. “Utilization review organization” means an entity that conducts utilization review, other than a health carrier performing a review for its own health benefit plans.

Section 4. Applicability and Scope

- A. Except as provided in Subsection B, this Act shall apply to all health carriers that provide or perform utilization review.
- B. The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers’ compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Section 5. Notice of Right to External Review

- A. (1) A health carrier shall notify the covered person in writing of the covered person’s right to request an external review to be conducted pursuant to Section 8, 9 or 10 of this Act and include the appropriate statements and information set forth in Subsection B at the time the health carrier sends written notice of:
 - (a) An adverse determination upon completion of the health carrier’s utilization review process set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act]; and
 - (b) A final adverse determination.
- (2) As part of the written notice required under Paragraph (1), a health carrier shall include the following, or substantially equivalent, language: “We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Office of the Insurance Commissioner [insert address and telephone number of the office of the insurance commissioner or other unit in the office that administers the external review program].”

Drafting Note: States that have not established an external review program in the office of the commissioner, such as those states that adopt Option 3 in Sections 8 and 9 of this Act, should alter the language in Paragraph (2) as appropriate.

- B. (1) The health carrier shall include in the notice required under Subsection A:
 - (a) For a notice related to an adverse determination, a statement informing the covered person that:

- (i) If the covered person has a medical condition where the timeframe for completion of an expedited review of a grievance involving an adverse determination set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to Section 9 of this Act, or Section 10 of this Act if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, at the same time the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act], but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review; and
 - (ii) The covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process as set forth in [insert reference in state law equivalent to Section 7 of the Health Carrier Grievance Procedure Model Act], but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within thirty (30) days following the date the covered person or the covered person's authorized representative files the grievance with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review pursuant to Section 6 of this Act and shall be considered to have exhausted the health carrier's internal grievance process for purposes of Section 7 of this Act; and
- (b) For a notice related to a final adverse determination, a statement informing the covered person that:
- (i) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to Section 9 of this Act; or
 - (ii) If the final adverse determination concerns:
 - (I) An admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person or the covered person's authorized representative may request an expedited external review pursuant to Section 9 of this Act; or

- (II) A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person or the covered person's authorized representative may file a request for a standard external review to be conducted pursuant to Section 10 of this Act or if the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, the covered person or the covered person's authorized representative may request an expedited external review to be conducted under Section 10 of this Act.

- (2) In addition to the information to be provided pursuant to Paragraph (1), the health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant to Section 18 of this Act, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

Drafting Note: States may wish to specify more particularly the information that must be included in the written notice.

- (3) As part of any forms provided under Paragraph (2), the health carrier shall include an authorization form, or other document approved by the commissioner, by which the covered person, for purposes of conducting an external review under this Act, authorizes the health carrier to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review, as provided in [insert reference to state law equivalent to Section 10H of the Health Information Privacy Model Act].

Section 6. Request for External Review

Option 1.

Drafting Note: The following Option 1 for Section 6A applies to states that choose to establish the external grievance process in the office of the commissioner and require that covered persons file all requests for external review with the commissioner.

- A. Except for a request for an expedited external review as set forth in Section 9 of this Act, all requests for external review shall be made in writing to the commissioner.

Option 2.

Drafting Note: The following Option 2 for Section 6A applies to states that choose to establish responsibility for the external grievance process with the health carrier and require that covered persons file requests for external review with the health carrier.

- A. Except for a request for an expedited external review as set forth in Section 9 of this Act, all requests for external review shall be made in writing to the health carrier.
- B. A covered person or the covered person's authorized representative may make a request for an external review of an adverse determination or final adverse determination.

Section 7. Exhaustion of Internal Grievance Process

- A. (1) Except as provided in Subsection B, a request for an external review pursuant to Section 8, 9 or 10 of this Act shall not be made until the covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].
- (2) A covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section, if the covered person or the covered person's authorized representative:

- (a) Has filed a grievance involving an adverse determination pursuant to [insert reference in state law equivalent to Section 7 of the Health Carrier Grievance Procedure Model Act]; and
 - (b) Except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within thirty (30) days following the date the covered person or the covered person's authorized representative filed the grievance with the health carrier.
- (3) Notwithstanding Paragraph (2), a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination made pursuant to [insert reference in state law equivalent to the Utilization Review and Benefit Determination Model Act] until the covered person has exhausted the health carrier's internal grievance process.
- B. (1) (a) At the same time a covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act], the covered person or the covered person's authorized representative may file a request for an expedited external review of the adverse determination:
- (i) Under Section 9 of this Act if the covered person has a medical condition where the timeframe for completion of an expedited review of the grievance involving an adverse determination set forth in [insert reference to state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or
 - (ii) Under Section 10 of this Act if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.
- (b) Upon receipt of a request for an expedited external review under Subparagraph (a), the independent review organization conducting the external review in accordance with the provisions of Section 9 or 10 of this Act shall determine whether the covered person shall be required to complete the expedited review process set forth in [insert reference to state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] before it conducts the expedited external review.
- (c) Upon a determination made pursuant to Subparagraph (b) that the covered person must first complete the expedited grievance review process set forth in [insert reference to state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act], 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 set forth in Section 9 of this Act until completion of the expedited grievance review process and the covered person's grievance at the completion of the expedited grievance review process remains unresolved.
- (2) A request for an external review of an adverse determination may be made before the covered person has exhausted the health carrier's internal grievance procedures as set forth in [insert reference to state law equivalent to Section 7 of the Health Carrier Grievance Procedure Model Act] whenever the health carrier agrees to waive the exhaustion requirement.

- C. If the requirement to exhaust the health carrier’s internal grievance procedures is waived under Subsection B(2), the covered person or the covered person’s authorized representative may file a request in writing for a standard external review as set forth in Section 8 or 10 of this Act.

Drafting Note: States are strongly encouraged to adopt both this Act and the NAIC’s Health Carrier Grievance Procedure Model Act, which sets out an internal grievance process for the review of written grievances stemming from adverse determinations, as defined in that Act. The external review procedures of this Act assume the existence of the internal grievance process outlined in the NAIC Health Carrier Grievance Procedure Model Act. This Act also assumes that any adverse determination that remains in dispute after the health carrier’s internal grievance process has been exhausted and for which a request for an external review is made under this Act, will be considered a “final adverse determination,” as that term is defined by this Act. Further, this Act assumes that, in a case in which the health carrier’s internal grievance process has not been exhausted prior to a request for external review under this Act, the subject of the request for external review will be the adverse determination made by the health carrier or its designee utilization review organization pursuant to the NAIC’s Utilization Review and Benefit Determination Model Act.

Drafting Note: States that do not require exhaustion of the internal grievance process prior to filing a request for external review should not adopt this section.

Section 8. Standard External Review

Option 1.

Drafting Note: Option 1 for this section of this Act applies to states that choose to establish the external review process in the office of the commissioner and require that covered persons file all requests for external review with the commissioner. This option also provides that the commissioner will conduct a preliminary review of the request for external review to ensure that it meets all of the requirements to be eligible for external review. If the request for external review is determined to be eligible for external review, the commissioner is required to assign an independent review organization to conduct the external review. This option requires the assigned independent review organization to provide the commissioner with a written recommendation on whether to uphold or reverse the adverse determination or final adverse determination. The commissioner is required to review the recommendation to ensure that it is not contrary to the terms of coverage under the covered person’s health benefit plan. After completion of the review, the commissioner is required to notify the covered person, if applicable, the covered person’s authorized representative and the health carrier of the external review decision.

- A. (1) Within sixty (60) days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 5 of this Act, a covered person or the covered person’s authorized representative may file a request for an external review with the commissioner.
- (2) Upon receipt of a request for an external review pursuant to Paragraph (1), 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.
- B. Within five (5) 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 whether:
- (1) 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;
- (2) 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, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;
- (3) The covered person has exhausted the health carrier’s internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier’s internal grievance process pursuant to Section 7 of this Act; and
- (4) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under Section 5B of this Act.
- C. (1) Upon completion of the preliminary review pursuant to Subsection B, the commissioner immediately shall notify the covered person and, if applicable, the covered person’s authorized representative in writing whether:

- (a) The request is complete; and
 - (b) The request has been accepted for external review.
- (2) If the request is accepted for external review, the commissioner shall:
- (a) Include in the notice provided pursuant to Paragraph (1) a statement that the covered person or the covered person's authorized representative may submit to the commissioner in writing within seven (7) days following the date of receipt of the notice additional information and supporting documentation that the assigned independent review organization shall consider when conducting the external review; and
 - (b) Immediately notify the health carrier in writing of the acceptance of the request for external review.
- (3) If the request:
- (a) 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; or
 - (b) Is not accepted for external review, the commissioner shall inform the covered person, if applicable, the covered person's authorized representative, and the health carrier in writing of the reasons for its nonacceptance.
- D. (1) At the time a request is accepted for external review pursuant to Subsection C, the commissioner shall assign an independent review organization that has been approved pursuant to Section 12 of this Act to conduct the external review and provide a written recommendation to the commissioner on whether to uphold or reverse the adverse determination or the final adverse determination.
- (2) 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 as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].
- E. (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Subsection C(2), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization, the documents and any information considered in making the adverse determination or the final adverse determination.
- (2) Except as provided in Paragraph (3), failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in Paragraph (1) shall not delay the conduct of the external review.
- (3) (a) 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 the time specified in Paragraph (1), the commissioner may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
- (b) Immediately upon making the decision under Subparagraph (a), the commissioner shall notify the assigned independent review organization, the covered person, if applicable, the covered person's authorized representative, and the health carrier.
- F. (1) The assigned independent review organization, shall review all of the information and documents received pursuant to Subsection E and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to Subsection C(2) that has been forwarded to the independent review organization by the commissioner.

- (2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection C(2), at the same time the commissioner forwards the information to the independent review organization, the commissioner shall forward the information to the health carrier.
- G.
- (1) Upon receipt of the information required to be forwarded pursuant to Subsection F(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.
 - (2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to Paragraph (1) shall not delay or terminate the external review.
 - (3) 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.
 - (4)
 - (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3), the health carrier shall notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.
 - (b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph (a).
- H.
- In addition to the documents and information provided pursuant to Subsection E, 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:
- (1) The covered person's pertinent medical records;
 - (2) The attending health care professional's recommendation;
 - (3) 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;
 - (4) The terms of coverage under the covered person's health benefit plan with the health carrier;
 - (5) 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, national or professional medical societies, boards and associations; and
 - (6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization.
- I.
- (1) The independent review organization assigned pursuant to Subsection D shall provide its recommendation to the commissioner within thirty (30) days after the date of receipt of the request for an external review.
 - (2) The independent review organization shall include in its recommendation provided pursuant to Paragraph (1):
 - (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; and
 - (g) References to the evidence or documentation, including the practice guidelines, considered in reaching its recommendation.
- (3) Upon receipt of the assigned independent review organization's recommendation pursuant to Paragraph (1), 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.

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

- J.
- (1) The commissioner shall notify the covered person, if applicable, the covered person's authorized representative, and the health carrier in writing of the decision to uphold or reverse the adverse determination or the final adverse determination within fifteen (15) days after the date of receipt of the selected independent review organization's recommendation provided pursuant to Subsection I(1).
 - (2) The commissioner shall include in the notice sent pursuant to Paragraph (1):
 - (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 by the selected independent review organization in regard to its recommendation pursuant to Subsection I(2); and
 - (b) If appropriate, the principal reason or reasons why the commissioner did not follow the assigned independent review organization's recommendation.
 - (3) Upon receipt of a notice of a decision pursuant to Paragraph (1) 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.

Option 2.

Drafting Note: Option 2 for this section of this Act applies to states that choose not to review the external review decision of an independent review organization as in Option 1. Option 2 requires covered persons to file all requests for external review with the commissioner. The commissioner then conducts a preliminary review of the request for external review to ensure that it meets all of the requirements to be eligible for external review. If the commissioner determines that the request meets specified requirements to be eligible for external review, the commissioner then assigns an independent review organization to conduct the external review.

- A.
- (1) Within sixty (60) days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 5 of this Act, a covered person or the covered person's authorized representative may file a request for an external review with the commissioner.
 - (2) Upon receipt of a request for an external review pursuant to Paragraph (1), 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.
- B. Within five (5) 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 whether:

- (1) 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;
 - (2) 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, but for a determination by the health carrier that the health care service is not covered because it does not meeting the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;
 - (3) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 7 of this Act; and
 - (4) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under Section 5B of this Act.
- C.
- (1) Upon completion of the preliminary review pursuant to Subsection B, the commissioner immediately shall notify the covered person and, if applicable, the covered person's authorized representative in writing whether:
 - (a) The request is complete; and
 - (b) The request has been accepted for external review.
 - (2) If the request is accepted for external review, the commissioner shall:
 - (a) Include in the notice provided pursuant to Paragraph (1) a statement that the covered person or the covered person's authorized representative may submit to the commissioner in writing within seven (7) days following the date of the notice additional information and supporting documentation that the independent review organization shall consider when conducting the external review; and
 - (b) Immediately notify the health carrier in writing of the acceptance of the request for external review.
 - (3) If the request:
 - (a) 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; or
 - (b) Is not accepted for external review, the commissioner shall inform the covered person, if applicable, the covered person's authorized representative, and the health carrier in writing of the reasons for its nonacceptance.
- D.
- (1) At the time a request for external review is accepted pursuant to Subsection C, the commissioner shall assign an independent review organization to conduct the external review that has been approved pursuant to Section 13 of this Act.
 - (2) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

- E.
 - (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Subsection C(2), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization, the documents and any information considered in making the adverse determination or the final adverse determination.
 - (2) Except as provided in Paragraph (3), failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in Paragraph (1) shall not delay the conduct of the external review.
 - (3)
 - (a) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in Paragraph (1), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
 - (b) Immediately upon making the decision under Subparagraph (a), the independent review organization shall notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner.
- F.
 - (1) The assigned independent review organization shall review all of the information and documents received pursuant to Subsection E and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to Subsection C(2) that has been forwarded to the independent review organization by the commissioner.
 - (2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection C(2), at the same time the commissioner forwards the information to the independent review organization, the commissioner shall forward the information to the health carrier.
- G.
 - (1) Upon receipt of the information required to be forwarded pursuant to Subsection F(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.
 - (2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to Paragraph (1) shall not delay or terminate the external review.
 - (3) 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.
 - (4)
 - (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3), the health carrier shall notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.
 - (b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph (a).
- H. In addition to the documents and information provided pursuant to Subsection E, the assigned independent review organization, to the extent the documents or information is available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:
 - (1) The covered person's medical records;
 - (2) The attending health care professional's recommendation;

- (3) 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;
- (4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

- (5) 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, national or professional medical societies, boards and associations; and
 - (6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization.
- I. (1) Within forty-five (45) days after the date of receipt of the request for external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or final adverse determination to:
- (a) The covered person;
 - (b) If applicable, the covered person's authorized representative;
 - (c) The health carrier; and
 - (d) The commissioner.

Drafting Note: States may want to consider requiring independent review organizations to identify in the notice provided to the commissioner under Subsection I(1) any problem contract or policy provisions, such as ambiguity, found during the conduct of the external review.

- (2) The independent review organization shall include in the notice sent pursuant to Paragraph (1):
 - (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 decision;
 - (e) The principal reason or reasons for its decision;
 - (f) The rationale for its decision; and
 - (g) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.
- (3) Upon receipt of a notice of a decision pursuant to Paragraph (1) 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.

Option 3.

Drafting Note: Option 3 for this section of this Act applies to states that choose to establish responsibility for the external review process with the health carrier and require that covered persons file requests for external review with the health carrier. This option also requires the health carrier to assign an independent review organization from the list of approved independent review organizations compiled by the commissioner to conduct a preliminary review of the request and conduct an external review of the request if the request has satisfied specified requirements to be eligible for external review.

- A. (1) Within sixty (60) days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 5 of this Act, a covered person or the covered person's authorized representative may file a request for an external review with the health carrier.
- (2) Upon receipt of a request for external review pursuant to Paragraph (1), the health carrier shall send a copy of the request to the commissioner.
- B. At the time the health carrier receives a request for an external review, the health carrier shall assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to Section 12 of this Act to conduct a preliminary review of the request to determine whether:
 - (1) 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;
 - (2) The health care service that is the subject of the adverse determination or the final adverse determination reasonably appears to be a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;
 - (3) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 7 of this Act; and
 - (4) The covered person has provided all the information and forms required to process an external review, including the release form provided under Section 5B of this Act.
- C. (1) Within five (5) days after receipt of the request for external review, the independent review organization assigned pursuant to Subsection B shall complete the preliminary review and immediately notify the covered person and, if applicable, the covered person's authorized representative in writing whether:
 - (a) The request is complete; and
 - (b) The request has been accepted for external review.
- (2) The assigned independent review organization shall include in the notice provided pursuant to Paragraph (1) a statement that the covered person or the covered person's authorized representative may submit in writing to the independent review organization within seven (7) days following the date of receipt of the notice additional information and supporting documentation that the independent review organization shall consider when conducting the external review.
- (3) If the request:
 - (a) Is not complete, the assigned independent review organization 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; or
 - (b) Is not accepted for external review, the assigned independent review organization shall inform the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner in writing of the reasons for its nonacceptance.
- D. (1) Whenever a request for external review is accepted for external review following the preliminary review conducted pursuant to Subsection C, the assigned independent review organization shall notify the health carrier and the commissioner.

- (2) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review Model and Benefit Determination Act] or the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].
- E.
- (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Section D(1), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.
 - (2) Except as provided in Paragraph (3), failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in Paragraph (1) shall not delay the conduct of the external review.
 - (3)
 - (a) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in Paragraph (1), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
 - (b) Immediately upon making the decision under Subparagraph (a), the independent review organization shall notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner.
- F.
- (1) The assigned independent review organization shall review all of the information and documents received pursuant to Subsection E and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to Subsection C(2).
 - (2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection C(2), the assigned independent review organization immediately shall forward the information to the health carrier.
- G.
- (1) Upon receipt of the information, if any, required to be forwarded pursuant to Subsection F(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.
 - (2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to Paragraph (1) shall not delay or terminate the external review.
 - (3) 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.
 - (4)
 - (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3), the health carrier shall notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.
 - (b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph (a).
- H. In addition to the documents and information provided pursuant to Subsection E, 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 decision:

- (1) The covered person's medical records;
- (2) The attending health care professional's recommendation;
- (3) 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;
- (4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

- (5) 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, national or professional medical societies, boards and associations; and
 - (6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization.
- I. (1) Within forty-five (45) days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:
- (a) The covered person;
 - (b) If applicable, the covered person's authorized representative;
 - (c) The health carrier; and
 - (d) The commissioner.

Drafting Note: States may want to consider requiring independent review organizations to identify in the notice provided to the commissioner under Subsection I(1) any problem contract or policy provisions, such as ambiguity, found during the conduct of the external review.

- (2) The independent review organization shall include in the notice sent pursuant to Paragraph (1):
 - (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 health carrier to conduct the preliminary review of the external review request;
 - (c) The date the external review was conducted, if appropriate;
 - (d) The date of its decision;
 - (e) The principal reason or reasons for its decision;
 - (f) The rationale for its decision; and
 - (g) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.
- (3) Upon receipt of a notice of a decision pursuant to Paragraph (1) 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.

- J. The assignment by a health carrier of an approved independent review organization to conduct an external review in accordance with this section shall be fair and impartial. The health carrier and the independent review organization shall comply with standards promulgated by the commissioner by regulation to ensure fairness and impartiality in the assignment by health carriers of approved independent review organizations to conduct external reviews, including its term, its termination and payment arrangement.

Section 9. Expedited External Review

Option 1.

Drafting Note: Option 1 for this section of this Act applies to states that choose to establish the expedited external review process in the office of the commissioner and require covered persons make all requests for an expedited external review with the commissioner. This option requires the commissioner to assign the conduct of the expedited external review to an independent review organization if the request has met specified requirements to be eligible for an expedited external review. The assigned independent review organization is required to provide to the commissioner with a recommendation on whether to uphold or reverse the adverse determination or final adverse determination.

- A. Except as provided in Subsection H, a covered person or the covered person's authorized representative may make a request for an expedited external review with the commissioner at the time the covered person receives:
- (1) An adverse determination if:
 - (a) The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and
 - (b) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act]; or
 - (2) A final adverse determination:
 - (a) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or
 - (b) If the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility.
- B. At the time the commissioner receives a request for an expedited external review, the commissioner immediately shall:
- (1) Notify and provide 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; and
 - (2) For a request that the commissioner has determined meets the reviewability requirements set forth in Section 8B of this Act, assign an independent review organization that has been approved pursuant to Section 12 of this Act to conduct the expedited external review and provide a written recommendation to the commissioner on whether to uphold or reverse the adverse determination or final adverse determination.

- C. 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 as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert state law equivalent to the Health Carrier Grievance Procedure Model Act].
- D. At the time the health carrier receives the notice pursuant to Subsection B, 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.
- E. In addition to the documents and information provided or transmitted pursuant to Subsection D, 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:
 - (1) The covered person's pertinent medical records;
 - (2) The attending health care professional's recommendation;
 - (3) 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;
 - (4) The terms of coverage under the covered person's health benefit plan with the health carrier;
 - (5) 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, national or professional medical societies, boards and associations; and
 - (6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations.
- F.
 - (1) The assigned independent review organization shall provide its recommendation to the commissioner as expeditiously as the covered person's medical condition or circumstances requires, but in no event more than forty-eight (48) hours after the date the commissioner received the request for an expedited external review pursuant to Subsection A.
 - (2) Upon receipt of the assigned independent review organization's recommendation pursuant to Paragraph (1), 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.

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

- G.
 - (1) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than twenty-four (24) hours after receiving the recommendation of the assigned independent review organization as required pursuant to Subsection F, 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.

- (2) If the notice provided pursuant to Paragraph (1) was not in writing, within two (2) days after the date of providing that notice, the commissioner shall:
 - (a) Provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, and the health carrier; and
 - (b) Include the information set forth in Section 8J(2) of this Act.
 - (3) Upon receipt of the notice a decision pursuant to Paragraph (1) 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.
- H. An expedited external review may not be provided for retrospective adverse or final adverse determinations.

Option 2.

Drafting Note: Option 2 for this section of this Act applies to states that choose not to review the external review decision of an independent review organization as in Option 1. Option 2 requires covered persons make all requests for an expedited external review with the commissioner. If the request has met specified requirements to be eligible for an expedited external review, the commissioner then immediately assigns an independent review organization to conduct the expedited external review.

- A. Except as provided in Subsection G, a covered person or the covered person's authorized representative may make a request for an expedited external review with the commissioner at the time the covered person receives:
- (1) An adverse determination if:
 - (a) The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and
 - (b) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act]; or
 - (2) A final adverse determination:
 - (a) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or
 - (b) If the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility.
- B. At the time the commissioner receives a request for an expedited external review, the commissioner immediately shall:
- (1) Notify and provide 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; and

- (2) For a request that the commissioner has determined meets the reviewability requirements set forth in Section 8B of this Act, assign an independent review organization that has been approved pursuant to Section 13 of this Act to conduct the review and to make a decision to uphold or reverse the adverse determination or final adverse determination.
- C. In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert state law equivalent to the Health Carrier Grievance Procedure Model Act].
- D. At the time the health carrier receives the notice pursuant to Subsection B, 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.
- E. In addition to the documents and information provided or transmitted pursuant to Subsection D, 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 decision:
 - (1) The covered person's pertinent medical records;
 - (2) The attending health care professional's recommendation;
 - (3) 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;
 - (4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;
 - (5) 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, national or professional medical societies, boards and associations; and
 - (6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations.
- F.
 - (1) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review, the assigned independent review organization shall:
 - (a) Make a decision to uphold or reverse the adverse determination or final adverse determination; and
 - (b) Notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner of the decision.
 - (2) If the notice provided pursuant to Paragraph (1) was not in writing, within two (2) days after the date of providing that notice, the assigned independent review organization shall:
 - (a) Provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner; and

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

- (b) Include the information set forth in Section 8 I(2) of this Act.
 - (3) Upon receipt of the notice a decision pursuant to Paragraph (1) 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.
- G. An expedited external review may not be provided for retrospective adverse or final adverse determinations.

Option 3.

Drafting Note: Option 3 for this section of this Act applies to states that choose to establish responsibility for the expedited external review process with the health carrier and require that covered persons file requests for an expedited external review with the health carrier. This option also requires the health carrier to assign an approved independent review organization to conduct an expedited external review of the request if the request has satisfied specified requirements to be eligible for an expedited external review.

- A. Except as provided in Subsection F, a covered person or the covered person's authorized representative may make a request for an expedited external review with the health carrier at the time the covered person receives:
 - (1) An adverse determination if:
 - (a) The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act] would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and
 - (b) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act]; or
 - (2) A final adverse determination:
 - (a) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or
 - (b) If the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility.
- B. (1) At the time the health carrier receives a request for an expedited external review, the health carrier immediately shall:
 - (a) Assign an independent review organization from the list compiled and maintained pursuant to Section 13 of this Act to determine whether the request meets the reviewability requirements set forth in Section 8B of this Act and conduct the external review if the request meets the reviewability requirements of Section 8B of this Act; and
 - (b) Send a copy of the request to the commissioner.
- (2) In reaching a decision in accordance with Subsection E, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert state law equivalent to the Health Carrier Grievance Procedure Model Act].

- C. At the time the health carrier assigns an independent review organization to conduct the expedited external review pursuant to Subsection B, 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.
- D. In addition to the documents and information provided or transmitted pursuant to Subsection C, 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 decision:
 - (1) The covered person's pertinent medical records;
 - (2) The attending health care professional's recommendation;
 - (3) 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;
 - (4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "medical necessity" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

- (5) 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, national or professional medical societies, boards and associations; and
 - (6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations.
- E.
 - (1) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in Section 8B of this Act, the assigned independent review organization shall:
 - (a) Make a decision to uphold or reverse the adverse determination or final adverse determination; and
 - (b) Notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner of the decision.
 - (2) If the notice provided pursuant to Paragraph (1) was not in writing, within two (2) days after the date of providing that notice, the assigned independent review organization shall:
 - (a) Provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner; and
 - (b) Include the information set forth in Section 8I(2) of this Act.
 - (3) Upon receipt of the notice a decision pursuant to Paragraph (1) 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.
- F. An expedited external review may not be provided for retrospective adverse or final adverse determinations.

- G. The assignment by a health carrier of an approved independent review organization to conduct an external review in accordance with this section shall be fair and impartial. The health carrier and the independent review organization shall comply with standards promulgated by the commissioner by regulation to ensure fairness and impartiality in the assignment by health carriers of approved independent review organizations to conduct external reviews, including its term, its termination and payment arrangement.

Section 10. External Review of Experimental or Investigational Treatment Adverse Determinations

Option 1.

Drafting Note: Option 1 for this section of this Act applies to states that choose to establish the external review process in the office of the commissioner and require that covered persons file all requests for external review with the commissioner. This option also provides that the commissioner will conduct a preliminary review of the request for external review to ensure that it meets all of the requirements to be eligible for external review. If the request for external review is determined to be eligible for external review, the commissioner is required to assign an independent review organization to conduct the external review. This option requires the assigned independent review organization to provide the commissioner with a written recommendation on whether to uphold or reverse the adverse determination or final adverse determination. The commissioner is required to review the recommendation to ensure that it is not contrary to the terms of coverage under the covered person's health benefit plan. After completion of the review, the commissioner is required to notify the covered person, if applicable, the covered person's authorized representative and the health carrier of the external review decision.

- A. (1) Within sixty (60) days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 5 of this Act that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the commissioner.
- (2) (a) A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to Paragraph (1) if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.
- (b) Upon receipt of a request for an expedited external review that meets the reviewability requirements of Subsection C, the commissioner immediately shall assign an independent review organization as set forth in Subsection E to conduct the review.
- B. (1) Upon receipt of a request for external review pursuant to Subsection A, 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) For an expedited external review request made pursuant to Subsection A(2), at the time the health carrier receives the notice pursuant to Paragraph (1), 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 manner.
- C. Except for a request for an expedited external review made pursuant to Subsection A(2), within five (5) days after the date of receipt of a request for external review, the commissioner shall complete a preliminary review of the request to determine whether:
- (1) The individual is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or 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 or treatment was provided;

- (2) The recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:
 - (a) Reasonably appears to be 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; and
 - (b) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier;
 - (3) The covered person's treating physician has certified that one of the following situations is applicable:
 - (a) Standard health care services or treatments have not been effective in improving the condition of the covered person;
 - (b) Standard health care services or treatments are not medically appropriate for the covered person; or
 - (c) 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 Paragraph (4);
 - (4) The covered person's treating physician:
 - (a) Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments; or
 - (b) Who 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, has 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;
 - (5) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 7 of this Act; and
 - (6) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under Section 5B of this Act.
- D. (1) Upon completion of the preliminary review pursuant to Subsection C, the commissioner immediately shall notify the covered person and, if applicable, the covered person's authorized representative in writing whether:
- (a) The request is complete; and
 - (b) The request has been accepted for external review.

- (2) If the request is accepted for external review, the commissioner shall:
 - (a) Include in the notice provided pursuant to Paragraph (1) a statement that the covered person or the covered person's authorized representative may submit to the commissioner in writing within seven (7) days following the date of receipt of the notice additional information and supporting documentation that each clinical peer reviewer selected by the assigned independent review organization pursuant to Subsection E shall consider when conducting the external review; and
 - (b) Immediately notify the health carrier in writing of the acceptance of the request for external review.
 - (3) If the request:
 - (a) 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; or
 - (b) Is not accepted for external review, the commissioner shall inform the covered person, the covered person's authorized representative, if applicable, and the health carrier in writing of the reasons for its nonacceptance.
- E.
- (1) At the time a request is accepted for external review pursuant to Subsection A(2) or Subsection D, the commissioner shall assign an independent review organization that has been approved pursuant to Section 13 of this Act that:
 - (a) Will be responsible for selecting one or more clinical peer reviewers, as it determines is appropriate, to conduct the external review; and
 - (b) Based on the opinion of the clinical peer reviewer, or opinions if more than one clinical peer reviewer has been selected to conduct the external review, shall provide a recommendation to the commissioner on whether to uphold or reverse the adverse determination or the final adverse determination.
 - (2)
 - (a) Immediately upon assignment under Paragraph (1), the independent review organization shall select one or more clinical peer reviews to conduct the external review.
 - (b) In accordance with Subsection I, each clinical peer reviewer shall provide a written opinion to the independent review organization on whether the recommended or requested health care service or treatment should be covered.
 - (3)
 - (a) In selecting clinical peer reviewers pursuant to Paragraph (2)(a), the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in Section 14 of this Act and, through clinical experience in the past three (3) years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.
 - (b) Neither the covered person, the covered person's authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.
 - (4) In reaching an opinion, clinical peer reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].

- F. (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Subsection D(2), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization, the documents and any information considered in making the adverse determination or the final adverse determination.
- (2) Except as provided in Paragraph (3), failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in Paragraph (1) shall not delay the conduct of the external review.
- (3) (a) 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 the time specified in Paragraph (1), the commissioner may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
- (b) Immediately upon making the decision under Subparagraph (a), the commissioner shall notify the assigned independent review organization, the covered person, the covered person's authorized representative, if applicable, and the health carrier.
- G. (1) Each clinical peer reviewer selected pursuant to Subsection E shall review all of the information and documents received pursuant to Subsection F and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to Subsection D(2) that has been forwarded to the independent review organization by the commissioner.
- (2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection D(2), at the same time the commissioner forwards the information to the independent review organization, the commissioner shall forward the information to the health carrier.
- H. (1) Upon receipt of the information required to be forwarded pursuant to Subsection G(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.
- (2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to Paragraph (1) shall not delay or terminate the external review.
- (3) The external review may be terminated only 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 recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.
- (4) (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3), the health carrier shall notify the covered person, the covered person's authorized representative if applicable, the assigned independent review organization, and the commissioner in writing of its decision.
- (b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph (a).
- I. (1) Except as provided in Paragraph (3), within twenty (20) days after being selected in accordance with Subsection E to conduct the external review, each clinical peer reviewer shall provide an opinion to the assigned independent review organization pursuant to Subsection J on whether the recommended or requested health care service or treatment should be covered.
- (2) Except for an opinion provided pursuant to Paragraph (3), each clinical peer reviewer's opinion shall be in writing and include the following information:
 - (a) A description of the covered person's medical condition;

- (b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments 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;
 - (c) A description and analysis of any medical or scientific evidence, as that term is defined in Section 3X of this Act, considered in reaching the opinion; and
 - (d) Information on whether the reviewer's rationale for the opinion is based on Subsection J(4)(a) or (b).
- (3)
 - (a) For an expedited external review, each clinical peer reviewer shall provide an opinion orally or in writing to the assigned independent review organization within five (5) days after being selected in accordance with Subsection E.
 - (b) If the opinion provided in accordance with Subparagraph (a) was not in writing, within two (2) days following the date the opinion was provided, the clinical peer reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under Paragraph (2).
- J. In addition to the documents and information provided pursuant to Subsection B(2) or Subsection F, each clinical peer reviewer selected pursuant to Subsection E, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to Subsection I:
 - (1) The covered person's pertinent medical records;
 - (2) The attending physician or health care professional's recommendation;
 - (3) 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 physician or health care professional; and
 - (4) Whether:
 - (a) The recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration for the condition; or
 - (b) Medical or scientific evidence demonstrates that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than 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.
- K.
 - (1)
 - (a) Except as provided in Subparagraph (b), within ten (10) days after the date it receives the opinion of each clinical peer reviewer pursuant to Subsection I, the assigned independent review organization shall, in accordance with Paragraph (2), make a recommendation and provide written notice of the recommendation to the commissioner.
 - (b)
 - (i) For an expedited external review, within two (2) days after the date it receives the opinion of each clinical peer reviewer pursuant to Subsection I, the assigned independent review organization shall, in accordance with Paragraph (2), make a recommendation and provide notice of the recommendation orally or in writing to the commissioner.

- (ii) If the recommendation provided under Item (i) was not in writing, within two (2) days after the date of providing the recommendation, the assigned independent review organization shall provide written confirmation of the recommendation to the commissioner and include the information set forth in Paragraph (3).
- (2)
 - (a) If a majority of the clinical peer reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall recommend to the commissioner that the health carrier's adverse determination or final adverse determination be reversed.
 - (b) If a majority of the clinical peer reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall recommend to the commissioner that the health carrier's adverse determination or final adverse determination be upheld.
 - (c)
 - (i) If the clinical peer reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical peer reviewer in order for the independent review organization to make a recommendation to the commissioner based on the opinions of a majority of the clinical peer reviewers pursuant to Subparagraph (a) or (b).
 - (ii) The additional clinical peer reviewer selected under Item (i) shall use the same information to reach an opinion as the clinical peer reviewers who have already submitted their opinions pursuant to Subsection I.
 - (iii) The selection of the additional clinical peer reviewer under this subparagraph shall not extend the time within which the assigned independent review organization is required to make a recommendation to the commissioner based on the opinions of the clinical peer reviewers selected under Subsection E pursuant to Paragraph (1).
- (3) The independent review organization shall include in the recommendation provided pursuant to Paragraph (1):
 - (a) A general description of the reason for the request for external review;
 - (b) The written opinion of each clinical peer reviewer, including the recommendation of each clinical peer reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
 - (c) The date the independent review organization received the assignment from the commissioner to conduct the external review;
 - (d) The date the external review was conducted;
 - (e) The date of its recommendation;
 - (f) The principal reason or reasons for its recommendation; and
 - (g) The rationale for its recommendation.
- (4) Upon receipt of the assigned independent review organization's recommendation pursuant to Paragraph (1), the commissioner immediately shall review the recommendation to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the recommendation is experimental or investigational, the recommendation is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines “experimental” or “investigational” because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

- L. (1) (a) Except as provided in Subparagraph (b), within ten (10) days after the date of receipt of the assigned independent review organization’s recommendation provided pursuant to Subsection K, the commissioner shall complete the review and notify the covered person, the covered person’s authorized representative, if applicable, and the health carrier in writing of the decision.
- (b) For an expedited external review, within two (2) days after the date of receipt of the assigned independent review organization’s recommendation provided pursuant to Subsection K, the commissioner shall complete the review and orally or in writing notify the covered person, the covered person’s authorized representative, if applicable, and the health carrier of the decision.
- (2) The commissioner shall include in a written notice sent pursuant to Paragraph (1):
 - (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 by the assigned independent review organization in regard to its recommendation pursuant to Subsection K; and
 - (b) If appropriate, the principal reason or reasons why the commissioner did not follow the assigned independent review organization’s recommendation.
- (3) If the notice provided pursuant to Paragraph (1)(b) was not in writing, within two (2) days after the date of providing that notice, the commissioner shall:
 - (a) Provide written confirmation of the decision to the covered person, if applicable, the covered person’s authorized representative, and the health carrier; and
 - (b) Include the information set forth in Paragraph (2).
- (4) Upon receipt of a notice of a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

Option 2.

Drafting Note: Option 2 for this section of this Act applies to states that choose not to review the external review decision of an independent review organization as in Option 1. Option 2 requires covered persons to file all requests for external review with the commissioner. The commissioner then conducts a preliminary review of the request for external review to ensure that it meets all of the requirements to be eligible for external review. If the commissioner determines that the request meets specified requirements to be eligible for external review, the commissioner then assigns an independent review organization to conduct the external review.

- A. (1) Within sixty (60) days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 5 of this Act that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person’s authorized representative may file a request for external review with the commissioner.
- (2) (a) A covered person or the covered person’s authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to Paragraph (1) if the covered person’s treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

- (b) Upon receipt of a request for an expedited external review that meets the reviewability requirements of Subsection C, the commissioner immediately shall assign an independent review organization as set forth in Subsection E to conduct the review.
- B.
 - (1) Upon receipt of a request for external review pursuant to Subsection A, 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) For an expedited external review request made pursuant to Subsection A(2), at the time the health carrier receives the notice pursuant to Paragraph (1), 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 manner.
- C. Except for a request for an expedited external review made pursuant to Subsection A(2), within five (5) days after the date of receipt of a request for external review, the commissioner shall complete a preliminary review of the request to determine whether:
 - (1) The individual is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or 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 or treatment was provided;
 - (2) The recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:
 - (a) Reasonably appears to be 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; and
 - (b) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier;
 - (3) The covered person's treating physician has certified that one of the following situations is applicable:
 - (a) Standard health care services or treatments have not been effective in improving the condition of the covered person;
 - (b) Standard health care services or treatments are not medically appropriate for the covered person; or
 - (c) 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 Paragraph (4);
 - (4) The covered person's treating physician:
 - (a) Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments; or
 - (b) Who 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, has 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;

- (5) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 7 of this Act; and
 - (6) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under Section 5B of this Act.
- D.
- (1) Upon completion of the preliminary review pursuant to Subsection C, the commissioner immediately shall notify the covered person and, if applicable, the covered person's authorized representative in writing whether:
 - (a) The request is complete; and
 - (b) The request has been accepted for external review.
 - (2) If the request is accepted for external review, the commissioner shall:
 - (a) Include in the notice provided pursuant to Paragraph (1) a statement that the covered person or the covered person's authorized representative may submit to the commissioner in writing within seven (7) days following the date of receipt of the notice additional information and supporting documentation that each clinical peer reviewer selected by the assigned independent review organization pursuant to Subsection E shall consider when conducting the external review; and
 - (b) Immediately notify the health carrier in writing of the acceptance of the request for external review.
 - (3) If the request:
 - (a) 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; or
 - (b) Is not accepted for external review, the commissioner shall inform the covered person, the covered person's authorized representative, if applicable, and the health carrier in writing of the reasons for its nonacceptance.
- E.
- (1) At the time a request is accepted for external review pursuant to Subsection A(2) or Subsection D, the commissioner shall assign an independent review organization that has been approved pursuant to Section 13 of this Act that:
 - (a) Will be responsible for selecting one or more clinical peer reviewers, as it determines is appropriate, to conduct the external review; and
 - (b) Based on the opinion of the clinical peer reviewer, or opinions if more than one clinical peer reviewer has been selected to conduct the external review, shall make a decision to uphold or reverse the adverse determination or final adverse determination.
 - (2)
 - (a) Immediately upon assignment under Paragraph (1), the independent review organization shall select one or more clinical peer reviewers to conduct the external review.
 - (b) In accordance with Subsection I, each clinical peer reviewer shall provide a written opinion to the independent review organization on whether the recommended or requested health care service or treatment should be covered.

- (4) (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3), the health carrier shall notify the covered person, the covered person's authorized representative if applicable, the assigned independent review organization, and the commissioner in writing of its decision.
 - (b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph (a).
 - I. (1) Except as provided in Paragraph (3), within twenty (20) days after being selected in accordance with Subsection E to conduct the external review, each clinical peer reviewer shall provide an opinion to the assigned independent review organization pursuant to Subsection J on whether the recommended or requested health care service or treatment should be covered.
 - (2) Except for an opinion provided pursuant to Paragraph (3), each clinical peer reviewer's opinion shall be in writing and include the following information:
 - (a) A description of the covered person's medical condition;
 - (b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments 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;
 - (c) A description and analysis of any medical or scientific evidence, as that term is defined in Section 3X of this Act, considered in reaching the opinion; and
 - (d) Information on whether the reviewer's rationale for the opinion is based on Subsection J(5)(a) or (b).
 - (3) (a) For an expedited external review, each clinical peer reviewer shall provide an opinion orally or in writing to the assigned independent review organization within five (5) days after being selected in accordance with Subsection E.
 - (b) If the opinion provided in accordance with Subparagraph (a) was not in writing, within two (2) days following the date the opinion was provided, the clinical peer reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under Paragraph (2).
- J. In addition to the documents and information provided pursuant to Subsection B(2) or Subsection F, each clinical peer reviewer selected pursuant to Subsection E, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to Subsection I:
 - (1) The covered person's pertinent medical records;
 - (2) The attending physician or health care professional's recommendation;
 - (3) 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 physician or health care professional;
 - (4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier; and

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines “experimental” or “investigational” because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

- (5) Whether:
 - (a) The recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration for the condition; or
 - (b) Medical or scientific evidence demonstrates that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than 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.

- K. (1) (a) Except as provided in Subparagraph (b), within twenty (20) days after the date it receives the opinion of each clinical peer reviewer pursuant to Subsection I, the assigned independent review organization shall, in accordance with Paragraph (2), make a decision and provide written notice of the decision to:
 - (i) The covered person;
 - (ii) If applicable, the covered person’s authorized representative;
 - (iii) The health carrier; and
 - (iv) The commissioner.

- (b) (i) For an expedited external review, within two (2) days after the date it receives the opinion of each clinical peer reviewer pursuant to Subsection I, the assigned independent review organization shall, in accordance with Paragraph (2), make a decision and provide notice of the decision orally or in writing to the persons listed in Subparagraph (a).

- (ii) If the notice provided under Item (i) was not in writing, within two (2) days after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the persons listed in Subparagraph (a) and include the information set forth in Paragraph (3).

Drafting Note: States may want to consider requiring independent review organizations to identify in the notice provided to commissioner under Subsection K(1) any problem contract or policy provisions, such as ambiguity, found during the conduct of the external review.

- (2) (a) If a majority of the clinical peer reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier’s adverse determination or final adverse determination.

- (b) If a majority of the clinical peer reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier’s adverse determination or final adverse determination.

- (c) (i) If the clinical peer reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical peer reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical peer reviewers pursuant to Subparagraph (a) or (b).

- (ii) The additional clinical peer reviewer selected under Item (i) shall use the same information to reach an opinion as the clinical peer reviewers who have already submitted their opinions pursuant to Subsection I.
 - (iii) The selection of the additional clinical peer reviewer under this subparagraph shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical peer reviewers selected under Subsection E pursuant to Paragraph (1).
- (3) The independent review organization shall include in the notice provided pursuant to Paragraph (1):
 - (a) A general description of the reason for the request for external review;
 - (b) The written opinion of each clinical peer reviewer, including the recommendation of each clinical peer reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
 - (c) The date the independent review organization received the assignment from the commissioner to conduct the external review;
 - (d) The date the external review was conducted;
 - (e) The date of its decision;
 - (f) The principal reason or reasons for its decision; and
 - (g) The rationale for its decision.
- (4) Upon receipt of a notice of a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

Option 3.

Drafting Note: Option 3 for this section of this Act applies to states that choose to establish responsibility for the external review process with the health carrier and require that covered persons file requests for external review with the health carrier. This option also requires the health carrier to assign an independent review organization from the list of approved independent review organizations compiled by the commissioner to conduct a preliminary review of the request and conduct an external review of the request if the request has satisfied specified requirements to be eligible for external review.

- A.
 - (1) Within sixty (60) days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 5 of this Act that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the health carrier.
 - (2)
 - (a) A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to Paragraph (1) if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.
 - (b) Upon receipt of a request for an expedited external review, the health carrier immediately shall assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to Section 13 of this Act to determine whether the request meets the reviewability requirements of Subsection C and, if the request meets those requirements, conduct the review pursuant to Subsection E.

- (c) At the time the health carrier assigns an independent review organization to review the request and, if appropriate, conduct the expedited external review pursuant to Subparagraph (b), 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.
- B. Upon receipt of a request for external review under Subsection A, the health carrier shall send a copy of the request to the commissioner.
- C. Except for a request for an expedited external review made pursuant to Subsection A(2), at the time the health carrier receives a request for an external review, the health carrier shall assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to Section 13 of this Act to conduct a preliminary review of the request to determine whether:
 - (1) The individual is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or 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 or treatment was provided;
 - (2) The recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:
 - (a) Reasonably appears to be 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; and
 - (b) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier;
 - (3) The covered person's treating physician has certified that one of the following situations is applicable:
 - (a) Standard health care services or treatments have not been effective in improving the condition of the covered person;
 - (b) Standard health care services or treatments are not medically appropriate for the covered person; or
 - (c) 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 Paragraph (4);
 - (4) The covered person's treating physician:
 - (a) Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments; or
 - (b) Who 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, has 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;

- (5) The covered person has exhausted the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 7 of this Act; and
 - (6) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under Section 5B of this Act.
- D.
- (1) Within five (5) days after receipt of the request for external review, the independent review organization assigned pursuant to Subsection C shall complete the preliminary review and immediately notify the covered person and, if applicable, the covered person's authorized representative in writing whether:
 - (a) The request is complete; and
 - (b) The request has been accepted for external review.
 - (2) The assigned independent review organization shall include in the notice provided pursuant to Paragraph (1) a statement that the covered person or, if applicable, the covered person's authorized representative may submit in writing to the independent review organization within seven (7) days following the date of receipt of the notice additional information and supporting documentation that each clinical peer reviewer selected by the assigned independent review organization pursuant to Subsection E shall consider when conducting the external review.
 - (3) If the request:
 - (a) Is not complete, the assigned independent review organization 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; or
 - (b) Is not accepted for external review, the assigned independent review organization shall inform the covered person, the covered person's authorized representative, if applicable, the health carrier, and the commissioner in writing of the reasons for its nonacceptance.
 - (4) Whenever a request for external review is accepted for external review, the assigned independent review organization shall notify the health carrier and the commissioner.
- E.
- (1) At the time a request is accepted for external review pursuant to Subsection A(2) or Subsection D(1), the assigned independent review organization shall:
 - (a) Immediately select one or more clinical peer reviewers, as it determines is appropriate, pursuant to Paragraph (2) to conduct the external review; and
 - (b) Based on the opinion of the clinical peer reviewer, or opinions if more than one clinical peer reviewer has been selected to conduct the external review, make a decision to uphold or reverse the adverse determination or final adverse determination.
 - (2)
 - (a) In selecting clinical peer reviewers pursuant to Paragraph (1)(a), the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in Section 14 of this Act and, through clinical experience in the past three (3) years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.
 - (b) Neither the covered person, the covered person's authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

- (3) In accordance with Subsection I, each clinical peer reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.
 - (4) In reaching an opinion, clinical peer reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] or the health carrier's internal grievance process as set forth in [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].
- F.
- (1) Within seven (7) days after the date of receipt of the notice provided pursuant to Subsection D(4), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization, the documents and any information considered in making the adverse determination or the final adverse determination.
 - (2) Except as provided in Paragraph (3), failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in Paragraph (1) shall not delay the conduct of the external review.
 - (3)
 - (a) If the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in Paragraph (1), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
 - (b) Immediately upon making the decision under Subparagraph (a), the independent review organization shall notify the covered person, the covered person's authorized representative, if applicable, the health carrier, and the commissioner.
- G.
- (1) Each clinical peer reviewer selected pursuant to Subsection E shall review all of the information and documents received pursuant to Subsection F and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to Subsection D(2).
 - (2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to Subsection D(2), at the assigned independent review organization immediately shall forward the information to the health carrier.
- H.
- (1) Upon receipt of the information required to be forwarded pursuant to Subsection G(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.
 - (2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to Paragraph (1) shall not delay or terminate the external review.
 - (3) The external review may be terminated only 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 recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.
 - (4)
 - (a) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3), the health carrier shall notify the covered person, the covered person's authorized representative if applicable, the assigned independent review organization, and the commissioner in writing of its decision.
 - (b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph (a).

- I.
 - (1) Except as provided in Paragraph (3), within twenty (20) days after being selected in accordance with Subsection E to conduct the external review, each clinical peer reviewer shall provide an opinion to the assigned independent review organization pursuant to Subsection J on whether the recommended or requested health care service or treatment should be covered.
 - (2) Except for an opinion provided pursuant to Paragraph (3), each clinical peer reviewer's opinion shall be in writing and include the following information:
 - (a) A description of the covered person's medical condition;
 - (b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments 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;
 - (c) A description and analysis of any medical or scientific evidence, as that term is defined in Section 3X of this Act, considered in reaching the opinion; and
 - (d) Information on whether the reviewer's rationale for the opinion is based on Subsection J(5)(a) or (b).
 - (3)
 - (a) For an expedited external review, each clinical peer reviewer shall provide an opinion orally or in writing to the assigned independent review organization within five (5) days after being selected in accordance with Subsection E.
 - (b) If the opinion provided pursuant to Subparagraph (a) was not in writing, within two (2) days following the date the opinion was provided, the clinical peer reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under Paragraph (2).
- J. In addition to the documents and information provided pursuant to Subsection A(2) or Subsection F, each clinical peer reviewer selected pursuant to Subsection E, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to Subsection I:
 - (1) The covered person's pertinent medical records;
 - (2) The attending physician or health care professional's recommendation;
 - (3) 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 physician or health care professional;
 - (4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier; and

Drafting Note: When reviewing health benefit plan policy or contract language describing the terms of coverage under the plan, states may wish to pay particular attention to language that defines "experimental" or "investigational" because of the effect of such a definition on the rights of covered persons to receive benefits under the health benefit plan.

 - (5) Whether:
 - (a) The recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration for the condition; or

- (b) Medical or scientific evidence demonstrates that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than 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.
- K. (1) (a) Except as provided in Subparagraph (b), within twenty (20) days after the date it receives the opinion of each clinical peer reviewer pursuant to Subsection I, the assigned independent review organization, in accordance with Paragraph (2), shall make a decision and provide written notice of the decision to:
- (i) The covered person;
 - (ii) If applicable, the covered person's authorized representative;
 - (iii) The health carrier; and
 - (iv) The commissioner.
- (b) (i) For an expedited external review, within two (2) days after the date it receives the opinion of each clinical peer reviewer pursuant to Subsection I, the assigned independent review organization, in accordance with Paragraph (2), shall make a decision and provide notice of the decision orally or in writing to the persons listed in Subparagraph (a).
- (ii) If the notice provided under Item (i) was not in writing, within two (2) days after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the persons listed in Subparagraph (a) and include the information set forth in Paragraph (3).

Drafting Note: States may want to consider requiring independent review organizations to identify in the notice provided to commissioner under Subsection K(1) any problem contract or policy provisions, such as ambiguity, found during the conduct of the external review.

- (2) (a) If a majority of the clinical peer reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.
- (b) If a majority of the clinical peer reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.
- (c) (i) If the clinical peer reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical peer reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical peer reviewers pursuant to Subparagraph (a) or (b).
- (ii) The additional clinical peer reviewer selected under Item (i) shall use the same information to reach an opinion as the clinical peer reviewers who have already submitted their opinions pursuant to Subsection I.
- (iii) The selection of the additional clinical peer reviewer under this subparagraph shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical peer reviewers selected under Subsection E pursuant to Paragraph (1).

- (3) The independent review organization shall include in the notice provided pursuant to Paragraph (1):
 - (a) A general description of the reason for the request for external review;
 - (b) The written opinion of each clinical peer reviewer, including the recommendation of each clinical peer reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
 - (c) The date the independent review organization received the assignment from the health carrier to conduct the preliminary review of the external review request;
 - (d) The date the external review was conducted, if appropriate;
 - (e) The date of its decision;
 - (f) The principal reason or reasons for its decision; and
 - (g) The rationale for its decision.
- (4) Upon receipt of a notice of a decision pursuant to Paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

- L. The assignment by a health carrier of an approved independent review organization to conduct an external review in accordance with this section shall be fair and impartial. The health carrier and the independent review organization shall comply with standards promulgated by the commissioner by regulation to ensure fairness and impartiality in the assignment by health carriers of approved independent review organizations to conduct external reviews, including its term, its termination and payment arrangement.

Section 11. Binding Nature of External Review Decision

Option 1.

Drafting Note: Option 1 for this section of this Act applies to states that choose to follow Option 1 for Sections 8 and 9 of this Act in establishing their external review processes where the commissioner makes the external review decision.

- A. An external review decision is binding on the health carrier except to the extent the health carrier has other remedies available under applicable state law.

Drafting Note: States may wish to review their administrative procedure rules to see how they impact this section. In their review, states should pay particular attention to whether health carriers have a right to an automatic stay for any departmental decision, including an external review decision.

- B. An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.
- C. 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 pursuant to this Act.

Option 2.

Drafting Note: Option 2 for this section of this Act applies to states that choose to follow Option 2 or Option 3 for Sections 8 and 9 of this Act in establishing their external review processes where the independent review organization makes the external review decision.

- A. An external review decision is binding on the health carrier.
- B. An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

- C. 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 pursuant to this Act.

Drafting Note: Regardless of whether a state uses Option 1 or Option 2 for this section of this Act, states may wish to add a provision that specifies whether an external review decision made in accordance with this Act is subject to the state's Administrative Procedure Act.

Section 12. Filing Fees (Optional)

- A. Except in the case of a request for an expedited external review, at the time of filing a request for external review, the covered person or the covered person's authorized representative shall submit to the commissioner with the request a filing fee of [\$25].
- B. The commissioner may waive the filing fee upon a showing of undue financial hardship.
- C. The filing fee shall be refunded to the person who paid the fee if the external review results in the reversal of the health carrier's adverse determination or final adverse determination that was the subject of the external review.

Drafting Note: This section is optional. Many states do not require filing fees for external reviews.

Section 13. Approval of Independent Review Organizations

- A. The commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this Act to ensure that an independent review organization satisfies the minimum qualifications established under Section 14 of this Act.
- B. The commissioner shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.
- C.
 - (1) Any independent review organization wishing to be approved to conduct external reviews under this Act shall submit the application form and include with the form all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under Section 14 of this Act.
 - (2) The commissioner may charge an application fee that independent review organizations shall submit to the commissioner with an application for approval and reapproval.
- D.
 - (1) An approval is effective for two (2) years, unless the commissioner determines before expiration of the approval that the independent review organization is not satisfying the minimum qualifications established under Section 14 of this Act.
 - (2) Whenever the commissioner determines that an independent review organization no longer satisfies the minimum requirements established under Section 14 of this Act, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Act that is maintained by the commissioner pursuant to Subsection E.
- E. The commissioner shall maintain and periodically update a list of approved independent review organizations.
- F. The commissioner may promulgate regulations to carry out the provisions of this section.

Drafting Note: Instead of requiring the commissioner to approve independent review organizations, states may wish to consider accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet the minimum qualifications established pursuant to Section 14 of this Act. Under such an approach, the accrediting entity will make available to the state its current standards to demonstrate that the entity's standards for independent review organizations meet or exceed the minimum qualifications established pursuant to Section 14 of this Act. The private accrediting entity shall file or provide the state with documentation that an independent review organization has been accredited by the entity. An independent review organization accredited by the private accrediting entity then would be deemed to have met the requirements of this section and Section 14 of this Act except for the requirement that the independent review organization maintain the information required under Section 16 of this Act. States should periodically review an independent review organization's private accreditation and eligibility for deemed compliance. Also, states may wish to consider utilizing a mechanism for monitoring the performance of an independent review organization, such as a peer review organization.

Section 14. Minimum Qualifications for Independent Review Organizations

A. To be approved under Section 13 of this Act to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in Sections 8 and 9 of this Act that include, at a minimum:

- (1) A quality assurance mechanism in place that:
 - (a) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;
 - (b) Ensures the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases;
 - (c) Ensures the confidentiality of medical and treatment records and clinical review criteria; and
 - (d) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this Act;
- (2) A toll-free telephone service to receive information on a 24-hour-day, 7-day-a-week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

Drafting Note: Paragraph (2) may not be necessary if the office of the commissioner is involved in the external review process. In such a case, the commissioner should maintain a toll-free telephone number for this purpose.

- (3) Agree to maintain and provide to the commissioner the information set out in Section 16 of this Act.
- B. All clinical peer reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:
- (1) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;
 - (2) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;
 - (3) Hold a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

- (4) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental or professional competence or moral character.
- C. In addition to the requirements set forth in Subsection A, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of health care providers.
- D. (1) In addition to the requirements set forth in Subsections A, B and C, to be approved pursuant to Section 13 of this Act to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:
- (a) The health carrier that is the subject of the external review;
 - (b) The covered person whose treatment is the subject of the external review or the covered person's authorized representative;
 - (c) Any officer, director or management employee of the health carrier that is the subject of the external review;
 - (d) The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;
 - (e) The facility at which the recommended health care service or treatment would be provided; or
 - (f) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review.
- (2) In determining whether an independent review organization or a clinical peer reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of Paragraph (1), the commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in Paragraph (1), but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical peer reviewer from conducting the external review.

Drafting Note: In applying Subsection D, states should be aware that conflict of interest questions involving independent review organizations and clinical peer reviewers might arise in a variety of situations. For example, conflict of interest questions may arise when a health care provider, including a physician or other health care professional, who is a clinical peer reviewer for an independent review organization or an academic medical center, or other similar medical research center, which is seeking to be an approved independent review organization, has a contract to provide health care services to enrollees of the health carrier that is the subject of an external review or when a health care provider, including a physician or other health care professional, who is a clinical peer reviewer for an independent review organization, has staff privileges at the facility where the recommended health care service or treatment would be provided if the health carrier's adverse or final adverse determination is reversed. The question for states to consider is whether a relationship or connection with persons involved in an external review is a material conflict of interest such that the objectivity of the independent review organization to be assigned to conduct the external review or any clinical peer reviewer to be assigned by the independent review organization to conduct the external review may actually be or may be perceived to be negatively impacted. Whether the relationship or connection is a material conflict of interest will depend on the characteristics of each state's market. Therefore, states should consider adding provisions to this section that provide additional guidelines or procedures to address this issue given their local market characteristics.

Section 15. Hold Harmless for Independent Review Organizations

No independent review organization or clinical peer reviewer working on behalf of an independent review organization shall be liable in damages to any person for any opinions rendered during or upon completion of an external review conducted pursuant to this Act, unless the opinion was rendered in bad faith or involved gross negligence.

Section 16. External Review Reporting Requirements

- A.
 - (1) An independent review organization assigned pursuant to Section 8 or Section 9 of this Act to conduct an external review shall maintain 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 and submit a report to the commissioner, as required under Paragraph (2).
 - (2) Each independent review organization required to maintain written records on all requests for external review pursuant to Paragraph (1) 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.
 - (3) The report shall include in the aggregate and for each health carrier:
 - (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 pursuant to Section 8G of this Act 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; and
 - (f) Any other information the commissioner may request or require.
 - (4) The independent review organization shall retain the written records required pursuant to this subsection for at least three (3) years.
- B.
 - (1) Each health carrier shall maintain 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 pursuant to this Act.
 - (2) Each health carrier required to maintain written records on all requests for external review pursuant to Paragraph (1) shall submit to the commissioner, at least annually, a report in the format specified by the commissioner.
 - (3) The report shall include in the aggregate and by type of health benefit plan:
 - (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 pursuant to Section 8G of this Act 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; and
 - (g) Any other information the commissioner may request or require.
- (4) The health carrier shall retain the written records required pursuant to this subsection for at least three (3) years.

Section 17. Funding of External Review

The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

Section 18. Disclosure Requirements

- A. Each health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons.
- B. The description required under Subsection A shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the commissioner. The statement may explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness. The statement shall include the telephone number and address of the commissioner.

Drafting Note: States that have not established an external review process in the office of the commissioner, such as those states that adopt Option 3 in Sections 8 and 9 of this Act, may wish to use the following provision in Subsection B: "The description required under Subsection A shall include a statement of the right of the covered person to contact the commissioner for assistance at any time. The statement shall include the telephone number and address of the commissioner."

- C. In addition to Subsection B, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

Section 19. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 20. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 21. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 22. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1999 Proc. 3rd Quarter 8, 21, 856, 856-878, 954 (adopted).

2000 Proc. 2nd Quarter 21, 22, 163, 172, 175, 176-194 (amended).

2003 Proc. 4th Quarter 389, 527, 534-572 (amended, adopted by parent committee).

2004 Proc. 1st Quarter 52 (adopted by Plenary).

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This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

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KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	NO CURRENT ACTIVITY	
Alaska		ALASKA STAT. §§ 21.07.050 to 21.07.250 (2000/2011).
American Samoa	NO CURRENT ACTIVITY	
Arizona		ARIZ. REV. STAT. ANN. §§ 20-2537 to 20-2539 (1997/2013).
Arkansas		054.00.76 ARK. CODE R. § 1 to 19; Apps. A to D (2011/2012); BULLETIN 10-2011 (2011).
California		CAL. HEALTH & SAFETY CODE § 1370.4 (1997/2001); CAL. INS. CODE § 10145.3 (1996/2001); CAL. INS. CODE §§ 10169 to 10169.5 (1999/2015); Notice 5-17-2011 (2011).
Colorado		COLO. REV. STAT. § 10-16-113.5 (2013); 3 COLO. CODE REGS. § 702-4-2-21 (2010); 3 COLO. CODE REGS. § 702-4-4-2-17 (1997/2013); BULLETIN B-4.20 (2015).
Connecticut		CONN. GEN. STAT. §§ 38a-591a to 38a-591i (2011/2013); BULLETIN HC-74 (2009); BULLETIN HC-84 (2011); BULLETIN HC-93 (2013).
Delaware		DEL. CODE ANN.tit.18, § 332 (1996/2012).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
District of Columbia		D.C. CODE §§ 44-301.01 to 44-301.11 (1998/2012).
Florida		FLA. STAT. § 408.7056 (1985/2004); Memorandum 2010-006 (2010); Memorandum 2011-07 (2011).
Georgia	NO CURRENT ACTIVITY	
Guam	NO CURRENT ACTIVITY	
Hawaii		HAWAII REV. STAT. §§ 432A to 432E-6 (1998/2011).
Idaho		IDAHO CODE ANN. §§ 41-5901 to 41-5917 (2009/2011); IDAHO ADMIN. CODE r. 18.01.05.000 to 18.01.05.030 (2009/2012); BULLETIN 2009-8 (2009); BULLETIN 2011-4 (2011).
Illinois		215 ILL. COMP. STAT. 180/5 to 180/75 (2010); 215 ILL. COMP. STAT. 134/45 (2000); ILL. ADMIN. CODE tit. 50, §§ 5430.10 to 5430.90; Apps. A to F (2015); Memorandum 5-27-2010 (2010); BULLETIN 2011-10 (2011).
Indiana		IND. CODE §§ 27-8-29-1 to 27-8-29-24 (2001/2003); §§ 27-13-10.1-1 to 27-13-10.1-12 (1999/2011) (HMOs); BULLETIN 99 (1999); BULLETIN 188 (2011).
Iowa		IOWA CODE §§ 514J.101 to 514J.120 (2011/2014); IOWA ADMIN. CODE r. 191-76.1 to 191-76.9 (1999/2012).
Kansas		KAN. STAT. ANN. §§ 40-22a13 to 40-22a16 (2000); KAN. ADMIN. REGS. §§ 40-4-42 to 40-4-42j (2000/2012).
Kentucky		KY. REV. STAT. ANN. §§ 304.17A-621 to 304.17A-633 (2000/2004); 806 KY. ADMIN. REGS. 17:290 (2001/2008); BULLETIN 2011-4 (2011).
Louisiana		LA. REV. STAT. ANN. §§ 22:2431 to 22:2445 (2013).
Maine		ME. REV. STAT. ANN. tit. 24-A, § 4312 (2000/2013).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Maryland		MD. CODE ANN. INS. §§ 15-10A-01.1 to 15-10A-5 (1998/2001); MD. CODE REGS. 31.10.18.02 to 31.10.18.15 (1999/2005); BULLETIN 2010-30 (2010).
Massachusetts		MASS. GEN. LAWS ANN. ch. 176O § 14 (2001/2013); 105 MASS. CODE REGS. 128:400 to 128:416 (2004/2011); 211 MASS. CODE REGS. 52.03 to 52.16 (2001/2005); 958 MASS. CODE REGS. 3.400 to 3.417 (2014).
Michigan	MICH. COMP. LAWS §§ 550.1901 to 550.1921 (2000/2001).	
Minnesota		MINN. STAT. § 62Q.73 (2000/2013).
Mississippi		19-1 MISS. CODE R. § 15.01 to 15.24 (2012/2014).
Missouri		MO. REV. STAT. § 376.1387 (1997); MO. CODE REGS. ANN. tit. 20, § 100-5.020 (1998/2012); BULLETIN 2011-08 (2011).
Montana		MONT. CODE ANN. §§ 33-32-401 to 33-32-423 (2015).
Nebraska	NEB. REV. STAT. §§ 44-1301 to 44-1318 (2013/2016).	BULLETIN CB-123 (2011).
Nevada		NEV. REV. STAT. §§ 616C.360 to 616C.363 (2013); NEV. ADMIN. CODE §§ 683A.600 to 683A.670 (2004); BULLETIN 2011-013 (2011).
New Hampshire		N.H. REV. STAT. ANN. §§ 420-J:5-a to 420-J:5-e (2000/2012); N.H. CODE R. INS. 2703.01 to 2703.09 (2001); BULLETIN 2006-041-ab (2006); BULLETIN 11-019-AB (2011).
New Jersey		N.J. REV. STAT. §§ 26:2S-11 to 26:2S-12 (1997); N.J. ADMIN. CODE § 8:38-8.7 (1997/2002).
New Mexico		N.M. STAT. ANN. § 59A-57-4.1 (2003); N.M. CODE R. §§ 13.10.17.23 to 13.10.17.32 (2000/2004); BULLETIN 2010-006 (2010); BULLETIN 2011-012 (2011).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
New York		N.Y. INS. LAW §§ 4910 to 4914 (1999/2014); N.Y. COMP. CODES R. & REGS. tit. 11, §§ 410.1 to 410.13 (2001/2008) (Regulation 166).
North Carolina	N.C. GEN. STAT. §§ 58-50-75 to 58-50-95 (2002/2014) (portions of model).	Memorandum 8-28-2009 (2009).
North Dakota		N.D. CENT. CODE § 26.1-36-44 (2005/2011); § 26.1-36-46 (2011).
Northern Marianas	NO CURRENT ACTIVITY	
Ohio		OHIO REV. CODE ANN. §§ 3922.01 to 3922.23 (2011/2012).
Oklahoma		OKLA. STAT. tit. 63, §§ 6475.1 to 6475.17 (2011/2013); OKLA. ADMIN. CODE §§ 365:10-29-1 to 365:10-29-10 (2011/2012).
Oregon		OR. REV. STAT. §§ 743b.250 to 743b.258 (2002); OR. ADMIN. R. 836-053-1300 to 836-053-1365 (2002/2014); OR. ADMIN. R. 443-002-0190 (2012).
Pennsylvania		40 PA. STAT. ANN. § 39-1262 (1998); § 1111.1 (1996/2009); Notice 12-31-2011 (2011).
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island		R.I. GEN. LAWS § 23-17.12-1 to 23-17.12-17 (1992/2008).
South Carolina	S.C. CODE ANN. §§ 38-71-1910 to 38-71-2060 (2002).	BULLETIN 01-4 (2001); BULLETIN 4-2011 (2011).
South Dakota		S.D. ADMIN. R. 20:06:53 (2010/2011).
Tennessee		TENN. CODE ANN. §§ 56-61-101 to 56-61-125 (2010).
Texas		TEX. INS. CODE ANN. §§ 4201.401 TO 4201.403 (2007/2009); 28 TEX. ADMIN. CODE §§ 19.1701 TO 19.1719 (2013); BULLETIN B-0051-11 (2011).
Utah		UTAH ADMIN. CODE r. 590-203-1 to 590-203-11 (2002/2011).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Vermont		H-99-1 VT. CODE R. §§ 1 to 13 (1999/2011).
Virgin Islands	NO CURRENT ACTIVITY	
Virginia		14 VA. ADMIN. CODE §§ 5-216-10 to 5-216-70 (2011/2012); VA. CODE ANN. §§ 32.1-137.7 to 32.1-137.17 (1998/2011).
Washington		WASH. REV. CODE § 48.43.535 (2011); WASH. ADMIN. CODE. § 284-43-3210; §§ 284-43-4000 to 4060 (2015).
West Virginia		W. VA. CODE R. §§ 114-97-1 to 114-97-15 (2014); W. VA. CODE R. §§ 114-58-1 to 114-58-13 (2002).
Wisconsin		WIS. STAT. § 632.835 (2000); WIS. ADMIN. CODE INS. §§ 18.10 to 18.18 (2001/2012).
Wyoming	NO CURRENT ACTIVITY	

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