

**Legislative Regulation  
Review Committee**

2010-014

Insurance Department

**UTILIZATION REVIEW & EXTERNAL  
APPEAL**

**IMPORTANT:** Read Instructions on bottom of Certification Page before completing this Form. Failure to comply with instructions may cause disapproval of proposed Regulations.

# REGULATION

OF

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 NAME OF AGENCY  
 INSURANCE DEPARTMENT
 

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Concerning

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 SUBJECT MATTER OF REGULATION
 

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## Updates to External Appeal and Utilization Review Regulations

### SECTION 1

Section 38a-226c-2 of the Regulations of Connecticut State Agencies is amended to read as follows:

#### **Sec. 38a-226c-2. Definitions**

As used in sections 38a-226c-1 to 38a-226c-10, inclusive, of the Regulations of Connecticut State Agencies:

(a) "Adverse determination" means [a determination by a utilization review company not to certify an admission, service, procedure or extension of stay because, based upon the information provided, the request does not meet the utilization review company's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness] "adverse determination" as defined in section 38a-478(1) of the Connecticut General Statutes as amended by Public Act 09-49;

(b) "Business day" means a day during which the state government of Connecticut conducts regular business;

(c) "Commissioner" means the Insurance Commissioner;

(d) "Enrollee" means "enrollee" as defined in section 38a-226 of the Connecticut General Statutes. For purposes of pursuing an appeal only, the term "enrollee" shall include any person the enrollee has designated as his or her legal representative;

(e) "Managed care organization" means "managed care organization" as defined in section 38a-478 of the Connecticut General Statutes;

(f) ["New information" means information that has not been previously made available to a utilization review company or a managed care organization for consideration when determining whether to certify an admission, service, procedure or extension of stay;

(g)] "Patient medical records" means all information, including personally identifiable information, that relates to an individual's health care history, diagnosis, condition, treatment or evaluation that is obtained from any source;

[(h)](g) "Personally identifiable information" means any data that identifies a particular patient. Personally identifiable information includes an individual's name, address and social security number;

[(i)](h) "Provider of record" or "Provider" means "provider of record" or "provider" as defined in section 38a-226 of the Connecticut General Statutes or a provider providing treatment or care to the enrollee and acting on behalf of an enrollee, with the enrollee's written consent;

[(j)] (i) "Utilization review" means "utilization review" as defined in section 38a-226 of the Connecticut General Statutes;

[(k)](j) "Utilization review company" means "utilization review company" as defined in section 38a-226 of the Connecticut General Statutes.

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**SECTION 2**

Section 38a-226c-4 of the Regulations of Connecticut State Agencies is amended to read as follows:

**Sec. 38a-226c-4. Standards**

(a) Pursuant to sections 38a-226c(a)(1)(E) and 38a-226c(a)(2) of the Connecticut General Statutes, each utilization review company shall maintain, and provide with each notice of a determination not to certify an admission, service, procedure or extension of stay, and make available upon request, a written description of the appeal procedure by which either the enrollee or the provider of record acting on behalf of the enrollee with the enrollee's written consent, may seek review of adverse determinations regarding certification of an admission, service, procedure or extension of stay. An appeal by the provider of record shall be deemed to be an enrollee level appeal made on behalf of the enrollee and with the consent of such enrollee if the admission, service, procedure or extension of stay has not yet been provided or if such determination not to certify creates a financial liability to the enrollee. The procedures and written description for appeals shall include the following:

(1) A reasonable period within which an appeal must be filed to be considered by the utilization review company,

(2) Except as provided in subsection (e) of this section, each utilization review company shall make review staff available by toll-free telephone, at least forty (40) hours per week during normal business hours. The utilization review company shall maintain records of duty rosters or other written documentation evidencing the required level of staffing, and

(3) Notification, in bold print, that an appeal of a determination not to certify an admission, service, procedure or extension of stay to the commissioner pursuant to section 38a-478n of the Connecticut General Statutes, must be submitted to the commissioner within ~~[30]~~sixty (60) days of receipt of a final written notice of a determination by the utilization review company.

(b) Pursuant to sections 38a-226c(a)(1)(E) and 38a-226c(a)(2) of the Connecticut General Statutes, each utilization review company shall maintain and provide with each final written notice of a determination not to certify an admission, service, procedure or extension of stay, a statement that all internal appeals have been exhausted for that service and a copy of a pamphlet, created and made available to utilization review companies by the commissioner and reproduced by the utilization review company, containing the procedure and application to appeal to the commissioner pursuant to section 38a-478n of the Connecticut General Statutes. The pamphlet may be created and made available to the utilization review company by the commissioner and shall be reproduced and used by the utilization review company if so made. A copy of the pamphlet shall also be available from the utilization review company to the enrollee, upon request.

(c) If the provider of record or enrollee has provided incomplete information to a utilization review company, the utilization review company shall indicate, in writing, to the provider of record and the enrollee all information that is needed to make a determination regarding certification of an admission, procedure, treatment or length of stay. Upon failure of the provider of record or enrollee to provide such information, the utilization review company shall either: (1) issue a denial of certification, in accordance with the policy of the utilization review company, based on the failure to provide requested documentation; or (2) not issue a denial of certification but rather notify the enrollee and the provider of record, in writing, that no further action will be taken on the matter, until such time as the requested information is received.

(d) An enrollee or provider of record acting on behalf of the enrollee with the enrollee's written consent, may appeal an adverse determination regarding a managed

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care plan in accordance with section 38a-478n of the Connecticut General Statutes. [If the appeal is accepted for full review, the external appeals entity shall immediately notify the enrollee, provider of record, and the utilization review company of their opportunity to submit the information described in subsection (g) of section 38a-478n-3 of the Regulations of Connecticut State Agencies concerning external appeals within five (5) business days from the date of such notice, for consideration during the external appeals entity's review. The external appeals entity shall provide such notice to the enrollee, provider of record, and to the utilization review company either by facsimile machine or by overnight service. The enrollee or provider of record shall state whether any information submitted in accordance with this subsection is new information. Upon receipt of any new information, the external appeals entity shall immediately contact the utilization review company by telephone and notify them that new information has been presented. The external appeals entity shall provide the utilization review company with the new information either by facsimile machine or by overnight service. The utilization review company shall have two (2) business days from receipt of the new information to determine whether the absence of such new information contributed to the adverse determination. If the utilization review company determines that the absence of such new information contributed to the adverse determination the utilization review company shall have the opportunity to reverse its adverse determination. The utilization review company shall promptly notify the external appeals entity of the decision. If the utilization review company's decision is to reverse its adverse determination, the external appeals entity shall promptly notify the enrollee or provider of record and the commissioner that the utilization review company has reversed the adverse determination based upon the new information. Any reversal of an adverse determination by a utilization review company based upon new information shall not be considered a reversal by the commissioner for the purposes of the reporting requirements established by section 38a-478a of the Connecticut General Statutes. ]

(e) If an enrollee has been admitted to an acute care hospital and the attending physician determines that the enrollee's life will be endangered or other serious injury or illness could occur if the patient is discharged or if treatment is delayed, the attending physician may transmit, in accordance with the standardized process developed pursuant to section 38a-478p of the Connecticut General Statutes, a request for an expedited review to the utilization review company. If the attending physician receives no response from the utilization review company after three hours have passed since the attending physician sent the request and all information needed to complete the review, the request shall be deemed approved. Each utilization review company shall make review staff available, daily, from 8:00 A.M. to 9:00 P.M. (eastern time) to process requests pursuant to this subsection.

### **SECTION 3**

Sections 38a-478n-1 to 38a-478n-4, inclusive, of the Regulations of Connecticut State Agencies are amended to read as follows:

#### **Sec. 38a-478n-1. Applicability and scope**

Nothing in Sections 38a-478n-1 to 38a-478n-5, inclusive, shall be construed to apply to:

(a) the arrangements of managed care organizations offered to individuals covered under self-insured employee welfare benefit plans established pursuant to the federal Employee Retirement Income Security Act of 1974, except for self-insured governmental plans; or

(b) any plan that provides for the financing or delivery of health care services solely for the purposes of workers' compensation benefits pursuant to chapter 568 of the general statutes.

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**Sec. 38a-478n-2. Definitions**

As used in Sections 38a-478n-1 to 38a-478n-5, inclusive, of the Regulations of Connecticut State Agencies:

(a) "Adverse determination" [means a determination by a utilization review company or managed care organization not to certify either before, during, or after services are received an admission, service, procedure or extension of stay because, based upon the information provided, the request does not meet the utilization review company or managed care organization's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness] means "adverse determination" as defined in section 38a-478(1) of the Connecticut General Statutes as amended by Public Act 09-49;

(b) [ "Business Day" means a day during which the state government of Connecticut conducts regular business;

(c) "Commissioner" means the Insurance Commissioner;

(d) "Department" means the Insurance Department;

(e) "Enrollee" means a person who has contracted for or who participates in a managed care plan for himself or his eligible dependents who participate in a managed care plan. For purposes of pursuing an appeal only, the term "enrollee" shall include any person the enrollee has designated as his or her legal representative;

(f) "External appeals entity" means an impartial health entity, selected by the commissioner, after consultation with the commissioner of Public Health to provide a binding decision in cases where all internal appeals within a licensed utilization review company or managed care organization have been exhausted;

(g) "Indigent individual" means an individual whose adjusted gross income (AGI) for the individual and spouse, as certified by the individual on a form provided by the commissioner, from the most recent federal tax return filed is less than two hundred percent of the applicable federal poverty level;

(h) "Internal appeals" means the procedures provided by the utilization review company or managed care organization in which either the enrollee or provider acting on behalf of an enrollee may seek review of decisions not to certify an admission, procedure, service or extension of stay;

(i) "Managed care organization" means "managed care organization" as defined in section 38a-478(2) of the Connecticut General Statutes;

(j) "Managed care plan" means "managed care plan" as defined in section 38a-478(3) of the Connecticut General Statutes;

(k) "Provider" means a person licensed (k) to provide health care services of the type specified in chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c, inclusive, of the Connecticut General Statutes, or chapter 400j of the Connecticut General Statutes;

(l) "Provider of record" means the physician or other licensed practitioner identified to the utilization review company or managed care organization as having responsibility for the care, treatment and services rendered to an individual;

(m) "Utilization review" means "utilization review" as defined in section 38a-226 of the Connecticut General Statutes; and

(n) "Utilization review company" means "utilization review company" as defined in section 38a-226 of the Connecticut General Statutes. ] "Authorized representative" means "authorized representative" as defined in section 38a-478n of the Connecticut General Statutes;

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(c) "Business Day" means a day during which the state government of Connecticut conducts regular business;

(d) "Commissioner" means the Insurance Commissioner;

(e) "Covered benefit" or "benefit" means "covered benefit" or "benefit" as defined in section 38a-478(3) of the Connecticut General Statutes ;

(f) "Department" means the Insurance Department;

(g) Except as provided in sections 38a-478m and 38a-478n of the Connecticut General Statutes, "enrollee" means a person who has contracted for or who participates in a managed care plan for himself or his eligible dependents who participate in a managed care plan. For purposes of pursuing an appeal only, the term "enrollee" shall include any person the enrollee has designated as his or her legal representative;

(h) "Health insurer" means "health insurer" as defined in section 38a-478n(a) as amended by Public Act 09-49 of the Connecticut General Statutes;

(i) "Health care services" means "health care services" as defined in section 38a-478(5) of the Connecticut General Statutes as amended by Public Act 09-49;

(j) "Indigent individual" means an individual whose adjusted gross income (AGI) for the individual and spouse, as certified by the individual on a form provided by the commissioner, from the most recent federal tax return filed is less than two hundred percent of the applicable federal poverty level;

(k) "Internal appeals" means the procedures provided by the utilization review company or managed care organization in which either the enrollee or provider acting on behalf of an enrollee may seek review of decisions not to certify an admission, procedure, service or extension of stay;

(l) "Managed care organization" means "managed care organization" as defined in section 38a-478(6) of the Connecticut General Statutes as amended by Public Act 09-49;

(m) "Managed care plan" means "managed care plan" as defined in section 38a-478(7) of the Connecticut General Statutes as amended by Public Act 09-49;

(n) "New information" means information that has not been previously made available to the managed care organization, health insurer or utilization review company for consideration when determining whether to certify an admission, service, procedure or extension of stay;

(o) "Preferred provider network" has the same meaning as provided in section 38a-479aa of the Connecticut General Statutes;

(p) "Provider" or "health care provider" means "provider" or "health care provider" as defined in section 38a-478(9) of the Connecticut General Statutes as amended by Public Act 09-49;

(q) "Provider of record" means the physician or other licensed practitioner identified to the utilization review company or managed care organization as having responsibility for the care, treatment and services rendered to an individual;

(r) "Review entity" means "review entity" as defined in section 38a-478(10) of the Connecticut General Statutes as amended by Public Act 09-49;

(s) "Standard External Appeal" means an external appeal that is not expedited.

(t) "Utilization review" means "utilization review" as defined in section 38a-226 of the Connecticut General Statutes; and

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(u) "Utilization review company" means "utilization review company" as defined in section 38a-226 as amended by Public Act 09-49 of the Connecticut General Statutes.

**Sec. 38a-478n-3. External appeals**

(a) Any enrollee, or any provider acting on behalf of an enrollee with the enrollee's consent, who, except for expedited external appeals, has exhausted the internal mechanisms provided by a managed care organization, health insurer or utilization review company to appeal the denial of a claim based on medical necessity or a determination not to certify an admission, service, procedure or extension of stay, regardless of whether such determination was made before, during or after the admission, service, procedure or extension of stay, may appeal such denial or determination to the commissioner. An enrollee or any provider acting on behalf of the enrollee with the enrollee's consent may make a request to the commissioner for an expedited external appeal at the time the enrollee receives an adverse determination if: (1) The time frame for completion of an expedited internal appeal set forth in section 38a-226c of the Connecticut General Statutes, as amended by Public Act 09-49, may cause or exacerbate an emergency or life-threatening situation for the enrollee; and (2) the enrollee or the provider acting on behalf of the enrollee with the enrollee's consent has filed a request for expedited review as set forth in section 38a-226c of the Connecticut General Statutes, as amended by Public Act 09-49. (3) Upon receipt of such request and all required documentation, including the executed release and appropriate fee set forth in subsection (b) of this section, the commissioner shall immediately assign the appeal for review to a review entity.

(b) To appeal a denial or determination pursuant to this section an enrollee or any provider acting on behalf of an enrollee with the enrollee's written consent shall, not later than [thirty (30)]sixty (60) days after receiving final written notice of the denial or determination from the enrollee's managed care organization, health insurer or utilization review company, file a written request with the commissioner. The appeal shall be on forms prescribed by the commissioner and shall include the filing fee set forth in section 38a-478n of the general statutes, [and] a general release executed by the enrollee for all medical records pertinent to the appeal and any other items the commissioner deems relevant for the appeal. The managed care organization, health insurer or utilization review company named in the appeal shall also pay to the commissioner the filing fee set forth in section 38a-478n of the general statutes. The commissioner shall waive the filing fee, on request, for individuals who demonstrate that they are indigent or unable to pay.

(c) For the purposes of sections 38a-478n-1 to 38a-478n-5, inclusive, of the Regulations of Connecticut State Agencies, not later than five (5) business days after receiving a written request from the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, or in the case of an expedited external appeal, not later than one (1) business day, a managed care organization, health insurer or utilization review company whose enrollee is the subject of an appeal shall:

(1) provide to the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, written verification of whether the enrollee's managed care plan or health insurance is fully insured, self-funded, or otherwise funded, and

(2) If the plan is a fully insured plan or a self-insured governmental plan, the managed care organization, health insurer or utilization review company shall send: (A) Written certification to the commissioner or [reviewing]review entity, as determined by the commissioner, that the benefit or service subject to the appeal is a covered benefit or service; (B) a copy of the entire policy or contract between the enrollee and the managed care organization or health insurer, except that with respect to a self-insured governmental plan, (i) the managed care organization or health insurer shall notify the plan sponsor, and (ii) the plan sponsor shall send, or require the managed care organization or health insurer to send, such copy; or (C) written certification that the

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policy or contract is accessible to the review entity electronically and clear and simple instructions on how to electronically access the policy.

(d) The commissioner shall assign the appeal to [an external appeals]review entity for review. In making such an assignment the commissioner shall consider the level of expertise of the entity to review the particular procedure or service for which the certification was denied. [The commissioner may consider recommendations regarding the choice of an appropriate entity for an appeal.]

(e) Within five (5) business days of receipt of the request for appeal from the commissioner, or in the case of an expedited external appeal, not later than two (2) business days, the [external appeals]review entity shall conduct a preliminary review of the appeal and accept it for full review if it determines that:

(1) the individual was or is an enrollee of the managed care organization or health insurer;

(2) the benefit or service that is the subject of the complaint or appeal reasonably appears to be a covered service or benefit under the agreement provided by contract to the enrollee and any benefit limitations have not been exhausted;

(3) for standard external appeals, all internal appeals have been exhausted, or in the case of expedited external appeal, the adverse determination may cause or exacerbate an emergency or life-threatening situation for the enrollee if not reviewed in an expedited time period; and

(4) the appeal includes all information required by the commissioner.

(f) [Upon completion of the preliminary review, the external appeals entity shall notify the commissioner, and the enrollee or provider of record, in writing as to whether the appeal has been accepted for full review and, if not so accepted, the reasons therefore. If the appeal is accepted for full review, the entity shall immediately notify either by facsimile machine or by overnight service, the enrollee or provider of record and the managed care organization or utilization review company of their opportunity to submit the information specified in subsection (g) of this section within five (5) business days from the date of such notice for consideration during its review.]Upon completion of the preliminary review, the review entity shall immediately notify the commissioner, the managed care organization, health insurer or utilization review company, enrollee and provider of record by either electronic mail, facsimile machine or by overnight service as to whether the appeal has been accepted for full review and, if not so accepted, the reasons therefore. No later than five (5) business days, or in the case of an expedited external appeal no later than (1) business day from the date of such notice of acceptance for full review, the managed care organization, health insurer or utilization review company shall provide to such review entity by electronic mail, telephone, facsimile or other expeditious method all documents and information that were considered in making the adverse determination that is the subject of such appeal. In the case of a standard external appeal, the notification of acceptance for full review shall state the opportunity to submit new information such as is specified in subsection (g) of this section within five (5) business days from the date of such notice for consideration during its review. Upon receipt of any additional information, the [external appeals] review entity shall determine if this is new information and if so immediately contact the managed care organization, health insurer or utilization review company by electronic mail, facsimile, or telephone and notify them that new information has been presented. The review entity shall provide the managed care organization, health insurer or utilization review company with the new information either by electronic mail, facsimile machine or by overnight service. The managed care organization, health insurer or utilization review company shall have two (2) business days from receipt of the new information to determine whether the absence of such new information contributed to the adverse determination. If the managed care organization, health insurer or utilization review company determines that the absence of such new information contributed to the adverse determination the managed care organization, health insurer or utilization review company shall have the opportunity to reverse its

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adverse determination. The managed care organization, health insurer or utilization review company shall promptly notify the review entity of the decision. If the managed care organization, health insurer or utilization review company's decision is to reverse its adverse determination, the review entity shall promptly notify the enrollee or provider of record and the commissioner that the managed care organization, health insurer or utilization review company has reversed the adverse determination based upon the new information. Any reversal of an adverse determination by a managed care organization, health insurer or utilization review company based upon new information shall not be considered a reversal by the commissioner for the purposes of the reporting requirements established by section 38a-478a of the Connecticut General Statutes.

(g) Upon acceptance of the appeal for review, the [external appeals]review entity shall conduct a full review to determine whether the adverse determination should be reversed, revised, or sustained. Such review shall be performed by a provider who is a specialist in the field related to the condition that is the subject of the appeal. The reviewing provider may take into consideration:

(1) pertinent medical records,

(2) consulting [physician reports]reports from appropriate health care professionals and other documents submitted by the health insurer, enrollee, the enrollee's authorized representative or the enrollee's provider,

(3) practice guidelines developed by the federal government, national, state or local medical societies, boards or associations, [and]

(4) clinical protocols or practice guidelines developed by the utilization review company or managed care organization[.], and

(5) such other criteria as set forth in section 38a-478n(e)(5) of the Connecticut General Statutes as amended by Public Act 09-49.

For the purposes of this subdivision, "authorized representative" means (i) a person to whom an enrollee has given express written consent to represent such enrollee in an external appeal, (ii) a person authorized by law to provide substituted consent for an enrollee, or (iii) a family member of the enrollee when such enrollee is unable to provide consent.

(h) The [external appeals]review entity shall complete its review and forward its decision to affirm, revise, or reverse the adverse determination to the commissioner within thirty (30) business days of completion of the preliminary review or in the case of expedited external appeal two (2) business days, together with a report of its review. The [external appeals]review entity may request an extension of time from the commissioner within which to complete its review as may be necessary due to circumstances beyond its control. If an extension is granted, the [external appeals]review entity shall provide written notice to the enrollee or provider, setting forth the status of its review, the specific reasons for the delay and the anticipated date of completion of the review.

(i) The commissioner may reassign an appeal to another [external appeals]review entity if the commissioner determines (1) that a conflict of interest exists which may negatively impact the objectivity of the review entity to which the appeal was initially assigned or (2) that the review entity to which an appeal was assigned is unable to complete its review within a reasonable time.

(j) The commissioner shall accept the decision of the [external appeals]review entity and notify the enrollee or provider and the utilization review company, health insurer or managed care organization of the decision, which shall be binding. The report of the [external appeals]review entity's review shall be made available to the enrollee or provider and the utilization review company, health insurer or managed care organization. The decision of the [external appeals]review entity shall not be construed as authorizing services in excess of those that are contractually provided for in the enrollee's managed care plan or health insurance plan.

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(k) The request for appeal submitted by the enrollee or provider of record, the associated materials received by the managed care organization, health insurer or utilization review company, the decision of the [external appeals] review entity, and communication by and between the commissioner, the [external appeals]review entity and the enrollee shall be maintained as confidential information protected by section 38a-8 of the Connecticut General Statutes.

**Sec. 38a-478n-4. External appeals entities**

(a) The commissioner shall enter into agreements for external appeals services with as many [external appeals]review entities as he deems necessary after consultation with the Commissioner of Public Health. The agreements shall set forth all terms which the commissioner deems necessary to assure a full and fair review of appeals. Selection of [an external appeals]a review entity shall include, but not be limited to, [review of the entity's application with regard to the following:

- (1) proposed scope of services;
- (2) fee structure;
- (3) number and qualifications of reviewers;
- (4) procedures to ensure the confidentiality of health care information;
- (5) procedures to ensure the neutrality of reviewers;
- (6) administrative and operational policies and procedures; and

(7) procedures to ensure that no conflict of interest exists among the entity and its reviewers and managed care organizations or the case under review.] the criteria set forth in section 38a-478n of the Connecticut General Statutes as amended by Public Act 09-49.

(b) After entering into an agreement with the commissioner, the entity shall report changes in its ownership, operational or administrative status to the commissioner within thirty (30) days of the effective date of such change. If the commissioner determines that the reported change(s) may negatively impact the effectiveness or objectivity of the external appeals entity, the commissioner reserves the right to terminate the agreement.

(c) Any agreement may be terminated without cause by either party upon [ninety (90)] fifteen (15) days written notice, except that the commissioner may terminate an agreement with [an external appeals entity at any time if the commissioner determines that continuation of the agreement may result in unfair, biased or unreliable determinations which pose a threat to the public health]a review entity is not satisfying the minimum qualifications set forth in section 38a-478n of the Connecticut General Statutes as amended by Public Act 09-49.

**Statement of purpose:**

To amend the external appeal regulations to conform to legislative changes enacted through Public Act 09-49.

**A. The problems, issues or circumstances that the regulation proposes to address.**

This proposed regulation amends the current external appeal regulations to reflect the amendments made to the external appeal statute which was revised to adopt provisions of the NAIC Model External Appeal Law.

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**B. A summary of the main provisions of the regulation.**

The regulation provides the processes used to address expedited and standard external appeal.

**C. The legal effects of the regulation, including all ways that the regulation would change existing regulations or other laws.**

No other laws or regulations will be affected.

**D. Impact on small businesses**

As required by Conn. Gen. Stat. § 4-168a as amended by Public Act 09-19, the Insurance Department considered the impact of the proposed amended regulations on small business, and in doing so, determined that the preparation of a regulatory flexibility analysis, as contemplated by this statute, was not needed. The amendments reflect activities to be undertaken by insurers, managed care organizations, and utilization review companies to support an individual's external appeal. The organizations are not considered to be small businesses under the statutory definition.

**CERTIFICATION**

R-39 REV. 1/77

Be it known that the foregoing:

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X Regulations  Emergency Regulations

Are:

Adopted  Amended as hereinabove stated  Repealed

By the aforesaid agency pursuant to:

Section \_\_\_\_\_ of the General Statutes.

Section 38a-226c, 38a-478n of the General Statutes, as amended by Public Act No. 49 of the 2009 Public Acts.

Public Act No. \_\_\_\_\_ of the Public Acts.

After publication in the Connecticut Law Journal on, \_\_\_\_\_ and \_\_\_\_\_ of the notice of the proposal to:

Adopt  Amend  Repeal such regulations

(If applicable):  And the holding of an advertised public hearing on \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

WHEREFORE, the foregoing regulations are hereby:

Adopted  Amended as hereinabove stated  Repealed

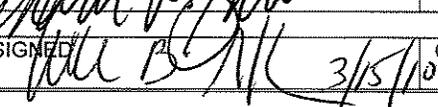
Effective:

X When filed with the Secretary of the State.

(OR)

The \_\_\_\_\_ day of \_\_\_\_\_.

In Witness Whereof:	DATE <u>3/1/10</u>	SIGNED (Head of Board, Agency or Commission) 	OFFICIAL TITLE, DULY AUTHORIZED INSURANCE COMMISSIONER
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Approved by the Attorney General as to legal sufficiency in accordance with Sec. 4-169, as amended, C. G. S. :	SIGNED 	DATE <u>3/15/10</u>	OFFICIAL TITLE, DULY AUTHORIZED ASSOC. ATTY. GENERAL
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- Approved
- Disapproved
- Disapproved in part, (Indicate Section Numbers disapproved only)
- Rejected without prejudice.

By the Legislative Regulation Review Committee in accordance With Sec. 4-170, as amended, of the General Statutes.	DATE	SIGNED (Clerk of the Legislative Regulation Review Committee)
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Two certified copies received and filed, and one such copy forwarded to the Commission on Official Legal Publications in accordance with Section 4-172, as amended, of the General Statutes.

DATE	SIGNED (Secretary of the State.)	BY
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**INSTRUCTION**

1. One copy of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the Attorney General for his determination of legal sufficiency. Section 4-169 of the General Statutes.
2. Seventeen copies of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the standing Legislative Regulation Review Committee for its approval. Section 4-170 of the General Statutes.
3. Each regulation must be in the form intended for publication and must include the appropriate regulation section number and section heading. Section 4-172 of the General Statutes.
4. Indicate by "(NEW)" in heading if new regulation. Amended regulations must contain new language in capitol letters and deleted language in brackets. Section 4-170 of the General Statutes.