



General Assembly

January Session, 2011

Committee Bill No. 18

LCO No. 749

00749SB00018INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

**AN ACT CONCERNING APPEALS OF HEALTH INSURANCE
BENEFITS DENIALS.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subsection (b) of section 38a-478n of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective*
3 *October 1, 2011*):

4 (b) (1) To appeal a denial or determination pursuant to this section,
5 an enrollee or any provider acting on behalf of an enrollee with the
6 enrollee's consent shall, not later than sixty days after receiving final
7 written notice of the denial or determination from the enrollee's
8 managed care organization, health insurer or utilization review
9 company, file a written request with the commissioner. The appeal
10 shall be on forms prescribed by the commissioner and shall include the
11 filing fee set forth in subdivision (2) of this subsection and a general
12 release executed by the enrollee for all medical records pertinent to the
13 appeal. The managed care organization, health insurer or utilization
14 review company named in the appeal shall also pay to the
15 commissioner the filing fee set forth in subdivision (2) of this
16 subsection. If the Insurance Commissioner receives three or more

17 appeals of denials or determinations by the same managed care
18 organization or utilization review company with respect to the same
19 procedural or diagnostic coding, the Insurance Commissioner may, on
20 said commissioner's own motion, issue an order specifying how such
21 managed care organization or utilization review company shall make
22 determinations about such procedural or diagnostic coding.

23 (2) The filing fee shall be twenty-five dollars and shall be deposited
24 in the Insurance Fund established in section 38a-52a. If the
25 commissioner finds that an enrollee is indigent or unable to pay the
26 fee, the commissioner shall waive the enrollee's fee. The commissioner
27 shall refund any paid filing fee to (A) the managed care organization,
28 health insurer or utilization review company if the appeal is not
29 accepted for full review, or (B) the prevailing party upon completion of
30 a full review pursuant to this section.

31 (3) Upon receipt of the appeal together with the executed release
32 and appropriate fee, the commissioner shall assign the appeal for
33 review to a review entity. For each review entity that conducts any
34 review under this section, there shall be a presumption that an
35 admission, service, procedure or extension of stay being appealed
36 pursuant to subsection (a) of this section is medically necessary,
37 provided such admission, service, procedure or extension of stay was
38 ordered by a licensed participating provider and was within the
39 provider's scope of practice. The managed care organization, health
40 insurer or utilization review company shall have the burden of
41 proving the admission, service, procedure or extension of stay is not
42 medically necessary.

43 (4) Upon receipt of the request for appeal from the commissioner,
44 the review entity conducting the appeal shall conduct a preliminary
45 review of the appeal and accept the appeal if such review entity
46 determines: (A) The individual was or is an enrollee of the managed
47 care organization or health insurer; (B) the benefit or service that is the
48 subject of the complaint or appeal reasonably appears to be a covered

49 service, benefit or service under the agreement provided by contract to
50 the enrollee; (C) the enrollee or provider acting on behalf of the
51 enrollee with the enrollee's consent has exhausted all internal appeal
52 mechanisms provided; (D) the enrollee or provider acting on behalf of
53 the enrollee with the enrollee's consent has provided all information
54 required by the commissioner to make a preliminary determination
55 including the appeal form, a copy of the final decision of denial and a
56 fully-executed release to obtain any necessary medical records from
57 the managed care organization or health insurer and any other
58 relevant provider.

59 (5) Upon completion of the preliminary review, the review entity
60 shall immediately notify the enrollee or provider, as applicable, in
61 writing as to whether the appeal has been accepted for full review and,
62 if not so accepted, the reasons why the appeal was not accepted for full
63 review.

64 (6) If accepted for full review, (A) the review entity shall conduct
65 such review in accordance with the regulations adopted by the
66 commissioner, after consultation with the Commissioner of Public
67 Health, in accordance with the provisions of chapter 54, and (B) the
68 commissioner shall notify the managed care organization, health
69 insurer or utilization review company of the receipt of a request for an
70 external appeal and provide the name of the review entity assigned to
71 such appeal. Not later than five business days after such notification,
72 the managed care organization, health insurer or utilization review
73 company shall provide to such review entity by electronic mail,
74 telephone, facsimile or other expeditious method all documents and
75 information that were considered in making the adverse determination
76 that is the subject of such appeal.

77 Sec. 2. Subsection (a) of section 38a-226c of the general statutes is
78 repealed and the following is substituted in lieu thereof (*Effective*
79 *October 1, 2011*):

80 (a) All utilization review companies shall meet the following

81 minimum standards:

82 (1) Each utilization review company shall maintain and make
83 available procedures for providing notification of its determinations
84 regarding certification in accordance with the following:

85 (A) Notification of any prospective determination by the utilization
86 review company shall be mailed or otherwise communicated to the
87 provider of record or the enrollee or other appropriate individual
88 within two business days of the receipt of all information necessary to
89 complete the review, provided any determination not to certify an
90 admission, service, procedure or extension of stay shall be in writing.
91 After a prospective determination that authorizes an admission,
92 service, procedure or extension of stay has been communicated to the
93 appropriate individual, based on accurate information from the
94 provider, the utilization review company may not reverse such
95 determination if such admission, service, procedure or extension of
96 stay has taken place in reliance on such determination.

97 (B) Notification of a concurrent determination shall be mailed or
98 otherwise communicated to the provider of record within two business
99 days of receipt of all information necessary to complete the review or,
100 provided all information necessary to perform the review has been
101 received, prior to the end of the current certified period and provided
102 any determination not to certify an admission, service, procedure or
103 extension of stay shall be in writing.

104 (C) The utilization review company shall not make a determination
105 not to certify based on incomplete information unless it has clearly
106 indicated, in writing, to the provider of record or the enrollee all the
107 information that is needed to make such determination.

108 (D) Notwithstanding subparagraphs (A) to (C), inclusive, of this
109 subdivision, the utilization review company may give authorization
110 orally, electronically or communicated other than in writing. If the
111 determination is an approval for a request, the company shall provide

112 a confirmation number corresponding to the authorization.

113 (E) Except as provided in subparagraph (F) of this subdivision with
114 respect to a final notice, each notice of a determination not to certify an
115 admission, service, procedure or extension of stay shall include in
116 writing (i) the principal reasons for the determination, (ii) the
117 procedures to initiate an appeal of the determination or the name and
118 telephone number of the person to contact with regard to an appeal
119 pursuant to the provisions of this section, and (iii) the procedure to
120 appeal to the commissioner pursuant to section 38a-478n, as amended
121 by this act.

122 (F) Each notice of a final determination not to certify an admission,
123 service, procedure or extension of stay shall include in writing (i) the
124 principal reasons for the determination, (ii) a statement that all internal
125 appeal mechanisms have been exhausted, [and] (iii) a statement that
126 the utilization review company shall provide to the provider of record
127 and to the enrollee a copy of all documents and information that were
128 considered in such final determination, and (iv) a copy of the
129 application and procedures prescribed by the commissioner for filing
130 an appeal to the commissioner pursuant to section 38a-478n, as
131 amended by this act.

132 (2) Each utilization review company shall maintain and make
133 available a written description of the appeal procedure by which either
134 [the enrollee or] the provider of record or the enrollee may seek review
135 of determinations not to certify an admission, service, procedure or
136 extension of stay. An appeal by the provider of record shall be deemed
137 to be made on behalf of the enrollee and with the consent of such
138 enrollee if the admission, service, procedure or extension of stay has
139 not yet been provided or if such determination not to certify creates a
140 financial liability to the enrollee. The procedures for appeals shall
141 include the following:

142 (A) Each utilization review company shall notify in writing the
143 [enrollee and] provider of record and the enrollee of its determination

144 on the appeal as soon as practical, but in no case later than thirty days
145 after receiving the required documentation on the appeal.

146 (B) On appeal, all determinations not to certify an admission,
147 service, procedure or extension of stay shall be made by a licensed
148 practitioner of the healing arts.

149 (C) On appeal of a determination not to certify the dispensing of a
150 drug prescribed by a licensed participating provider, each managed
151 care organization or health insurer shall issue immediate electronic
152 authorization to the enrollee's pharmacy for such drug for the duration
153 of the appeal process, including any appeal to the commissioner
154 pursuant to section 38a-478n, as amended by this act. Such
155 authorization shall include confirmation of the availability of payment
156 for such supply of such drug.

157 (3) With respect to a final determination not to certify an admission,
158 service, procedure or extension of stay, each utilization review
159 company shall, not later than five business days after notification of
160 such final determination, provide to the provider of record and the
161 enrollee by electronic mail, facsimile or other expeditious method all
162 documents and information that were considered in making such final
163 determination.

164 ~~[(3)]~~ (4) The process established by each utilization review company
165 may include a reasonable period within which an appeal must be filed
166 to be considered.

167 ~~[(4)]~~ (5) Each utilization review company shall also provide for an
168 expedited appeals process for emergency or life threatening situations.
169 Each utilization review company shall complete the adjudication of
170 such expedited appeals within two business days of the date the
171 appeal is filed and all information necessary to complete the appeal is
172 received by the utilization review company.

173 ~~[(5)]~~ (6) Each utilization review company shall utilize written

174 clinical criteria and review procedures which are established and
175 periodically evaluated and updated with appropriate involvement
176 from practitioners.

177 [(6)] (7) Physicians, nurses and other licensed health professionals
178 making utilization review decisions shall have current licenses from a
179 state licensing agency in the United States or appropriate certification
180 from a recognized accreditation agency in the United States, provided
181 [.] any final determination not to certify an admission, service,
182 procedure or extension of stay for an enrollee within this state, except
183 for a claim brought pursuant to chapter 568, shall be made by a
184 physician, nurse or other licensed health professional under the
185 authority of a physician, nurse or other licensed health professional
186 who has a current Connecticut license from the Department of Public
187 Health.

188 [(7)] (8) In cases where an appeal to reverse a determination not to
189 certify is unsuccessful, each utilization review company shall [assure]
190 ensure that a practitioner in a specialty related to the condition is
191 reasonably available to review the case. When the reason for the
192 determination not to certify is based on medical necessity, including
193 whether a treatment is experimental or investigational, each utilization
194 review company shall have the case reviewed by a physician who is a
195 specialist in the field related to the condition that is the subject of the
196 appeal. Any such review, except for a claim brought pursuant to
197 chapter 568, that upholds a final determination not to certify in the
198 case of an enrollee within this state shall be conducted by such
199 practitioner or physician under the authority of a practitioner or
200 physician who has a current Connecticut license from the Department
201 of Public Health. The review shall be completed within thirty days of
202 the request for review. The utilization review company shall be
203 financially responsible for the review and shall maintain, for the
204 commissioner's verification, documentation of the review, including
205 the name of the reviewing physician.

206 [(8)] (9) Except as provided in subsection (e) of this section, each
207 utilization review company shall make review staff available by toll-
208 free telephone, at least forty hours per week during normal business
209 hours.

210 [(9)] (10) Each utilization review company shall comply with all
211 applicable federal and state laws to protect the confidentiality of
212 individual medical records. Summary and aggregate data shall not be
213 considered confidential if it does not provide sufficient information to
214 allow identification of individual patients.

215 [(10)] (11) Each utilization review company shall allow a minimum
216 of twenty-four hours following an emergency admission, service or
217 procedure for an enrollee or his representative to notify the utilization
218 review company and request certification or continuing treatment for
219 that condition.

220 [(11)] (12) No utilization review company may give an employee
221 any financial incentive based on the number of denials of certification
222 such employee makes.

223 [(12)] (13) Each utilization review company shall annually file with
224 the commissioner:

225 (A) The names of all managed care organizations, as defined in
226 section 38a-478, that the utilization review company services in
227 Connecticut;

228 (B) Any utilization review services for which the utilization review
229 company has contracted out for services and the name of such
230 company providing the services;

231 (C) The number of utilization review determinations not to certify
232 an admission, service, procedure or extension of stay and the outcome
233 of such determination upon appeal within the utilization review
234 company. Determinations related to mental or nervous conditions, as
235 defined in section 38a-514, shall be reported separately from all other

236 determinations reported under this subdivision; and

237 (D) The following information relative to requests for utilization
238 review of mental health services for enrollees of fully insured health
239 benefit plans or self-insured or self-funded employee health benefit
240 plans, separately and by category: (i) The reason for the request,
241 including, but not limited to, an inpatient admission, service,
242 procedure or extension of inpatient stay or an outpatient treatment, (ii)
243 the number of requests denied by type of request, and (iii) whether the
244 request was denied or partially denied.

245 ~~[(13)]~~ (14) Any utilization review decision to initially deny services
246 shall be made by a licensed health professional.

247 Sec. 3. Subsection (m) of section 38a-479aa of the general statutes is
248 repealed and the following is substituted in lieu thereof (*Effective*
249 *October 1, 2011*):

250 (m) Each utilization review determination made by or on behalf of a
251 preferred provider network shall be made in accordance with sections
252 38a-226 to 38a-226d, inclusive, as amended by this act, except that any
253 initial appeal of a determination not to certify an admission, service,
254 procedure or extension of stay shall be conducted in accordance with
255 subdivision ~~[(7)]~~ (8) of subsection (a) of section 38a-226c, as amended
256 by this act, and any subsequent appeal shall be referred to the
257 managed care organization on whose behalf the preferred provider
258 network provides services. The managed care organization shall
259 conduct the subsequent appeal in accordance with said subdivision.

260 Sec. 4. Subdivision (12) of subsection (d) of section 38a-479bb of the
261 general statutes is repealed and the following is substituted in lieu
262 thereof (*Effective October 1, 2011*):

263 (12) A provision that the preferred provider network shall ensure
264 that utilization review determinations are made in accordance with
265 sections 38a-226 to 38a-226d, inclusive, as amended by this act, except

266 that any initial appeal of a determination not to certify an admission,
267 service, procedure or extension of stay shall be made in accordance
268 with subdivision [(7)] (8) of subsection (a) of section 38a-226c, as
269 amended by this act. In cases where an appeal to reverse a
270 determination not to certify is unsuccessful, the preferred provider
271 network shall refer the case to the managed care organization which
272 shall conduct the subsequent appeal, if any, in accordance with said
273 subdivision.

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2011	38a-478n(b)
Sec. 2	October 1, 2011	38a-226c(a)
Sec. 3	October 1, 2011	38a-479aa(m)
Sec. 4	October 1, 2011	38a-479bb(d)(12)

Statement of Purpose:

To specify a presumption of medical necessity for appeals reviewed by review entities on behalf of the Insurance Commissioner pursuant to section 38a-478n of the general statutes, to require managed care companies, health insurers and utilization review companies to provide to providers of record and enrollees after a final determination not to certify an admission, service, procedure or extension of stay, documents and information considered in such final determination, and to require dispensation and coverage of a prescribed drug for the duration of any appeal of a determination not to certify such dispensation.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

Co-Sponsors: SEN. LOONEY, 11th Dist.

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