



General Assembly

Substitute Bill No. 18

January Session, 2011

* SB00018INS__030911__ *

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2 repealed and the following is substituted in lieu thereof (*Effective*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

4 (a) All utilization review companies shall meet the following
5 minimum standards:

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

9 (A) Notification of any prospective determination by the utilization
10 review company shall be mailed or otherwise communicated to the
11 provider of record or the enrollee or other appropriate individual
12 within two business days of the receipt of all information necessary to
13 complete the review, provided any determination not to certify an
14 admission, service, procedure or extension of stay shall be in writing.
15 After a prospective determination that authorizes an admission,
16 service, procedure or extension of stay has been communicated to the
17 appropriate individual, based on accurate information from the
18 provider, the utilization review company may not reverse such

19 determination if such admission, service, procedure or extension of
20 stay has taken place in reliance on such determination.

21 (B) Notification of a concurrent determination shall be mailed or
22 otherwise communicated to the provider of record within two business
23 days of receipt of all information necessary to complete the review or,
24 provided all information necessary to perform the review has been
25 received, prior to the end of the current certified period and provided
26 any determination not to certify an admission, service, procedure or
27 extension of stay shall be in writing.

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

32 (D) Notwithstanding subparagraphs (A) to (C), inclusive, of this
33 subdivision, the utilization review company may give authorization
34 orally, electronically or communicated other than in writing. If the
35 determination is an approval for a request, the company shall provide
36 a confirmation number corresponding to the authorization.

37 (E) Except as provided in subparagraph (F) of this subdivision with
38 respect to a final notice, each notice of a determination not to certify an
39 admission, service, procedure or extension of stay shall include in
40 writing (i) the principal reasons for the determination, (ii) the
41 procedures to initiate an appeal of the determination or the name and
42 telephone number of the person to contact with regard to an appeal
43 pursuant to the provisions of this section, and (iii) the procedure to
44 appeal to the commissioner pursuant to section 38a-478n, as amended
45 by this act.

46 (F) Each notice of a final determination not to certify an admission,
47 service, procedure or extension of stay shall include in writing (i) the
48 principal reasons for the determination, (ii) a statement that all internal
49 appeal mechanisms have been exhausted, [and] (iii) a statement that

50 the utilization review company shall provide to the enrollee, upon
51 request, a copy of all enrollee-specific documents and information that
52 were not provided by the provider of record or the enrollee and were
53 considered in such final determination, and (iv) a copy of the
54 application and procedures prescribed by the commissioner for filing
55 an appeal to the commissioner pursuant to section 38a-478n.

56 (2) Each utilization review company shall maintain and make
57 available a written description of the appeal procedure by which either
58 [the enrollee or] the provider of record or the enrollee may seek review
59 of determinations not to certify an admission, service, procedure or
60 extension of stay. An appeal by the provider of record shall be deemed
61 to be made on behalf of the enrollee and with the consent of such
62 enrollee if the admission, service, procedure or extension of stay has
63 not yet been provided or if such determination not to certify creates a
64 financial liability to the enrollee. The procedures for appeals shall
65 include the following:

66 (A) Each utilization review company shall notify in writing the
67 [enrollee and] provider of record and the enrollee of its determination
68 on the appeal as soon as practical, but in no case later than thirty days
69 after receiving the required documentation on the appeal.

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

73 (3) With respect to a final determination not to certify an admission,
74 service, procedure or extension of stay, each utilization review
75 company shall, not later than five business days after receiving a
76 request from the enrollee, provide to the provider of record and the
77 enrollee by electronic mail, facsimile or other expeditious method all
78 documents and information that were considered in making such final
79 determination.

80 [(3)] (4) The process established by each utilization review company

81 may include a reasonable period within which an appeal must be filed
82 to be considered.

83 [(4)] (5) Each utilization review company shall also provide for an
84 expedited appeals process for emergency or life threatening situations.
85 Each utilization review company shall complete the adjudication of
86 such expedited appeals within two business days of the date the
87 appeal is filed and all information necessary to complete the appeal is
88 received by the utilization review company.

89 [(5)] (6) Each utilization review company shall utilize written
90 clinical criteria and review procedures which are established and
91 periodically evaluated and updated with appropriate involvement
92 from practitioners.

93 [(6)] (7) Physicians, nurses and other licensed health professionals
94 making utilization review decisions shall have current licenses from a
95 state licensing agency in the United States or appropriate certification
96 from a recognized accreditation agency in the United States, provided
97 [.] any final determination not to certify an admission, service,
98 procedure or extension of stay for an enrollee within this state, except
99 for a claim brought pursuant to chapter 568, shall be made by a
100 physician, nurse or other licensed health professional under the
101 authority of a physician, nurse or other licensed health professional
102 who has a current Connecticut license from the Department of Public
103 Health.

104 [(7)] (8) In cases where an appeal to reverse a determination not to
105 certify is unsuccessful, each utilization review company shall [assure]
106 ensure that a practitioner in a specialty related to the condition is
107 reasonably available to review the case. When the reason for the
108 determination not to certify is based on medical necessity, including
109 whether a treatment is experimental or investigational, each utilization
110 review company shall have the case reviewed by a physician who is a
111 specialist in the field related to the condition that is the subject of the
112 appeal. Any such review, except for a claim brought pursuant to

113 chapter 568, that upholds a final determination not to certify in the
114 case of an enrollee within this state shall be conducted by such
115 practitioner or physician under the authority of a practitioner or
116 physician who has a current Connecticut license from the Department
117 of Public Health. The review shall be completed within thirty days of
118 the request for review. The utilization review company shall be
119 financially responsible for the review and shall maintain, for the
120 commissioner's verification, documentation of the review, including
121 the name of the reviewing physician.

122 ~~[(8)]~~ (9) Except as provided in subsection (e) of this section, each
123 utilization review company shall make review staff available by toll-
124 free telephone, at least forty hours per week during normal business
125 hours.

126 ~~[(9)]~~ (10) Each utilization review company shall comply with all
127 applicable federal and state laws to protect the confidentiality of
128 individual medical records. Summary and aggregate data shall not be
129 considered confidential if it does not provide sufficient information to
130 allow identification of individual patients.

131 ~~[(10)]~~ (11) Each utilization review company shall allow a minimum
132 of twenty-four hours following an emergency admission, service or
133 procedure for an enrollee or his representative to notify the utilization
134 review company and request certification or continuing treatment for
135 that condition.

136 ~~[(11)]~~ (12) No utilization review company may give an employee
137 any financial incentive based on the number of denials of certification
138 such employee makes.

139 ~~[(12)]~~ (13) Each utilization review company shall annually file with
140 the commissioner:

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

144 (B) Any utilization review services for which the utilization review
145 company has contracted out for services and the name of such
146 company providing the services;

147 (C) The number of utilization review determinations not to certify
148 an admission, service, procedure or extension of stay and the outcome
149 of such determination upon appeal within the utilization review
150 company. Determinations related to mental or nervous conditions, as
151 defined in section 38a-514, shall be reported separately from all other
152 determinations reported under this subdivision; and

153 (D) The following information relative to requests for utilization
154 review of mental health services for enrollees of fully insured health
155 benefit plans or self-insured or self-funded employee health benefit
156 plans, separately and by category: (i) The reason for the request,
157 including, but not limited to, an inpatient admission, service,
158 procedure or extension of inpatient stay or an outpatient treatment, (ii)
159 the number of requests denied by type of request, and (iii) whether the
160 request was denied or partially denied.

161 ~~[(13)]~~ (14) Any utilization review decision to initially deny services
162 shall be made by a licensed health professional.

163 Sec. 2. Subsection (m) of section 38a-479aa of the general statutes is
164 repealed and the following is substituted in lieu thereof (*Effective*
165 *October 1, 2011*):

166 (m) Each utilization review determination made by or on behalf of a
167 preferred provider network shall be made in accordance with sections
168 38a-226 to 38a-226d, inclusive, as amended by this act, except that any
169 initial appeal of a determination not to certify an admission, service,
170 procedure or extension of stay shall be conducted in accordance with
171 subdivision ~~[(7)]~~ (8) of subsection (a) of section 38a-226c, as amended
172 by this act, and any subsequent appeal shall be referred to the
173 managed care organization on whose behalf the preferred provider
174 network provides services. The managed care organization shall

175 conduct the subsequent appeal in accordance with said subdivision.

176 Sec. 3. Subdivision (12) of subsection (d) of section 38a-479bb of the
177 general statutes is repealed and the following is substituted in lieu
178 thereof (*Effective October 1, 2011*):

179 (12) A provision that the preferred provider network shall ensure
180 that utilization review determinations are made in accordance with
181 sections 38a-226 to 38a-226d, inclusive, as amended by this act, except
182 that any initial appeal of a determination not to certify an admission,
183 service, procedure or extension of stay shall be made in accordance
184 with subdivision [(7)] (8) of subsection (a) of section 38a-226c, as
185 amended by this act. In cases where an appeal to reverse a
186 determination not to certify is unsuccessful, the preferred provider
187 network shall refer the case to the managed care organization which
188 shall conduct the subsequent appeal, if any, in accordance with said
189 subdivision.

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

INS *Joint Favorable Subst.*