



General Assembly

**Amendment**

February Session, 2012

LCO No. 4138

**\*SB0041004138SD0\***

Offered by:

SEN. LOONEY, 11<sup>th</sup> Dist.

SEN. CRISCO, 17<sup>th</sup> Dist.

REP. MEGNA, 97<sup>th</sup> Dist.

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SEN. KELLY, 21<sup>st</sup> Dist.

To: Subst. Senate Bill No. 410

File No. 283

Cal. No. 225

**"AN ACT CONCERNING ADVERSE DETERMINATION REVIEWS."**

1 Strike everything after the enacting clause and substitute the  
2 following in lieu thereof:

3 "Section 1. Section 38a-591d of the 2012 supplement to the general  
4 statutes is repealed and the following is substituted in lieu thereof  
5 (*Effective October 1, 2012*):

6 (a) (1) Each health carrier shall maintain written procedures for (A)  
7 utilization review and benefit determinations, (B) expedited utilization  
8 review and benefit determinations with respect to prospective urgent  
9 care requests and concurrent review urgent care requests, and (C)  
10 notifying covered persons or covered persons' authorized  
11 representatives of such review and benefit determinations. Each health  
12 carrier shall make such review and benefit determinations within the

13 specified time periods under this section."

14 (2) In determining whether a benefit request shall be considered an  
15 urgent care request, an individual acting on behalf of a health carrier  
16 shall apply the judgment of a prudent layperson who possesses an  
17 average knowledge of health and medicine, except that any benefit  
18 request determined to be an urgent care request by a health care  
19 professional with knowledge of the covered person's medical  
20 condition shall be deemed an urgent care request.

21 (b) With respect to a nonurgent care request:

22 (1) For a prospective or concurrent review request, a health carrier  
23 shall make a determination within a reasonable period of time  
24 appropriate to the covered person's medical condition, but not later  
25 than fifteen calendar days after the date the health carrier receives such  
26 request, and shall notify the covered person and, if applicable, the  
27 covered person's authorized representative of such determination,  
28 whether or not the carrier certifies the provision of the benefit.

29 (2) For a retrospective review request, a health carrier shall make a  
30 determination within a reasonable period of time, but not later than  
31 thirty calendar days after the date the health carrier receives such  
32 request.

33 (3) The time periods specified in subdivisions (1) and (2) of this  
34 subsection may be extended once by the health carrier for up to fifteen  
35 calendar days, provided the health carrier:

36 (A) Determines that an extension is necessary due to circumstances  
37 beyond the health carrier's control; and

38 (B) Notifies the covered person and, if applicable, the covered  
39 person's authorized representative prior to the expiration of the initial  
40 time period, of the circumstances requiring the extension of time and  
41 the date by which the health carrier expects to make a determination.

42 (4) (A) If the extension pursuant to subdivision (3) of this subsection

43 is necessary due to the failure of the covered person or the covered  
44 person's authorized representative to provide information necessary to  
45 make a determination on the request, the health carrier shall:

46 (i) Specifically describe in the notice of extension the required  
47 information necessary to complete the request; and

48 (ii) Provide the covered person and, if applicable, the covered  
49 person's authorized representative with not less than forty-five  
50 calendar days after the date of receipt of the notice to provide the  
51 specified information.

52 (B) If the covered person or the covered person's authorized  
53 representative fails to submit the specified information before the end  
54 of the period of the extension, the health carrier may deny certification  
55 of the benefit requested.

56 (c) With respect to an urgent care request:

57 (1) Unless the covered person or the covered person's authorized  
58 representative has failed to provide information necessary for the  
59 health carrier to make a determination, the health carrier shall make a  
60 determination as soon as possible, taking into account the covered  
61 person's medical condition, but not later than seventy-two hours after  
62 the health carrier receives such request, provided, if the urgent care  
63 request is a concurrent review request to extend a course of treatment  
64 beyond the initial period of time or the number of treatments, such  
65 request is made at least twenty-four hours prior to the expiration of the  
66 prescribed period of time or number of treatments;

67 (2) (A) If the covered person or the covered person's authorized  
68 representative has failed to provide information necessary for the  
69 health carrier to make a determination, the health carrier shall notify  
70 the covered person or the covered person's representative, as  
71 applicable, as soon as possible, but not later than twenty-four hours  
72 after the health carrier receives such request.

73 (B) The health carrier shall provide the covered person or the  
74 covered person's authorized representative, as applicable, a reasonable  
75 period of time to submit the specified information, taking into account  
76 the covered person's medical condition, but not less than forty-eight  
77 hours after notifying the covered person or the covered person's  
78 authorized representative, as applicable.

79 (3) The health carrier shall notify the covered person and, if  
80 applicable, the covered person's authorized representative of its  
81 determination as soon as possible, but not later than forty-eight hours  
82 after the earlier of (A) the date on which the covered person and the  
83 covered person's authorized representative, as applicable, provides the  
84 specified information to the health carrier, or (B) the date on which the  
85 specified information was to have been submitted.

86 (d) (1) Whenever a health carrier receives a review request from a  
87 covered person or a covered person's authorized representative that  
88 fails to meet the health carrier's filing procedures, the health carrier  
89 shall notify the covered person and, if applicable, the covered person's  
90 authorized representative of such failure not later than five calendar  
91 days after the health carrier receives such request, except that for an  
92 urgent care request, the health carrier shall notify the covered person  
93 and, if applicable, the covered person's authorized representative of  
94 such failure not later than twenty-four hours after the health carrier  
95 receives such request.

96 (2) If the health carrier provides such notice orally, the health carrier  
97 shall provide confirmation in writing to the covered person and the  
98 covered person's health care professional of record not later than five  
99 calendar days after providing the oral notice.

100 (e) Each health carrier shall provide promptly to a covered person  
101 and, if applicable, the covered person's authorized representative a  
102 notice of an adverse determination.

103 (1) Such notice may be provided in writing or by electronic means  
104 and shall set forth, in a manner calculated to be understood by the

105 covered person or the covered person's authorized representative:

106 [(1)] (A) Information sufficient to identify the benefit request or  
107 claim involved, including the date of service, if applicable, the health  
108 care professional and the claim amount;

109 [(2)] (B) The specific reason or reasons for the adverse determination  
110 and a description of the health carrier's standard, if any, that was used  
111 in reaching the denial;

112 [(3)] (C) Reference to the specific health benefit plan provisions on  
113 which the determination is based;

114 [(4)] (D) A description of any additional material or information  
115 necessary for the covered person to perfect the benefit request or claim,  
116 including an explanation of why the material or information is  
117 necessary to perfect the request or claim;

118 [(5)] (E) A description of the health carrier's internal grievance  
119 process that includes [(A)] (i) the health carrier's expedited review  
120 procedures, [(B)] (ii) any time limits applicable to such process or  
121 procedures, [(C)] (iii) the contact information for the organizational  
122 unit designated to coordinate the review on behalf of the health carrier,  
123 and [(D)] (iv) a statement that the covered person or, if applicable, the  
124 covered person's authorized representative is entitled, pursuant to the  
125 requirements of the health carrier's internal grievance process, to [(i)]  
126 (I) submit written comments, documents, records and other material  
127 relating to the covered person's benefit request for consideration by the  
128 individual or individuals conducting the review, and [(ii)] (II) receive  
129 from the health carrier, free of charge upon request, reasonable access  
130 to and copies of all documents, records, communications and other  
131 information [relevant to] and evidence regarding the covered person's  
132 benefit request;

133 [(6)] (F) If the adverse determination is based on a health carrier's  
134 internal rule, guideline, protocol or other similar criterion, [(A)] (i) the  
135 specific rule, guideline, protocol or other similar criterion, or [(B)] (ii) a

136 statement that a specific rule, guideline, protocol or other similar  
137 criterion of the health carrier was relied upon to make the adverse  
138 determination and that a copy of such rule, guideline, protocol or other  
139 similar criterion will be provided to the covered person free of charge  
140 upon request, and instructions for requesting such copy;

141 [(7)] (G) If the adverse determination is based on medical necessity  
142 or an experimental or investigational treatment or similar exclusion or  
143 limit, the written statement of the scientific or clinical rationale for the  
144 adverse determination and [(A)] (i) an explanation of the scientific or  
145 clinical rationale used to make the determination that applies the terms  
146 of the health benefit plan to the covered person's medical  
147 circumstances or [(B)] (ii) a statement that an explanation will be  
148 provided to the covered person free of charge upon request, and  
149 instructions for requesting a copy of such explanation; and

150 [(8)] (H) A statement explaining the right of the covered person to  
151 contact the commissioner's office or the Office of the Healthcare  
152 Advocate at any time for assistance or, upon completion of the health  
153 carrier's internal grievance process, to file a civil suit in a court of  
154 competent jurisdiction. Such statement shall include the contact  
155 information for said offices.

156 (2) Upon request pursuant to subparagraph (E) of subdivision (1) of  
157 this subsection, the health carrier shall provide such copies in  
158 accordance with subsection (a) of section 5 of this act.

159 (f) If the adverse determination is a rescission, the health carrier  
160 shall include with the advance notice of the application for rescission  
161 required to be sent to the covered person, a written statement that  
162 includes:

163 (1) Clear identification of the alleged fraudulent act, practice or  
164 omission or the intentional misrepresentation of material fact;

165 (2) An explanation as to why the act, practice or omission was  
166 fraudulent or was an intentional misrepresentation of a material fact;

167 (3) A disclosure that the covered person or the covered person's  
168 authorized representative may file immediately, without waiting for  
169 the date such advance notice of the proposed rescission ends, a  
170 grievance with the health carrier to request a review of the adverse  
171 determination to rescind coverage, pursuant to sections 38a-591e and  
172 38a-591f, as amended by this act;

173 (4) A description of the health carrier's grievance procedures  
174 established under sections 38a-591e and 38a-591f, as amended by this  
175 act, including [,] any time limits applicable to those procedures; and

176 (5) The date such advance notice of the proposed rescission ends  
177 and the date back to which the coverage will be retroactively  
178 rescinded.

179 (g) (1) Whenever a health carrier fails to strictly adhere to the  
180 requirements of this section with respect to making utilization review  
181 and benefit determinations of a benefit request or claim, the covered  
182 person shall be deemed to have exhausted the internal grievance  
183 process of such health carrier and may file a request for an external  
184 review in accordance with the provisions of section 38a-591g, as  
185 amended by this act, regardless of whether the health carrier asserts it  
186 substantially complied with the requirements of this section or that  
187 any error it committed was de minimis.

188 (2) A covered person who has exhausted the internal grievance  
189 process of a health carrier may, in addition to filing a request for an  
190 external review, pursue any available remedies under state or federal  
191 law on the basis that the health carrier failed to provide a reasonable  
192 internal grievance process that would yield a decision on the merits of  
193 the claim.

194 Sec. 2. Section 38a-591e of the 2012 supplement to the general  
195 statutes is repealed and the following is substituted in lieu thereof  
196 (*Effective October 1, 2012*):

197 (a) (1) Each health carrier shall establish and maintain written

198 procedures for (A) the review of grievances of adverse determinations  
199 that were based, in whole or in part, on medical necessity, (B) the  
200 expedited review of grievances of adverse determinations of urgent  
201 care requests, including concurrent review urgent care requests  
202 involving an admission, availability of care, continued stay or health  
203 care service for a covered person who has received emergency services  
204 but has not been discharged from a facility, and (C) notifying covered  
205 persons or covered persons' authorized representatives of such  
206 adverse determinations.

207 (2) Each health carrier shall file with the commissioner a copy of  
208 such procedures, including all forms used to process requests, and any  
209 subsequent material modifications to such procedures.

210 (3) In addition to a copy of such procedures, each health carrier shall  
211 file annually with the commissioner, as part of its annual report  
212 required under subsection (e) of section 38a-591b, a certificate of  
213 compliance stating that the health carrier has established and  
214 maintains grievance procedures for each of its health benefit plans that  
215 are fully compliant with the provisions of sections 38a-591a to 38a-  
216 591m, inclusive, as amended by this act, and section 5 of this act.

217 (b) (1) A covered person or a covered person's authorized  
218 representative may file a grievance of an adverse determination that  
219 was based, in whole or in part, on medical necessity with the health  
220 carrier not later than one hundred eighty calendar days after the  
221 covered person or the covered person's authorized representative, as  
222 applicable, receives the notice of an adverse determination.

223 (2) For prospective or concurrent urgent care requests, a covered  
224 person or a covered person's authorized representative may make a  
225 request for an expedited review orally or in writing.

226 (c) (1) (A) When conducting a review of an adverse determination  
227 under this section, the health carrier shall ensure that such review is  
228 conducted in a manner to ensure the independence and impartiality of  
229 the individual or individuals involved in making the review decision.

230 (B) If the adverse determination involves utilization review, the  
231 health carrier shall designate an appropriate clinical peer or peers to  
232 review such adverse determination. Such clinical peer or peers shall  
233 not have been involved in the initial adverse determination.

234 (C) The individual or individuals conducting a review under this  
235 section shall take into consideration all comments, documents, records  
236 and other information relevant to the covered person's benefit request  
237 that is the subject of the adverse determination under review, that are  
238 submitted by the covered person or the covered person's authorized  
239 representative, regardless of whether such information was submitted  
240 or considered in making the initial adverse determination.

241 (D) Prior to issuing a decision, the health carrier shall provide free  
242 of charge, by facsimile, electronic means or any other expeditious  
243 method available, to the covered person or the covered person's  
244 authorized representative, as applicable, any new or additional  
245 documents, communications, information and evidence relied upon  
246 and any new or additional scientific or clinical rationale used by the  
247 health carrier in connection with the grievance. Such documents,  
248 communications, information, evidence and rationale shall be  
249 provided sufficiently in advance of the date the health carrier is  
250 required to issue a decision to permit the covered person or the  
251 covered person's authorized representative, as applicable, a reasonable  
252 opportunity to respond prior to such date.

253 (2) If the review under subdivision (1) of this subsection is an  
254 expedited review, all necessary information, including the health  
255 carrier's decision, shall be transmitted between the health carrier and  
256 the covered person or the covered person's authorized representative,  
257 as applicable, by telephone, facsimile, electronic means or any other  
258 expeditious method available.

259 (3) If the review under subdivision (1) of this subsection is an  
260 expedited review of a grievance involving an adverse determination of  
261 a concurrent review urgent care request, the treatment shall be

262 continued without liability to the covered person until the covered  
263 person has been notified of the review decision.

264 (d) (1) The health carrier shall notify the covered person and, if  
265 applicable, the covered person's authorized representative, in writing  
266 or by electronic means, of its decision within a reasonable period of  
267 time appropriate to the covered person's medical condition, but not  
268 later than:

269 (A) For prospective review and concurrent review requests, thirty  
270 calendar days after the health carrier receives the grievance;

271 (B) For retrospective review requests, sixty calendar days after the  
272 health carrier receives the grievance; and

273 (C) For expedited review requests, seventy-two hours after the  
274 health carrier receives the grievance.

275 (2) The time periods set forth in subdivision (1) of this subsection  
276 shall apply regardless of whether all of the information necessary to  
277 make a decision accompanies the filing.

278 (e) (1) The notice required under subsection (d) of this section shall  
279 set forth, in a manner calculated to be understood by the covered  
280 person or the covered person's authorized representative:

281 [(1)] (A) The titles and qualifying credentials of the individual or  
282 individuals participating in the review process;

283 [(2)] (B) Information sufficient to identify the claim involved with  
284 respect to the grievance, including the date of service, if applicable, the  
285 health care professional and the claim amount;

286 [(3)] (C) A statement of such individual's or individuals'  
287 understanding of the covered person's grievance;

288 [(4)] (D) The individual's or individuals' decision in clear terms and  
289 the health benefit plan contract basis or scientific or clinical rationale

290 for such decision in sufficient detail for the covered person to respond  
291 further to the health carrier's position;

292 [(5)] (E) Reference to the evidence or documentation used as the  
293 basis for the decision;

294 [(6)] (F) For a decision that upholds the adverse determination:

295 [(A)] (i) The specific reason or reasons for the final adverse  
296 determination, including the denial code and its corresponding  
297 meaning, as well as a description of the health carrier's standard, if  
298 any, that was used in reaching the denial;

299 [(B)] (ii) Reference to the specific health benefit plan provisions on  
300 which the decision is based;

301 [(C)] (iii) A statement that the covered person may receive from the  
302 health carrier, free of charge and upon request, reasonable access to  
303 and copies of, all documents, records, communications and other  
304 information [relevant to] and evidence not previously provided  
305 regarding the adverse determination under review;

306 [(D)] (iv) If the final adverse determination is based on a health  
307 carrier's internal rule, guideline, protocol or other similar criterion, [(i)]  
308 (I) the specific rule, guideline, protocol or other similar criterion, or  
309 [(ii)] (II) a statement that a specific rule, guideline, protocol or other  
310 similar criterion of the health carrier was relied upon to make the final  
311 adverse determination and that a copy of such rule, guideline, protocol  
312 or other similar criterion will be provided to the covered person free of  
313 charge upon request and instructions for requesting such copy;

314 [(E)] (v) If the final adverse determination is based on medical  
315 necessity or an experimental or investigational treatment or similar  
316 exclusion or limit, the written statement of the scientific or clinical  
317 rationale for the final adverse determination and [(i)] (I) an explanation  
318 of the scientific or clinical rationale used to make the determination  
319 that applies the terms of the health benefit plan to the covered person's

320 medical circumstances, or ~~[(ii)]~~ [(II)] a statement that an explanation will  
321 be provided to the covered person free of charge upon request and  
322 instructions for requesting a copy of such explanation;

323 ~~[(F)]~~ [(vi)] A statement describing the procedures for obtaining an  
324 external review of the final adverse determination;

325 ~~[(7)]~~ [(G)] If applicable, the following statement: "You and your plan  
326 may have other voluntary alternative dispute resolution options such  
327 as mediation. One way to find out what may be available is to contact  
328 your state Insurance Commissioner."; and

329 ~~[(8)]~~ [(H)] A statement disclosing the covered person's right to contact  
330 the commissioner's office or the Office of the Healthcare Advocate at  
331 any time. Such disclosure shall include the contact information for said  
332 offices.

333 [(2) Upon request pursuant to subparagraph (F)(iii) of subdivision (1)  
334 of this subsection, the health carrier shall provide such copies in  
335 accordance with subsection (b) of section 5 of this act.

336 (f) (1) Whenever a health carrier fails to strictly adhere to the  
337 requirements of this section with respect to receiving and resolving  
338 grievances involving an adverse determination, the covered person  
339 shall be deemed to have exhausted the internal grievance process of  
340 such health carrier and may file a request for an external review,  
341 regardless of whether the health carrier asserts that it substantially  
342 complied with the requirements of this section, or that any error it  
343 committed was de minimis.

344 (2) A covered person who has exhausted the internal grievance  
345 process of a health carrier may, in addition to filing a request for an  
346 external review, pursue any available remedies under state or federal  
347 law on the basis that the health carrier failed to provide a reasonable  
348 internal grievance process that would yield a decision on the merits of  
349 the claim.

350 Sec. 3. Section 38a-591f of the 2012 supplement to the general  
351 statutes is repealed and the following is substituted in lieu thereof  
352 (*Effective October 1, 2012*):

353 (a) Each health carrier shall establish and maintain written  
354 procedures (1) for the review of grievances of adverse determinations  
355 that were not based on medical necessity, and (2) notifying covered  
356 persons or covered persons' authorized representatives of such  
357 adverse determinations.

358 (b) (1) A covered person or the covered person's authorized  
359 representative may file a grievance of an adverse determination that  
360 was not based on medical necessity with the health carrier not later  
361 than one hundred eighty calendar days after the covered person or the  
362 covered person's representative, as applicable, receives the notice of an  
363 adverse determination.

364 (2) The health carrier shall notify the covered person and, if  
365 applicable, the covered person's authorized representative not later  
366 than three business days after the health carrier receives a grievance  
367 that the covered person or the covered person's authorized  
368 representative, as applicable, is entitled to submit written material to  
369 the health carrier to be considered when conducting a review of the  
370 grievance.

371 (3) (A) Upon receipt of a grievance, a health carrier shall designate  
372 an individual or individuals to conduct a review of the grievance.

373 (B) The health carrier shall not designate the same individual or  
374 individuals who denied the claim or handled the matter that is the  
375 subject of the grievance to conduct the review of the grievance.

376 (C) The health carrier shall provide the covered person and, if  
377 applicable, the covered person's authorized representative with the  
378 name, address and telephone number of the individual or the  
379 organizational unit designated to coordinate the review on behalf of  
380 the health carrier.

381 (c) (1) The health carrier shall notify the covered person and, if  
382 applicable, the covered person's authorized representative in writing,  
383 of its decision not later than twenty business days after the health  
384 carrier received the grievance.

385 (2) If the health carrier is unable to comply with the time period  
386 specified in subdivision (1) of this subsection due to circumstances  
387 beyond the health carrier's control, the time period may be extended  
388 by the health carrier for up to ten business days, provided that on or  
389 before the twentieth business day after the health carrier received the  
390 grievance, the health carrier provides written notice to the covered  
391 person and, if applicable, the covered person's authorized  
392 representative of the extension and the reasons for the delay.

393 (d) (1) The written decision issued pursuant to subsection (c) of this  
394 section shall contain:

395 [(1)] (A) The titles and qualifying credentials of the individual or  
396 individuals participating in the review process;

397 [(2)] (B) A statement of such individual's or individuals'  
398 understanding of the covered person's grievance;

399 [(3)] (C) The individual's or individuals' decision in clear terms and  
400 the health benefit plan contract basis for such decision in sufficient  
401 detail for the covered person to respond further to the health carrier's  
402 position; [and]

403 [(4)] (D) Reference to the documents, communications, information  
404 and evidence [or documentation] used as the basis for the decision;  
405 and

406 (E) For a decision that upholds the adverse determination, a  
407 statement that the covered person may receive from the health carrier,  
408 free of charge and upon request, reasonable access to and copies of, all  
409 documents, communications, information and evidence regarding the  
410 adverse determination that is the subject of the final adverse

411 determination.

412 (2) Upon request pursuant to subparagraph (E) of subdivision (1) of  
413 this subsection, the health carrier shall provide such copies in  
414 accordance with subsection (b) of section 5 of this act.

415 Sec. 4. Section 38a-591g of the 2012 supplement to the general  
416 statutes is repealed and the following is substituted in lieu thereof  
417 (*Effective October 1, 2012*):

418 (a) (1) A covered person or a covered person's authorized  
419 representative may file a request for an external review or an  
420 expedited external review of an adverse determination or a final  
421 adverse determination in accordance with the provisions of this  
422 section. All requests for external review or expedited external review  
423 shall be made in writing to the commissioner. The commissioner may  
424 prescribe the form and content of such requests.

425 (2) (A) All requests for external review or expedited external review  
426 shall be accompanied by a filing fee of twenty-five dollars, except that  
427 no covered person or covered person's authorized representative shall  
428 pay more than seventy-five dollars in a calendar year for such covered  
429 person. Any filing fee paid by a covered person's authorized  
430 representative shall be deemed to have been paid by the covered  
431 person. If the commissioner finds that the covered person is indigent  
432 or unable to pay the filing fee, the commissioner shall waive such fee.  
433 Any such fees shall be deposited in the Insurance Fund established  
434 under section 38a-52a.

435 (B) The commissioner shall refund any paid filing fee to the covered  
436 person or the covered person's authorized representative, as  
437 applicable, or the health care professional if the adverse determination  
438 or the final adverse determination that is the subject of the external  
439 review request or expedited external review request is reversed or  
440 revised.

441 (3) The health carrier that issued the adverse determination or the

442 final adverse determination that is the subject of the external review  
443 request or the expedited external review request shall pay the  
444 independent review organization for the cost of conducting the review.

445 (4) An external review decision, whether such review is a standard  
446 external review or an expedited external review, shall be binding on  
447 the health carrier or a self-insured governmental plan and the covered  
448 person, except to the extent such health carrier or covered person has  
449 other remedies available under federal or state law. A covered person  
450 or a covered person's authorized representative shall not file a  
451 subsequent request for an external review or an expedited external  
452 review that involves the same adverse determination or final adverse  
453 determination for which the covered person or the covered person's  
454 authorized representative already received an external review decision  
455 or an expedited external review decision.

456 (5) Each health carrier shall maintain written records of external  
457 reviews as set forth in section 38a-591h.

458 (6) Each independent review organization shall maintain written  
459 records as set forth in subsection (e) of section 38a-591m.

460 (b) (1) Except as otherwise provided under subdivision (2) of this  
461 subsection or subsection (d) of this section, a covered person or a  
462 covered person's authorized representative shall not file a request for  
463 an external review or an expedited external review until the covered  
464 person or the covered person's authorized representative has  
465 exhausted the health carrier's internal grievance process.

466 (2) A health carrier may waive its internal grievance process and the  
467 requirement for a covered person to exhaust such process prior to  
468 filing a request for an external review or an expedited external review.

469 (c) (1) At the same time a health carrier sends to a covered person or  
470 a covered person's authorized representative a written notice of an  
471 adverse determination or a final adverse determination issued by the  
472 health carrier, the health carrier shall include a written disclosure to

473 the covered person and, if applicable, the covered person's authorized  
474 representative of the covered person's right to request an external  
475 review.

476 (2) The written notice shall include:

477 (A) The following statement or a statement in substantially similar  
478 language: "We have denied your request for benefit approval for a  
479 health care service or course of treatment. You may have the right to  
480 have our decision reviewed by health care professionals who have no  
481 association with us by submitting a request for external review to the  
482 office of the Insurance Commissioner, if our decision involved making  
483 a judgment as to the medical necessity, appropriateness, health care  
484 setting, level of care or effectiveness of the health care service or  
485 treatment you requested.";

486 (B) For a notice related to an adverse determination, a statement  
487 informing the covered person that:

488 (i) If the covered person has a medical condition for which the time  
489 period for completion of an expedited internal review of a grievance  
490 involving an adverse determination would seriously jeopardize the life  
491 or health of the covered person or would jeopardize the covered  
492 person's ability to regain maximum function, the covered person or the  
493 covered person's authorized representative may (I) file a request for an  
494 expedited external review, or (II) file a request for an expedited  
495 external review if the adverse determination involves a denial of  
496 coverage based on a determination that the recommended or  
497 requested health care service or treatment is experimental or  
498 investigational and the covered person's treating health care  
499 professional certifies in writing that such recommended or requested  
500 health care service or treatment would be significantly less effective if  
501 not promptly initiated; and

502 (ii) Such request for expedited external review may be filed at the  
503 same time the covered person or the covered person's authorized  
504 representative files a request for an expedited internal review of a

505 grievance involving an adverse determination, except that the  
506 independent review organization assigned to conduct the expedited  
507 external review shall determine whether the covered person shall be  
508 required to complete the expedited internal review of the grievance  
509 prior to conducting the expedited external review;

510 (C) For a notice related to a final adverse determination, a statement  
511 informing the covered person that:

512 (i) If the covered person has a medical condition for which the time  
513 period for completion of an external review would seriously  
514 jeopardize the life or health of the covered person or would jeopardize  
515 the covered person's ability to regain maximum function, the covered  
516 person or the covered person's authorized representative may file a  
517 request for an expedited external review; or

518 (ii) If the final adverse determination concerns (I) an admission,  
519 availability of care, continued stay or health care service for which the  
520 covered person received emergency services but has not been  
521 discharged from a facility, the covered person or the covered person's  
522 authorized representative may file a request for an expedited external  
523 review, or (II) a denial of coverage based on a determination that the  
524 recommended or requested health care service or treatment is  
525 experimental or investigational and the covered person's treating  
526 health care professional certifies in writing that such recommended or  
527 requested health care service or treatment would be significantly less  
528 effective if not promptly initiated, the covered person or the covered  
529 person's authorized representative may file a request for an expedited  
530 external review;

531 (D) (i) A copy of the description of both the standard and expedited  
532 external review procedures the health carrier is required to provide,  
533 highlighting the provisions in the external review procedures that give  
534 the covered person or the covered person's authorized representative  
535 the opportunity to submit additional information and including any  
536 forms used to process an external review or an expedited external

537 review;

538 (ii) As part of any forms provided under subparagraph (D)(i) of this  
539 subdivision, an authorization form or other document approved by the  
540 commissioner that complies with the requirements of 45 CFR 164.508,  
541 as amended from time to time, by which the covered person shall  
542 authorize the health carrier and the covered person's treating health  
543 care professional to release, transfer or otherwise divulge, in  
544 accordance with sections 38a-975 to 38a-999a, inclusive, the covered  
545 person's protected health information including medical records for  
546 purposes of conducting an external review or an expedited external  
547 review;

548 (E) A statement that the covered person or the covered person's  
549 authorized representative may request, free of charge, copies of all  
550 documents, communications, information and evidence regarding the  
551 adverse determination or the final adverse determination that were not  
552 previously provided to the covered person or the covered person's  
553 authorized representative.

554 (3) Upon request pursuant to subparagraph (E) of subdivision (2) of  
555 this subsection, the health carrier shall provide such copies in  
556 accordance with subsection (b) of section 5 of this act.

557 (d) (1) A covered person or a covered person's authorized  
558 representative may file a request for an expedited external review of an  
559 adverse determination or a final adverse determination with the  
560 commissioner, except that an expedited external review shall not be  
561 provided for a retrospective review request of an adverse  
562 determination or a final adverse determination.

563 (2) Such request may be filed at the time the covered person  
564 receives:

565 (A) An adverse determination, if:

566 (i) (I) The covered person has a medical condition for which the time

567 period for completion of an expedited internal review of the adverse  
568 determination would seriously jeopardize the life or health of the  
569 covered person or would jeopardize the covered person's ability to  
570 regain maximum function; or

571 (II) The denial of coverage is based on a determination that the  
572 recommended or requested health care service or treatment is  
573 experimental or investigational and the covered person's treating  
574 health care professional certifies in writing that such recommended or  
575 requested health care service or treatment would be significantly less  
576 effective if not promptly initiated; and

577 (ii) The covered person or the covered person's authorized  
578 representative has filed a request for an expedited internal review of  
579 the adverse determination; or

580 (B) A final adverse determination if:

581 (i) The covered person has a medical condition where the time  
582 period for completion of a standard external review would seriously  
583 jeopardize the life or health of the covered person or would jeopardize  
584 the covered person's ability to regain maximum function;

585 (ii) The final adverse determination concerns an admission,  
586 availability of care, continued stay or health care service for which the  
587 covered person received emergency services but has not been  
588 discharged from a facility; or

589 (iii) The denial of coverage is based on a determination that the  
590 recommended or requested health care service or treatment is  
591 experimental or investigational and the covered person's treating  
592 health care professional certifies in writing that such recommended or  
593 requested health care service or treatment would be significantly less  
594 effective if not promptly initiated.

595 (3) Such covered person or covered person's authorized  
596 representative shall not be required to file a request for an external

597 review prior to, or at the same time as, the filing of a request for an  
598 expedited external review and shall not be precluded from filing a  
599 request for an external review, within the time periods set forth in  
600 subsection (e) of this section, if the request for an expedited external  
601 review is determined to be ineligible for such review.

602 (e) (1) Not later than one hundred twenty calendar days after a  
603 covered person or a covered person's authorized representative  
604 receives a notice of an adverse determination or a final adverse  
605 determination, the covered person or the covered person's authorized  
606 representative may file a request for an external review or an  
607 expedited external review with the commissioner in accordance with  
608 this section.

609 (2) Not later than one business day after the commissioner receives  
610 a request that is complete, the commissioner shall send a copy of such  
611 request to the health carrier that issued the adverse determination or  
612 the final adverse determination that is the subject of the request.

613 (3) Not later than [(A)] five business days after the health carrier  
614 receives the copy of an external review request [,] or [(B)] one calendar  
615 day after the health carrier receives the copy of an expedited external  
616 review request, from the commissioner, the health carrier shall  
617 complete a preliminary review of the request to determine whether:

618 (A) The individual is or was a covered person under the health  
619 benefit plan at the time the health care service was requested or, in the  
620 case of an external review of a retrospective review request, was a  
621 covered person in the health benefit plan at the time the health care  
622 service was provided;

623 (B) The health care service that is the subject of the adverse  
624 determination or the final adverse determination is a covered service  
625 under the covered person's health benefit plan but for the health  
626 carrier's determination that the health care service is not covered  
627 because it does not meet the health carrier's requirements for medical  
628 necessity, appropriateness, health care setting, level of care or

629 effectiveness;

630 (C) If the health care service or treatment is experimental or  
631 investigational:

632 (i) Is a covered benefit under the covered person's health benefit  
633 plan but for the health carrier's determination that the service or  
634 treatment is experimental or investigational for a particular medical  
635 condition;

636 (ii) Is not explicitly listed as an excluded benefit under the covered  
637 person's health benefit plan;

638 (iii) The covered person's treating health care professional has  
639 certified that one of the following situations is applicable:

640 (I) Standard health care services or treatments have not been  
641 effective in improving the medical condition of the covered person;

642 (II) Standard health care services or treatments are not medically  
643 appropriate for the covered person; or

644 (III) There is no available standard health care service or treatment  
645 covered by the health carrier that is more beneficial than the  
646 recommended or requested health care service or treatment; and

647 (iv) The covered person's treating health care professional:

648 (I) Has recommended a health care service or treatment that the  
649 health care professional certifies, in writing, is likely to be more  
650 beneficial to the covered person, in the health care professional's  
651 opinion, than any available standard health care services or treatments;  
652 or

653 (II) Is a licensed, board certified or board eligible health care  
654 professional qualified to practice in the area of medicine appropriate to  
655 treat the covered person's condition and has certified in writing that  
656 scientifically valid studies using accepted protocols demonstrate that

657 the health care service or treatment requested by the covered person  
658 that is the subject of the adverse determination or the final adverse  
659 determination is likely to be more beneficial to the covered person than  
660 any available standard health care services or treatments;

661 (D) The covered person has exhausted the health carrier's internal  
662 grievance process or the covered person or the covered person's  
663 authorized representative has filed a request for an expedited external  
664 review as provided under subsection (d) of this section; and

665 (E) The covered person has provided all the information and forms  
666 required to process an external review or an expedited external review,  
667 including an authorization form as set forth in subparagraph (D)(ii) of  
668 subdivision (2) of subsection (c) of this section.

669 (4) (A) Not later than [(i)] one business day after the preliminary  
670 review of an external review request [,] or [(ii)] the day the preliminary  
671 review of an expedited external review request is completed, the  
672 health carrier shall notify the commissioner, the covered person and, if  
673 applicable, the covered person's authorized representative in writing  
674 whether the request for an external review or an expedited external  
675 review is complete and eligible for such review. The commissioner  
676 may specify the form for the health carrier's notice of initial  
677 determination under this subdivision and any supporting information  
678 required to be included in the notice.

679 (B) If the request:

680 (i) Is not complete, the health carrier shall notify the commissioner  
681 and the covered person and, if applicable, the covered person's  
682 authorized representative in writing and include in the notice what  
683 information or materials are needed to perfect the request; or

684 (ii) Is not eligible for external review or expedited external review,  
685 the health carrier shall notify the commissioner, the covered person  
686 and, if applicable, the covered person's authorized representative in  
687 writing and include in the notice the reasons for its ineligibility.

688 (C) The notice of initial determination shall include a statement  
689 informing the covered person and, if applicable, the covered person's  
690 authorized representative that a health carrier's initial determination  
691 that the request for an external review or an expedited external review  
692 is ineligible for review may be appealed to the commissioner.

693 (D) Notwithstanding a health carrier's initial determination that a  
694 request for an external review or an expedited external review is  
695 ineligible for review, the commissioner may determine, pursuant to  
696 the terms of the covered person's health benefit plan, that such request  
697 is eligible for such review and assign an independent review  
698 organization to conduct such review. Any such review shall be  
699 conducted in accordance with this section.

700 (f) (1) Whenever the commissioner is notified pursuant to  
701 subparagraph (A) of subdivision (4) of subsection (e) of this section  
702 that a request is eligible for external review or expedited external  
703 review, the commissioner shall, not later than [(A)] one business day  
704 after receiving such notice for an external review [,] or [(B)] one  
705 calendar day after receiving such notice for an expedited external  
706 review:

707 [(i)] (A) Assign an independent review organization from the list of  
708 approved independent review organizations compiled and maintained  
709 by the commissioner pursuant to section 38a-591l to conduct the  
710 review and notify the health carrier of the name of the assigned  
711 independent review organization. Such assignment shall be done on a  
712 random basis among those approved independent review  
713 organizations qualified to conduct the particular review based on the  
714 nature of the health care service that is the subject of the adverse  
715 determination or the final adverse determination and other  
716 circumstances, including conflict of interest concerns as set forth in  
717 section 38a-591m; and

718 [(ii)] (B) Notify the covered person and, if applicable, the covered  
719 person's authorized representative in writing of the request's eligibility

720 and acceptance for external review or expedited external review. For  
721 an external review, the commissioner shall include in such notice [(I)]  
722 (i) a statement that the covered person or the covered person's  
723 authorized representative may submit, not later than five business  
724 days after the covered person or the covered person's authorized  
725 representative, as applicable, received such notice, additional  
726 information in writing to the assigned independent review  
727 organization that such organization shall consider when conducting  
728 the external review, and [(II)] (ii) where and how such additional  
729 information is to be submitted. If additional information is submitted  
730 later than five business days after the covered person or the covered  
731 person's authorized representative, as applicable, received such notice,  
732 the independent review organization may, but shall not be required to,  
733 accept and consider such additional information.

734 (2) Not later than [(A)] five business days for an external review [ ]  
735 or [(B)] one calendar day for an expedited external review, after the  
736 health carrier receives notice of the name of the assigned independent  
737 review organization from the commissioner, the health carrier or its  
738 designee utilization review company shall provide to the assigned  
739 independent review organization the documents and any information  
740 such health carrier or utilization review company considered in  
741 making the adverse determination or the final adverse determination.

742 (3) The failure of the health carrier or its designee utilization review  
743 company to provide the documents and information within the time  
744 specified in subdivision (2) of this subsection shall not delay the  
745 conducting of the review.

746 (4) [(i)] (A) If the health carrier or its designee utilization review  
747 company fails to provide the documents and information within the  
748 time period specified in subdivision (2) of this subsection, the  
749 independent review organization may terminate the review and make  
750 a decision to reverse the adverse determination or the final adverse  
751 determination.

752 [(ii)] (B) Not later than one business day after terminating the  
753 review and making the decision to reverse the adverse determination  
754 or the final adverse determination, the independent review  
755 organization shall notify the commissioner, the health carrier, the  
756 covered person and, if applicable, the covered person's authorized  
757 representative in writing of such decision.

758 (g) (1) The assigned independent review organization shall review  
759 all the information and documents received pursuant to subsection (f)  
760 of this section. In reaching a decision, the independent review  
761 organization shall not be bound by any decisions or conclusions  
762 reached during the health carrier's utilization review process.

763 (2) Not later than one business day after receiving any information  
764 submitted by the covered person or the covered person's authorized  
765 representative pursuant to subparagraph (B) of subdivision (1) of  
766 subsection (f) of this section, the independent review organization  
767 shall forward such information to the health carrier.

768 (3) (A) Upon the receipt of any information forwarded pursuant to  
769 subdivision (2) of this subsection, the health carrier may reconsider its  
770 adverse determination or the final adverse determination that is the  
771 subject of the review. Such reconsideration shall not delay or terminate  
772 the review.

773 (B) The independent review organization shall terminate the review  
774 if the health carrier decides, upon completion of its reconsideration  
775 and notice to such organization as provided in subparagraph (C) of  
776 this subdivision, to reverse its adverse determination or its final  
777 adverse determination and provide coverage or payment for the health  
778 care service or treatment that is the subject of the adverse  
779 determination or the final adverse determination.

780 (C) Not later than one business day after making the decision to  
781 reverse its adverse determination or its final adverse determination,  
782 the health carrier shall notify the commissioner, the assigned  
783 independent review organization, the covered person and, if

784 applicable, the covered person's authorized representative in writing  
785 of such decision.

786 (h) In addition to the documents and information received pursuant  
787 to subsection (f) of this section, the independent review organization  
788 shall consider, to the extent the documents or information are available  
789 and the independent review organization considers them appropriate,  
790 the following in reaching a decision:

791 (1) The covered person's medical records;

792 (2) The attending health care professional's recommendation;

793 (3) Consulting reports from appropriate health care professionals  
794 and other documents submitted by the health carrier, the covered  
795 person, the covered person's authorized representative or the covered  
796 person's treating health care professional;

797 (4) The terms of coverage under the covered person's health benefit  
798 plan to ensure that the independent review organization's decision is  
799 not contrary to the terms of coverage under such health benefit plan;

800 (5) The most appropriate practice guidelines, which shall include  
801 applicable evidence-based standards and may include any other  
802 practice guidelines developed by the federal government, national or  
803 professional medical societies, medical boards or medical associations;

804 (6) Any applicable clinical review criteria developed and used by  
805 the health carrier or its designee utilization review company; and

806 (7) The opinion or opinions of the independent review  
807 organization's clinical peer or peers who conducted the review after  
808 considering subdivisions (1) to (6), inclusive, of this subsection.

809 (i) (1) The independent review organization shall notify the  
810 commissioner, the health carrier, the covered person and, if applicable,  
811 the covered person's authorized representative in writing of its  
812 decision to uphold, reverse or revise the adverse determination or the

813 final adverse determination, not later than:

814 (A) For external reviews, forty-five calendar days after such  
815 organization receives the assignment from the commissioner to  
816 conduct such review;

817 (B) For external reviews involving a determination that the  
818 recommended or requested health care service or treatment is  
819 experimental or investigational, twenty calendar days after such  
820 organization receives the assignment from the commissioner to  
821 conduct such review;

822 (C) For expedited external reviews, as expeditiously as the covered  
823 person's medical condition requires, but not later than seventy-two  
824 hours after such organization receives the assignment from the  
825 commissioner to conduct such review; and

826 (D) For expedited external reviews involving a determination that  
827 the recommended or requested health care service or treatment is  
828 experimental or investigational, as expeditiously as the covered  
829 person's medical condition requires, but not later than five calendar  
830 days after such organization receives the assignment from the  
831 commissioner to conduct such review.

832 (2) Such notice shall include:

833 (A) A general description of the reason for the request for the  
834 review;

835 (B) The date the independent review organization received the  
836 assignment from the commissioner to conduct the review;

837 (C) The date the review was conducted;

838 (D) The date the organization made its decision;

839 (E) The principal reason or reasons for its decision, including what  
840 applicable evidence-based standards, if any, were used as a basis for its

841 decision;

842 (F) The rationale for the organization's decision;

843 (G) Reference to the evidence or documentation, including any  
844 evidence-based standards, considered by the organization in reaching  
845 its decision; and

846 (H) For a review involving a determination that the recommended  
847 or requested health care service or treatment is experimental or  
848 investigational:

849 (i) A description of the covered person's medical condition;

850 (ii) A description of the indicators relevant to determining whether  
851 there is sufficient evidence to demonstrate that (I) the recommended or  
852 requested health care service or treatment is likely to be more  
853 beneficial to the covered person than any available standard health  
854 care services or treatments, and (II) the adverse risks of the  
855 recommended or requested health care service or treatment would not  
856 be substantially increased over those of available standard health care  
857 services or treatments;

858 (iii) A description and analysis of any medical or scientific evidence  
859 considered in reaching the opinion;

860 (iv) A description and analysis of any evidence-based standard; and

861 (v) Information on whether the clinical peer's rationale for the  
862 opinion is based on the documents and information set forth in  
863 subsection (f) of this section.

864 (3) Upon the receipt of a notice of the independent review  
865 organization's decision to reverse or revise an adverse determination  
866 or a final adverse determination, the health carrier shall immediately  
867 approve the coverage that was the subject of the adverse determination  
868 or the final adverse determination.

869 Sec. 5. (NEW) (*Effective October 1, 2012*) (a) (1) Upon request  
870 pursuant to subparagraph (E) of subdivision (1) of subsection (e) of  
871 section 38a-591d of the general statutes, as amended by this act, the  
872 health carrier shall provide free of charge to a covered person or a  
873 covered person's authorized representative, as applicable, copies of all  
874 documents, communications, information and evidence, including  
875 citations to any medical journals, regarding the covered person's  
876 benefit request that is the subject of the adverse determination that  
877 were not submitted by the covered person or the covered person's  
878 authorized representative and were available to the health carrier or  
879 the utilization review entity that made the adverse determination at  
880 the time such adverse determination was made.

881 (2) The health carrier shall provide such copies by facsimile,  
882 electronic means or any other expeditious method available not later  
883 than five business days after the health carrier receives such request in  
884 the case of an adverse determination of a nonurgent care request or  
885 one calendar day after the health carrier receives such request in the  
886 case of an adverse determination of an urgent care request.

887 (b) (1) Upon request pursuant to subparagraph (F)(iii) of  
888 subdivision (1) of subsection (e) of section 38a-591e of the general  
889 statutes, as amended by this act, subparagraph (E) of subdivision (1) of  
890 subsection (d) of section 38a-591f of the general statutes, as amended  
891 by this act, or subparagraph (E) of subdivision (2) of subsection (c) of  
892 section 38a-591g of the general statutes, as amended by this act, the  
893 health carrier shall provide free of charge to a covered person or a  
894 covered person's authorized representative, as applicable, copies of all  
895 documents, communications, information and evidence, including  
896 citations to any medical journals, if applicable, regarding the adverse  
897 determination or the final adverse determination, as applicable, that  
898 were not submitted by the covered person or the covered person's  
899 authorized representative and were not previously provided by the  
900 health carrier to the covered person or the covered person's authorized  
901 representative.

902 (2) The health carrier shall provide such copies by facsimile,  
903 electronic means or any other expeditious method available not later  
904 than:

905 (A) Five business days after the health carrier receives such request  
906 (i) in the case of a final adverse determination of a prospective,  
907 concurrent or retrospective review request under section 38a-591e of  
908 the general statutes, as amended by this act, (ii) in the case of a final  
909 adverse determination of a review request under section 38a-591f of  
910 the general statutes, as amended by this act, or (iii) pursuant to section  
911 38a-591g of the general statutes, as amended by this act, except if the  
912 covered person or the covered person's authorized representative  
913 notifies the health carrier at the time of such request that any of the  
914 provisions set forth in subparagraph (B)(i) or subparagraph (C) of  
915 subdivision (2) of subsection (c) of section 38a-591g of the general  
916 statutes, as amended by this act, applies, the health carrier shall  
917 provide such copies by facsimile, electronic means or any other  
918 expeditious method available not later than one calendar day after the  
919 health carrier receives such request; or

920 (B) One calendar day after the health carrier receives such request in  
921 the case of a final adverse determination of an expedited review  
922 request under 38a-591e of the general statutes, as amended by this act.

923 Sec. 6. Section 38a-591a of the 2012 supplement to the general  
924 statutes is repealed and the following is substituted in lieu thereof  
925 (*Effective October 1, 2012*):

926 As used in this section and sections 38a-591b to 38a-591m, inclusive,  
927 as amended by this act, and section 5 of this act:

928 (1) "Adverse determination" means:

929 (A) The denial, reduction, termination or failure to provide or make  
930 payment, in whole or in part, for a benefit under the health carrier's  
931 health benefit plan requested by a covered person or a covered  
932 person's treating health care professional, based on a determination by

933 a health carrier or its designee utilization review company:

934 (i) That, based upon the information provided, (I) upon application  
935 of any utilization review technique, such benefit does not meet the  
936 health carrier's requirements for medical necessity, appropriateness,  
937 health care setting, level of care or effectiveness, or (II) is determined to  
938 be experimental or investigational;

939 (ii) Of a covered person's eligibility to participate in the health  
940 carrier's health benefit plan; or

941 (B) Any prospective review, concurrent review or retrospective  
942 review determination that denies, reduces or terminates or fails to  
943 provide or make payment, in whole or in part, for a benefit under the  
944 health carrier's health benefit plan requested by a covered person or a  
945 covered person's treating health care professional.

946 "Adverse determination" includes a rescission of coverage  
947 determination for grievance purposes.

948 (2) "Authorized representative" means:

949 (A) A person to whom a covered person has given express written  
950 consent to represent the covered person for the purposes of this section  
951 and sections 38a-591b to 38a-591m, inclusive, as amended by this act,  
952 and section 5 of this act;

953 (B) A person authorized by law to provide substituted consent for a  
954 covered person;

955 (C) A family member of the covered person or the covered person's  
956 treating health care professional when the covered person is unable to  
957 provide consent;

958 (D) A health care professional when the covered person's health  
959 benefit plan requires that a request for a benefit under the plan be  
960 initiated by the health care professional; or

961 (E) In the case of an urgent care request, a health care professional  
962 with knowledge of the covered person's medical condition.

963 (3) "Best evidence" means evidence based on (A) randomized  
964 clinical trials, (B) if randomized clinical trials are not available, cohort  
965 studies or case-control studies, (C) if such trials and studies are not  
966 available, case-series, or (D) if such trials, studies and case-series are  
967 not available, expert opinion.

968 (4) "Case-control study" means a retrospective evaluation of two  
969 groups of patients with different outcomes to determine which specific  
970 interventions the patients received.

971 (5) "Case-series" means an evaluation of a series of patients with a  
972 particular outcome, without the use of a control group.

973 (6) "Certification" means a determination by a health carrier or its  
974 designee utilization review company that a request for a benefit under  
975 the health carrier's health benefit plan has been reviewed and, based  
976 on the information provided, satisfies the health carrier's requirements  
977 for medical necessity, appropriateness, health care setting, level of care  
978 and effectiveness.

979 (7) "Clinical peer" means a physician or other health care  
980 professional who holds a nonrestricted license in a state of the United  
981 States and in the same or similar specialty as typically manages the  
982 medical condition, procedure or treatment under review.

983 (8) "Clinical review criteria" means the written screening  
984 procedures, decision abstracts, clinical protocols and practice  
985 guidelines used by the health carrier to determine the medical  
986 necessity and appropriateness of health care services.

987 (9) "Cohort study" means a prospective evaluation of two groups of  
988 patients with only one group of patients receiving a specific  
989 intervention or specific interventions.

990 (10) "Commissioner" means the Insurance Commissioner.

991 (11) "Concurrent review" means utilization review conducted  
992 during a patient's stay or course of treatment in a facility, the office of a  
993 health care professional or other inpatient or outpatient health care  
994 setting, including home care.

995 (12) "Covered benefits" or "benefits" means health care services to  
996 which a covered person is entitled under the terms of a health benefit  
997 plan.

998 (13) "Covered person" means a policyholder, subscriber, enrollee or  
999 other individual participating in a health benefit plan.

1000 (14) "Emergency medical condition" means a medical condition  
1001 manifesting itself by acute symptoms of sufficient severity, including  
1002 severe pain, such that a prudent layperson with an average knowledge  
1003 of health and medicine, acting reasonably, would have believed that  
1004 the absence of immediate medical attention would result in serious  
1005 impairment to bodily functions or serious dysfunction of a bodily  
1006 organ or part, or would place the person's health or, with respect to a  
1007 pregnant woman, the health of the woman or her unborn child, in  
1008 serious jeopardy.

1009 (15) "Emergency services" means, with respect to an emergency  
1010 medical condition:

1011 (A) A medical screening examination that is within the capability of  
1012 the emergency department of a hospital, including ancillary services  
1013 routinely available to the emergency department to evaluate such  
1014 emergency medical condition; and

1015 (B) Such further medical examination and treatment, to the extent  
1016 they are within the capability of the staff and facilities available at a  
1017 hospital, to stabilize a patient.

1018 (16) "Evidence-based standard" means the conscientious, explicit  
1019 and judicious use of the current best evidence based on an overall  
1020 systematic review of medical research when making determinations

1021 about the care of individual patients.

1022 (17) "Expert opinion" means a belief or an interpretation by  
1023 specialists with experience in a specific area about the scientific  
1024 evidence pertaining to a particular service, intervention or therapy.

1025 (18) "Facility" means an institution providing health care services or  
1026 a health care setting. "Facility" includes a hospital and other licensed  
1027 inpatient center, ambulatory surgical or treatment center, skilled  
1028 nursing center, residential treatment center, diagnostic, laboratory and  
1029 imaging center, and rehabilitation and other therapeutic health care  
1030 setting.

1031 (19) "Final adverse determination" means an adverse determination  
1032 (A) that has been upheld by the health carrier at the completion of its  
1033 internal grievance process, or (B) for which the internal grievance  
1034 process has been deemed exhausted.

1035 (20) "Grievance" means a written complaint or, if the complaint  
1036 involves an urgent care request, an oral complaint, submitted by or on  
1037 behalf of a covered person regarding:

1038 (A) The availability, delivery or quality of health care services,  
1039 including a complaint regarding an adverse determination made  
1040 pursuant to utilization review;

1041 (B) Claims payment, handling or reimbursement for health care  
1042 services; or

1043 (C) Any matter pertaining to the contractual relationship between a  
1044 covered person and a health carrier.

1045 (21) (A) "Health benefit plan" means an insurance policy or contract,  
1046 certificate or agreement offered, delivered, issued for delivery,  
1047 renewed, amended or continued in this state to provide, deliver,  
1048 arrange for, pay for or reimburse any of the costs of health care  
1049 services;

- 1050 (B) "Health benefit plan" does not include:
- 1051 (i) Coverage of the type specified in subdivisions (5) to (9), inclusive,  
1052 (14) and (15) of section 38a-469 or any combination thereof;
- 1053 (ii) Coverage issued as a supplement to liability insurance;
- 1054 (iii) Liability insurance, including general liability insurance and  
1055 automobile liability insurance;
- 1056 (iv) Workers' compensation insurance;
- 1057 (v) Automobile medical payment insurance;
- 1058 (vi) Credit insurance;
- 1059 (vii) Coverage for on-site medical clinics;
- 1060 (viii) Other insurance coverage similar to the coverages specified in  
1061 subparagraphs (B)(ii) to (B)(vii), inclusive, of this subdivision that are  
1062 specified in regulations issued pursuant to the Health Insurance  
1063 Portability and Accountability Act of 1996, P.L. 104-191, as amended  
1064 from time to time, under which benefits for health care services are  
1065 secondary or incidental to other insurance benefits;
- 1066 (ix) (I) Limited scope dental or vision benefits, (II) benefits for long-  
1067 term care, nursing home care, home health care, community-based  
1068 care or any combination thereof, or (III) other similar, limited benefits  
1069 specified in regulations issued pursuant to the Health Insurance  
1070 Portability and Accountability Act of 1996, P.L. 104-191, as amended  
1071 from time to time, provided any benefits specified in subparagraphs  
1072 (B)(ix)(I) to (B)(ix)(III), inclusive, of this subdivision are provided  
1073 under a separate insurance policy, certificate or contract and are not  
1074 otherwise an integral part of a health benefit plan; or
- 1075 (x) Coverage of the type specified in subdivisions (3) and (13) of  
1076 section 38a-469 or other fixed indemnity insurance if (I) they are  
1077 provided under a separate insurance policy, certificate or contract, (II)

1078 there is no coordination between the provision of the benefits and any  
1079 exclusion of benefits under any group health plan maintained by the  
1080 same plan sponsor, and (III) the benefits are paid with respect to an  
1081 event without regard to whether benefits were also provided under  
1082 any group health plan maintained by the same plan sponsor.

1083 (22) "Health care center" has the same meaning as provided in  
1084 section 38a-175.

1085 (23) "Health care professional" means a physician or other health  
1086 care practitioner licensed, accredited or certified to perform specified  
1087 health care services consistent with state law.

1088 (24) "Health care services" has the same meaning as provided in  
1089 section 38a-478.

1090 (25) "Health carrier" means an entity subject to the insurance laws  
1091 and regulations of this state or subject to the jurisdiction of the  
1092 commissioner, that contracts or offers to contract to provide, deliver,  
1093 arrange for, pay for or reimburse any of the costs of health care  
1094 services, including a sickness and accident insurance company, a  
1095 health care center, a managed care organization, a hospital service  
1096 corporation, a medical service corporation or any other entity  
1097 providing a plan of health insurance, health benefits or health care  
1098 services.

1099 (26) "Health information" means information or data, whether oral  
1100 or recorded in any form or medium, and personal facts or information  
1101 about events or relationships that relate to (A) the past, present or  
1102 future physical, mental, or behavioral health or condition of a covered  
1103 person or a member of the covered person's family, (B) the provision of  
1104 health care services to a covered person, or (C) payment for the  
1105 provision of health care services to a covered person.

1106 (27) "Independent review organization" means an entity that  
1107 conducts independent external reviews of adverse determinations and  
1108 final adverse determinations. Such review entities include, but are not

1109 limited to, medical peer review organizations, independent utilization  
1110 review companies, provided such organizations or companies are not  
1111 related to or associated with any health carrier, and nationally  
1112 recognized health experts or institutions approved by the Insurance  
1113 Commissioner.

1114 (28) "Medical or scientific evidence" means evidence found in the  
1115 following sources:

1116 (A) Peer-reviewed scientific studies published in or accepted for  
1117 publication by medical journals that meet nationally recognized  
1118 requirements for scientific manuscripts and that submit most of their  
1119 published articles for review by experts who are not part of the  
1120 editorial staff;

1121 (B) Peer-reviewed medical literature, including literature relating to  
1122 therapies reviewed and approved by a qualified institutional review  
1123 board, biomedical compendia and other medical literature that meet  
1124 the criteria of the National Institutes of Health's Library of Medicine  
1125 for indexing in Index Medicus (Medline) or Elsevier Science for  
1126 indexing in Excerpta Medicus (EMBASE);

1127 (C) Medical journals recognized by the Secretary of the United  
1128 States Department of Health and Human Services under Section  
1129 1861(t)(2) of the Social Security Act;

1130 (D) The following standard reference compendia: (i) The American  
1131 Hospital Formulary Service - Drug Information; (ii) Drug Facts and  
1132 Comparisons; (iii) The American Dental Association's Accepted Dental  
1133 Therapeutics; and (iv) The United States Pharmacopoeia - Drug  
1134 Information;

1135 (E) Findings, studies or research conducted by or under the auspices  
1136 of federal government agencies and nationally recognized federal  
1137 research institutes, including: (i) The Agency for Healthcare Research  
1138 and Quality; (ii) the National Institutes of Health; (iii) the National  
1139 Cancer Institute; (iv) the National Academy of Sciences; (v) the Centers

1140 for Medicare and Medicaid Services; (vi) the Food and Drug  
1141 Administration; and (vii) any national board recognized by the  
1142 National Institutes of Health for the purpose of evaluating the medical  
1143 value of health care services; or

1144 (F) Any other findings, studies or research conducted by or under  
1145 the auspices of a source comparable to those listed in subparagraphs  
1146 (E)(i) to (E)(v), inclusive, of this subdivision.

1147 (29) "Medical necessity" has the same meaning as provided in  
1148 sections 38a-482a and 38a-513c.

1149 (30) "Participating provider" means a health care professional who,  
1150 under a contract with the health carrier, its contractor or subcontractor,  
1151 has agreed to provide health care services to covered persons, with an  
1152 expectation of receiving payment or reimbursement directly or  
1153 indirectly from the health carrier, other than coinsurance, copayments  
1154 or deductibles.

1155 (31) "Person" has the same meaning as provided in section 38a-1.

1156 (32) "Prospective review" means utilization review conducted prior  
1157 to an admission or the provision of a health care service or a course of  
1158 treatment, in accordance with a health carrier's requirement that such  
1159 service or treatment be approved, in whole or in part, prior to such  
1160 service's or treatment's provision.

1161 (33) "Protected health information" means health information (A)  
1162 that identifies an individual who is the subject of the information, or  
1163 (B) for which there is a reasonable basis to believe that such  
1164 information could be used to identify such individual.

1165 (34) "Randomized clinical trial" means a controlled, prospective  
1166 study of patients that have been randomized into an experimental  
1167 group and a control group at the beginning of the study, with only the  
1168 experimental group of patients receiving a specific intervention, and  
1169 that includes study of the groups for variables and anticipated

1170 outcomes over time.

1171 (35) "Rescission" means a cancellation or discontinuance of coverage  
1172 under a health benefit plan that has a retroactive effect. "Rescission"  
1173 does not include a cancellation or discontinuance of coverage under a  
1174 health benefit plan if (A) such cancellation or discontinuance has a  
1175 prospective effect only, or (B) such cancellation or discontinuance is  
1176 effective retroactively to the extent it is attributable to the covered  
1177 person's failure to timely pay required premiums or contributions  
1178 towards the cost of such coverage.

1179 (36) "Retrospective review" means any review of a request for a  
1180 benefit that is not a prospective review or concurrent review.  
1181 "Retrospective review" does not include a review of a request that is  
1182 limited to the veracity of documentation or the accuracy of coding.

1183 (37) "Stabilize" means, with respect to an emergency medical  
1184 condition, that (A) no material deterioration of such condition is likely,  
1185 within reasonable medical probability, to result from or occur during  
1186 the transfer of the individual from a facility, or (B) with respect to a  
1187 pregnant woman, the woman has delivered, including the placenta.

1188 (38) "Urgent care request" means a request for a health care service  
1189 or course of treatment for which the time period for making a non-  
1190 urgent care request determination (A) could seriously jeopardize the  
1191 life or health of the covered person or the ability of the covered person  
1192 to regain maximum function, or (B) in the opinion of a health care  
1193 professional with knowledge of the covered person's medical  
1194 condition, would subject the covered person to severe pain that cannot  
1195 be adequately managed without the health care service or treatment  
1196 being requested.

1197 (39) "Utilization review" means the use of a set of formal techniques  
1198 designed to monitor the use of, or evaluate the medical necessity,  
1199 appropriateness, efficacy or efficiency of, health care services, health  
1200 care procedures or health care settings. Such techniques may include  
1201 the monitoring of or evaluation of (A) health care services performed

1202 or provided in an outpatient setting, (B) the formal process for  
1203 determining, prior to discharge from a facility, the coordination and  
1204 management of the care that a patient receives following discharge  
1205 from a facility, (C) opportunities or requirements to obtain a clinical  
1206 evaluation by a health care professional other than the one originally  
1207 making a recommendation for a proposed health care service, (D)  
1208 coordinated sets of activities conducted for individual patient  
1209 management of serious, complicated, protracted or other health  
1210 conditions, or (E) prospective review, concurrent review, retrospective  
1211 review or certification.

1212 (40) "Utilization review company" means an entity that conducts  
1213 utilization review.

1214 Sec. 7. Subsections (a) and (b) of section 38a-591b of the 2012  
1215 supplement to the general statutes are repealed and the following is  
1216 substituted in lieu thereof (*Effective October 1, 2012*):

1217 (a) Sections 38a-591a to 38a-591m, inclusive, as amended by this act,  
1218 and section 5 of this act shall apply to (1) any health carrier offering a  
1219 health benefit plan and that provides or performs utilization review  
1220 including prospective, concurrent or retrospective review benefit  
1221 determinations, and (2) any utilization review company or designee of  
1222 a health carrier that performs utilization review on the health carrier's  
1223 behalf, including prospective, concurrent or retrospective review  
1224 benefit determinations.

1225 (b) Each health carrier shall be responsible for monitoring all  
1226 utilization review program activities carried out by or on behalf of  
1227 such health carrier. Such health carrier shall comply with the  
1228 provisions of sections 38a-591a to 38a-591m, inclusive, as amended by  
1229 this act, and section 5 of this act and any regulations adopted  
1230 thereunder, and shall be responsible for ensuring that any utilization  
1231 review company or other entity such health carrier contracts with to  
1232 perform utilization review complies with said sections and regulations.  
1233 Each health carrier shall ensure that appropriate personnel have

1234 operational responsibility for the activities of the health carrier's  
1235 utilization review program.

1236 Sec. 8. Section 38a-591i of the 2012 supplement to the general  
1237 statutes is repealed and the following is substituted in lieu thereof  
1238 (*Effective October 1, 2012*):

1239 The commissioner shall adopt regulations, in accordance with  
1240 chapter 54, to implement the provisions of sections 38a-591a to 38a-  
1241 591m, inclusive, as amended by this act, and section 5 of this act.

1242 Sec. 9. Section 38a-478s of the 2012 supplement to the general  
1243 statutes is repealed and the following is substituted in lieu thereof  
1244 (*Effective October 1, 2012*):

1245 (a) Nothing in sections 38a-478 to 38a-478o, inclusive, [or] sections  
1246 38a-591a to 38a-591h, inclusive, as amended by this act, or section 5 of  
1247 this act shall be construed to apply to the arrangements of managed  
1248 care organizations or health insurers offered to individuals covered  
1249 under self-insured employee welfare benefit plans established  
1250 pursuant to the federal Employee Retirement Income Security Act of  
1251 1974.

1252 (b) The provisions of sections 38a-478 to 38a-478o, inclusive, [and]  
1253 sections 38a-591a to 38a-591h, inclusive, as amended by this act, and  
1254 section 5 of this act shall not apply to any plan that provides for the  
1255 financing or delivery of health care services solely for the purposes of  
1256 workers' compensation benefits pursuant to chapter 568."

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2012</i>	38a-591d
Sec. 2	<i>October 1, 2012</i>	38a-591e
Sec. 3	<i>October 1, 2012</i>	38a-591f
Sec. 4	<i>October 1, 2012</i>	38a-591g
Sec. 5	<i>October 1, 2012</i>	New section
Sec. 6	<i>October 1, 2012</i>	38a-591a

Sec. 7	<i>October 1, 2012</i>	38a-591b(a) and (b)
Sec. 8	<i>October 1, 2012</i>	38a-591i
Sec. 9	<i>October 1, 2012</i>	38a-478s