



General Assembly

January Session, 2013

Raised Bill No. 6557

LCO No. 3846



Referred to Committee on PROGRAM REVIEW AND INVESTIGATIONS

Introduced by:
(PRI)

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE HEALTH CARRIER UTILIZATION REVIEW AND GRIEVANCE PROCESS.

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

1 Section 1. Subdivision (38) of section 38a-591a of the general statutes
2 is repealed and the following is substituted in lieu thereof (*Effective*
3 *September 1, 2013*):

4 (38) "Urgent care request" means a request for a health care service
5 or course of treatment (A) for which the time period for making a non-
6 urgent care request determination [(A)] (i) could seriously jeopardize
7 the life or health of the covered person or the ability of the covered
8 person to regain maximum function, or [(B)] (ii) in the opinion of a
9 health care professional with knowledge of the covered person's
10 medical condition, would subject the covered person to severe pain
11 that cannot be adequately managed without the health care service or
12 treatment being requested, or (B) for a substance use disorder, as

13 described in section 17a-458, or for a co-occurring disorder.

14 Sec. 2. Section 38a-591d of the general statutes is repealed and the
15 following is substituted in lieu thereof (*Effective September 1, 2013*):

16 (a) (1) Each health carrier shall maintain written procedures for (A)
17 utilization review and benefit determinations, (B) expedited utilization
18 review and benefit determinations with respect to prospective urgent
19 care requests and concurrent review urgent care requests, and (C)
20 notifying covered persons or covered persons' authorized
21 representatives of such review and benefit determinations. Each health
22 carrier shall make such review and benefit determinations within the
23 specified time periods under this section.

24 (2) In determining whether a benefit request shall be considered an
25 urgent care request, an individual acting on behalf of a health carrier
26 shall apply the judgment of a prudent layperson who possesses an
27 average knowledge of health and medicine, except that any benefit
28 request determined to be an urgent care request by a health care
29 professional with knowledge of the covered person's medical
30 condition shall be deemed an urgent care request.

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

32 (1) For a prospective or concurrent review request, a health carrier
33 shall make a determination within a reasonable period of time
34 appropriate to the covered person's medical condition, but not later
35 than fifteen calendar days after the date the health carrier receives such
36 request, and shall notify the covered person and, if applicable, the
37 covered person's authorized representative of such determination,
38 whether or not the carrier certifies the provision of the benefit.

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

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

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

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

52 (4) (A) If the extension pursuant to subdivision (3) of this subsection
53 is necessary due to the failure of the covered person or the covered
54 person's authorized representative to provide information necessary to
55 make a determination on the request, the health carrier shall:

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

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

62 (B) If the covered person or the covered person's authorized
63 representative fails to submit the specified information before the end
64 of the period of the extension, the health carrier may deny certification
65 of the benefit requested.

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

67 (1) (A) Unless the covered person or the covered person's
68 authorized representative has failed to provide information necessary
69 for the health carrier to make a determination and except as specified
70 under subparagraph (B) of this subdivision, the health carrier shall
71 make a determination as soon as possible, taking into account the

72 covered person's medical condition, but not later than seventy-two
73 hours after the health carrier receives such request, provided, if the
74 urgent care request is a concurrent review request to extend a course of
75 treatment beyond the initial period of time or the number of
76 treatments, such request is made at least twenty-four hours prior to the
77 expiration of the prescribed period of time or number of treatments;

78 (B) Unless the covered person or the covered person's authorized
79 representative has failed to provide information necessary for the
80 health carrier to make a determination, for an urgent care request for
81 inpatient substance use disorder treatment, the health carrier shall
82 make a determination as soon as possible, taking into account the
83 covered person's medical condition, but not later than twenty-four
84 hours after the health carrier receives such request, provided, if the
85 urgent care request is a concurrent review request to extend a course of
86 treatment beyond the initial period of time or the number of
87 treatments, such request is made at least twenty-four hours prior to the
88 expiration of the prescribed period of time or number of treatments.

89 (2) (A) If the covered person or the covered person's authorized
90 representative has failed to provide information necessary for the
91 health carrier to make a determination, the health carrier shall notify
92 the covered person or the covered person's representative, as
93 applicable, as soon as possible, but not later than twenty-four hours
94 after the health carrier receives such request.

95 (B) The health carrier shall provide the covered person or the
96 covered person's authorized representative, as applicable, a reasonable
97 period of time to submit the specified information, taking into account
98 the covered person's medical condition, but not less than forty-eight
99 hours after notifying the covered person or the covered person's
100 authorized representative, as applicable.

101 (3) The health carrier shall notify the covered person and, if
102 applicable, the covered person's authorized representative of its

103 determination as soon as possible, but not later than forty-eight hours
104 after the earlier of (A) the date on which the covered person and the
105 covered person's authorized representative, as applicable, provides the
106 specified information to the health carrier, or (B) the date on which the
107 specified information was to have been submitted.

108 (d) (1) Whenever a health carrier receives a review request from a
109 covered person or a covered person's authorized representative that
110 fails to meet the health carrier's filing procedures, the health carrier
111 shall notify the covered person and, if applicable, the covered person's
112 authorized representative of such failure not later than five calendar
113 days after the health carrier receives such request, except that for an
114 urgent care request, the health carrier shall notify the covered person
115 and, if applicable, the covered person's authorized representative of
116 such failure not later than twenty-four hours after the health carrier
117 receives such request.

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

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

125 (1) Such notice may be provided in writing or by electronic means
126 and shall set forth, in a manner calculated to be understood by the
127 covered person or the covered person's authorized representative:

128 (A) Information sufficient to identify the benefit request or claim
129 involved, including the date of service, if applicable, the health care
130 professional and the claim amount;

131 (B) The specific reason or reasons for the adverse determination and
132 a description of the health carrier's standard, if any, that was used in

133 reaching the denial;

134 (C) Reference to the specific health benefit plan provisions on which
135 the determination is based;

136 (D) A description of any additional material or information
137 necessary for the covered person to perfect the benefit request or claim,
138 including an explanation of why the material or information is
139 necessary to perfect the request or claim;

140 (E) A description of the health carrier's internal grievance process
141 that includes (i) the health carrier's expedited review procedures, (ii)
142 any time limits applicable to such process or procedures, (iii) the
143 contact information for the organizational unit designated to
144 coordinate the review on behalf of the health carrier, and (iv) a
145 statement that the covered person or, if applicable, the covered
146 person's authorized representative is entitled, pursuant to the
147 requirements of the health carrier's internal grievance process, to [(I)
148 submit written comments, documents, records and other material
149 relating to the covered person's benefit request for consideration by the
150 individual or individuals conducting the review, and (II)] receive from
151 the health carrier, free of charge upon request, reasonable access to and
152 copies of all documents, records, communications and other
153 information and evidence regarding the covered person's benefit
154 request;

155 (F) If the adverse determination is based on a health carrier's
156 internal rule, guideline, protocol or other similar criterion, (i) the
157 specific rule, guideline, protocol or other similar criterion, or (ii) a
158 statement that a specific rule, guideline, protocol or other similar
159 criterion of the health carrier was relied upon to make the adverse
160 determination and that a copy of such rule, guideline, protocol or other
161 similar criterion will be provided to the covered person free of charge
162 upon request, and instructions for requesting such copy;

163 (G) If the adverse determination is based on medical necessity or an

164 experimental or investigational treatment or similar exclusion or limit,
165 the written statement of the scientific or clinical rationale for the
166 adverse determination and (i) an explanation of the scientific or clinical
167 rationale used to make the determination that applies the terms of the
168 health benefit plan to the covered person's medical circumstances or
169 (ii) a statement that an explanation will be provided to the covered
170 person free of charge upon request, and instructions for requesting a
171 copy of such explanation; [and]

172 (H) A statement explaining the right of the covered person to
173 contact the commissioner's office or the Office of the Healthcare
174 Advocate at any time for assistance or, upon completion of the health
175 carrier's internal grievance process, to file a civil suit in a court of
176 competent jurisdiction. Such statement shall include the contact
177 information for said offices; [.] and

178 (I) A statement that if the covered person or the covered person's
179 authorized representative chooses to file a grievance of an adverse
180 determination, (i) such appeals are sometimes successful, (ii) such
181 covered person or covered person's authorized representative may
182 benefit from free assistance from the Office of the Healthcare
183 Advocate, (iii) such covered person or covered person's authorized
184 representative is entitled and encouraged to submit supporting
185 documentation for the health carrier's clinical peer's or peers'
186 consideration during the review of an adverse determination,
187 including narratives from such covered person or covered person's
188 authorized representative describing the problem or problems, when
189 each arose and the covered person's symptoms, and letters and
190 treatment notes from such covered person's health care professionals,
191 and (iv) such covered person or covered person's authorized
192 representative has the right to ask such covered person's health care
193 professionals for such letters and treatment notes.

194 (2) Upon request pursuant to subparagraph (E) of subdivision (1) of
195 this subsection, the health carrier shall provide such copies in

196 accordance with subsection (a) of section 38a-591n.

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

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

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

205 (3) A disclosure that the covered person or the covered person's
206 authorized representative may file immediately, without waiting for
207 the date such advance notice of the proposed rescission ends, a
208 grievance with the health carrier to request a review of the adverse
209 determination to rescind coverage, pursuant to sections 38a-591e and
210 38a-591f, as amended by this act;

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

214 (5) The date such advance notice of the proposed rescission ends
215 and the date back to which the coverage will be retroactively
216 rescinded.

217 (g) (1) Whenever a health carrier fails to strictly adhere to the
218 requirements of this section with respect to making utilization review
219 and benefit determinations of a benefit request or claim, the covered
220 person shall be deemed to have exhausted the internal grievance
221 process of such health carrier and may file a request for an external
222 review in accordance with the provisions of section 38a-591g,
223 regardless of whether the health carrier asserts it substantially
224 complied with the requirements of this section or that any error it

225 committed was de minimis.

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

232 Sec. 3. Section 38a-591e of the general statutes is repealed and the
233 following is substituted in lieu thereof (*Effective September 1, 2013*):

234 (a) (1) Each health carrier shall establish and maintain written
235 procedures for (A) the review, by one or more clinical peers, of
236 grievances of adverse determinations that were based, in whole or in
237 part, on medical necessity, (B) the expedited review, by one or more
238 clinical peers, of grievances of adverse determinations of urgent care
239 requests, including concurrent review urgent care requests involving
240 an admission, availability of care, continued stay or health care service
241 for a covered person who has received emergency services but has not
242 been discharged from a facility, and (C) notifying covered persons or
243 covered persons' authorized representatives of such adverse
244 determinations.

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

248 (3) In addition to a copy of such procedures, each health carrier shall
249 file annually with the commissioner, as part of its annual report
250 required under subsection (e) of section 38a-591b, a certificate of
251 compliance stating that the health carrier has established and
252 maintains grievance procedures for each of its health benefit plans that
253 are fully compliant with the provisions of sections 38a-591a to 38a-
254 591n, inclusive, as amended by this act.

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

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

264 (c) (1) (A) When conducting a review of an adverse determination
265 under this section, the health carrier shall ensure that such review is
266 conducted in a manner to ensure the independence and impartiality of
267 the [individual or individuals] clinical peer or peers involved in
268 making the review decision.

269 (B) If the adverse determination involves utilization review, the
270 health carrier shall designate an appropriate clinical peer or peers to
271 review such adverse determination. Such clinical peer or peers shall
272 not have been involved in the initial adverse determination.

273 (C) The [individual or individuals] clinical peer or peers conducting
274 a review under this section shall take into consideration all comments,
275 documents, records and other information relevant to the covered
276 person's benefit request that is the subject of the adverse determination
277 under review, that are submitted by the covered person or the covered
278 person's authorized representative, regardless of whether such
279 information was submitted or considered in making the initial adverse
280 determination.

281 (D) Prior to issuing a decision, the health carrier shall provide free
282 of charge, by facsimile, electronic means or any other expeditious
283 method available, to the covered person or the covered person's
284 authorized representative, as applicable, any new or additional
285 documents, communications, information and evidence relied upon

286 and any new or additional scientific or clinical rationale used by the
287 health carrier in connection with the grievance. Such documents,
288 communications, information, evidence and rationale shall be
289 provided sufficiently in advance of the date the health carrier is
290 required to issue a decision to permit the covered person or the
291 covered person's authorized representative, as applicable, a reasonable
292 opportunity to respond prior to such date.

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

299 (3) If the review under subdivision (1) of this subsection is an
300 expedited review of a grievance involving an adverse determination of
301 a concurrent review urgent care request, the treatment shall be
302 continued without liability to the covered person until the covered
303 person has been notified of the review decision.

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

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

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

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

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

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

321 (A) The titles and qualifying credentials of the [individual or
322 individuals] clinical peer or peers participating in the review process;

323 (B) Information sufficient to identify the claim involved with respect
324 to the grievance, including the date of service, if applicable, the health
325 care professional and the claim amount;

326 (C) A statement of such [individual's or individuals'] clinical peer's
327 or peers' understanding of the covered person's grievance;

328 (D) The [individual's or individuals'] clinical peer's or peers'
329 decision in clear terms and the health benefit plan contract basis or
330 scientific or clinical rationale for such decision in sufficient detail for
331 the covered person to respond further to the health carrier's position;

332 (E) Reference to the evidence or documentation used as the basis for
333 the decision;

334 (F) For a decision that upholds the adverse determination:

335 (i) The specific reason or reasons for the final adverse
336 determination, including the denial code and its corresponding
337 meaning, as well as a description of the health carrier's standard, if
338 any, that was used in reaching the denial;

339 (ii) Reference to the specific health benefit plan provisions on which
340 the decision is based;

341 (iii) A statement that the covered person may receive from the

342 health carrier, free of charge and upon request, reasonable access to
343 and copies of, all documents, records, communications and other
344 information and evidence not previously provided regarding the
345 adverse determination under review;

346 (iv) If the final adverse determination is based on a health carrier's
347 internal rule, guideline, protocol or other similar criterion, (I) the
348 specific rule, guideline, protocol or other similar criterion, or (II) a
349 statement that a specific rule, guideline, protocol or other similar
350 criterion of the health carrier was relied upon to make the final adverse
351 determination and that a copy of such rule, guideline, protocol or other
352 similar criterion will be provided to the covered person free of charge
353 upon request and instructions for requesting such copy;

354 (v) If the final adverse determination is based on medical necessity
355 or an experimental or investigational treatment or similar exclusion or
356 limit, the written statement of the scientific or clinical rationale for the
357 final adverse determination and (I) an explanation of the scientific or
358 clinical rationale used to make the determination that applies the terms
359 of the health benefit plan to the covered person's medical
360 circumstances, or (II) a statement that an explanation will be provided
361 to the covered person free of charge upon request and instructions for
362 requesting a copy of such explanation;

363 (vi) A statement describing the procedures for obtaining an external
364 review of the final adverse determination;

365 (G) If applicable, the following statement: "You and your plan may
366 have other voluntary alternative dispute resolution options such as
367 mediation. One way to find out what may be available is to contact
368 your state Insurance Commissioner."; and

369 (H) A statement disclosing the covered person's right to contact the
370 commissioner's office or the Office of the Healthcare Advocate at any
371 time. Such disclosure shall include the contact information for said
372 offices.

373 (2) Upon request pursuant to subparagraph (F)(iii) of subdivision (1)
374 of this subsection, the health carrier shall provide such copies in
375 accordance with subsection (b) of section 38a-591n.

376 (f) (1) Whenever a health carrier fails to strictly adhere to the
377 requirements of this section with respect to receiving and resolving
378 grievances involving an adverse determination, the covered person
379 shall be deemed to have exhausted the internal grievance process of
380 such health carrier and may file a request for an external review,
381 regardless of whether the health carrier asserts that it substantially
382 complied with the requirements of this section, or that any error it
383 committed was de minimis.

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

390 (g) Notwithstanding subdivision (7) of section 38a-591a, as amended
391 by this act, for purposes of this section, on and after September 1, 2013,
392 and prior to January 1, 2015:

393 (1) "Clinical peer" means:

394 (A) A licensed health care professional who (i) holds a nonrestricted
395 license in a state of the United States, (ii) holds a doctoral or medical
396 degree, and (iii) (I) holds an appropriate national board certification
397 including at the subspecialty level where available, or (II) actively
398 practices and typically manages the medical condition under review or
399 provides the procedure or treatment under review; or

400 (B) For a review of an adverse determination under this section
401 concerning an adolescent substance use disorder treatment, as such
402 disorder is described in section 17a-458, a licensed health care

403 professional who (i) holds a nonrestricted license in a state of the
404 United States, (ii) holds a doctoral or medical degree, and (iii) (I) holds
405 a national board certification in child and adolescent psychiatry or
406 child and adolescent psychology, and (II) has training or clinical
407 experience in the treatment of adolescent substance use disorder.

408 (2) "Appropriate national board certification" means, for a clinical
409 peer who conducts any reviews of adverse determinations under this
410 section concerning adult substance use disorder treatment, as such
411 disorder is described in section 17a-458, certification by a national
412 addiction board.

413 Sec. 4. Subdivision (7) of section 38a-591a of the general statutes is
414 repealed and the following is substituted in lieu thereof (*Effective*
415 *September 1, 2013*):

416 (7) ["Clinical peer"] Except as provided in subsection (g) of section
417 38a-591e, as amended by this act, "clinical peer" means a [physician or
418 other] health care professional who holds a nonrestricted license in a
419 state of the United States and in the same or similar specialty as
420 typically manages the medical condition, procedure or treatment
421 under review.

422 Sec. 5. Subsection (d) of section 38a-591f of the general statutes is
423 repealed and the following is substituted in lieu thereof (*Effective*
424 *September 1, 2013*):

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

427 (A) The titles and qualifying credentials of the individual or
428 individuals participating in the review process;

429 (B) A statement of such individual's or individuals' understanding
430 of the covered person's grievance;

431 (C) The individual's or individuals' decision in clear terms and the

432 health benefit plan contract basis for such decision in sufficient detail
433 for the covered person to respond further to the health carrier's
434 position;

435 (D) Reference to the documents, communications, information and
436 evidence used as the basis for the decision; and

437 (E) For a decision that upholds the adverse determination, a
438 statement (i) that the covered person may receive from the health
439 carrier, free of charge and upon request, reasonable access to and
440 copies of, all documents, communications, information and evidence
441 regarding the adverse determination that is the subject of the final
442 adverse determination, and (ii) disclosing the covered person's right to
443 contact the commissioner's office or the Office of the Healthcare
444 Advocate at any time, and that such covered person may benefit from
445 free assistance from the Office of the Healthcare Advocate. Such
446 disclosure shall include the contact information for said offices.

447 (2) Upon request pursuant to subparagraph (E) of subdivision (1) of
448 this subsection, the health carrier shall provide such copies in
449 accordance with subsection (b) of section 38a-591n.

450 Sec. 6. Section 38a-591a of the general statutes, as amended by
451 sections 1 and 4 of this act, is repealed and the following is substituted
452 in lieu thereof (*Effective January 1, 2015*):

453 As used in this section and sections 38a-591b to 38a-591n, inclusive:

454 (1) "Adverse determination" means:

455 (A) The denial, reduction, termination or failure to provide or make
456 payment, in whole or in part, for a benefit under the health carrier's
457 health benefit plan requested by a covered person or a covered
458 person's treating health care professional, based on a determination by
459 a health carrier or its designee utilization review company:

460 (i) That, based upon the information provided, (I) upon application

461 of any utilization review technique, such benefit does not meet the
462 health carrier's requirements for medical necessity, appropriateness,
463 health care setting, level of care or effectiveness, or (II) is determined to
464 be experimental or investigational;

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

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

472 "Adverse determination" includes a rescission of coverage
473 determination for grievance purposes.

474 (2) "Appropriate national board certification" means, for a clinical
475 peer who conducts any reviews of or benefit determinations for adult
476 substance use disorder treatment, as such disorder is described in
477 section 17a-458, certification by a national addiction board.

478 [(2)] (3) "Authorized representative" means:

479 (A) A person to whom a covered person has given express written
480 consent to represent the covered person for the purposes of this section
481 and sections 38a-591b to 38a-591n, inclusive;

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

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

487 (D) A health care professional when the covered person's health
488 benefit plan requires that a request for a benefit under the plan be

489 initiated by the health care professional; or

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

492 [(3)] (4) "Best evidence" means evidence based on (A) randomized
493 clinical trials, (B) if randomized clinical trials are not available, cohort
494 studies or case-control studies, (C) if such trials and studies are not
495 available, case-series, or (D) if such trials, studies and case-series are
496 not available, expert opinion.

497 [(4)] (5) "Case-control study" means a retrospective evaluation of
498 two groups of patients with different outcomes to determine which
499 specific interventions the patients received.

500 [(5)] (6) "Case-series" means an evaluation of a series of patients
501 with a particular outcome, without the use of a control group.

502 [(6)] (7) "Certification" means a determination by a health carrier or
503 its designee utilization review company that a request for a benefit
504 under the health carrier's health benefit plan has been reviewed and,
505 based on the information provided, satisfies the health carrier's
506 requirements for medical necessity, appropriateness, health care
507 setting, level of care and effectiveness.

508 [(7) Except as provided in subsection (g) of section 38a-591e,
509 "clinical peer" means a health care professional who holds a
510 nonrestricted license in a state of the United States and in the same or
511 similar specialty as typically manages the medical condition,
512 procedure or treatment under review.]

513 (8) "Clinical peer" means:

514 (A) A licensed health care professional who (i) holds a nonrestricted
515 license in a state of the United States, (ii) holds a doctoral or medical
516 degree, and (iii) (I) holds an appropriate national board certification
517 including at the subspecialty level where available, or (II) actively

518 practices and typically manages the medical condition under review or
519 provides the procedure or treatment under review; or

520 (B) For a review or benefit determination concerning an adolescent
521 substance use disorder treatment, as such disorder is described in
522 section 17a-458, a licensed health care professional who (i) holds a
523 nonrestricted license in a state of the United States, (ii) holds a doctoral
524 or medical degree, and (iii) (I) holds a national board certification in
525 child and adolescent psychiatry or child and adolescent psychology,
526 and (II) has training or clinical experience in the treatment of
527 adolescent substance use disorder.

528 ~~[(8)]~~ (9) "Clinical review criteria" means the written screening
529 procedures, decision abstracts, clinical protocols and practice
530 guidelines used by the health carrier to determine the medical
531 necessity and appropriateness of health care services.

532 ~~[(9)]~~ (10) "Cohort study" means a prospective evaluation of two
533 groups of patients with only one group of patients receiving a specific
534 intervention or specific interventions.

535 ~~[(10)]~~ (11) "Commissioner" means the Insurance Commissioner.

536 ~~[(11)]~~ (12) "Concurrent review" means utilization review conducted
537 during a patient's stay or course of treatment in a facility, the office of a
538 health care professional or other inpatient or outpatient health care
539 setting, including home care.

540 ~~[(12)]~~ (13) "Covered benefits" or "benefits" means health care
541 services to which a covered person is entitled under the terms of a
542 health benefit plan.

543 ~~[(13)]~~ (14) "Covered person" means a policyholder, subscriber,
544 enrollee or other individual participating in a health benefit plan.

545 ~~[(14)]~~ (15) "Emergency medical condition" means a medical
546 condition manifesting itself by acute symptoms of sufficient severity,

547 including severe pain, such that a prudent layperson with an average
548 knowledge of health and medicine, acting reasonably, would have
549 believed that the absence of immediate medical attention would result
550 in serious impairment to bodily functions or serious dysfunction of a
551 bodily organ or part, or would place the person's health or, with
552 respect to a pregnant woman, the health of the woman or her unborn
553 child, in serious jeopardy.

554 [(15)] (16) "Emergency services" means, with respect to an
555 emergency medical condition:

556 (A) A medical screening examination that is within the capability of
557 the emergency department of a hospital, including ancillary services
558 routinely available to the emergency department to evaluate such
559 emergency medical condition; and

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

563 [(16)] (17) "Evidence-based standard" means the conscientious,
564 explicit and judicious use of the current best evidence based on an
565 overall systematic review of medical research when making
566 determinations about the care of individual patients.

567 [(17)] (18) "Expert opinion" means a belief or an interpretation by
568 specialists with experience in a specific area about the scientific
569 evidence pertaining to a particular service, intervention or therapy.

570 [(18)] (19) "Facility" means an institution providing health care
571 services or a health care setting. "Facility" includes a hospital and other
572 licensed inpatient center, ambulatory surgical or treatment center,
573 skilled nursing center, residential treatment center, diagnostic,
574 laboratory and imaging center, and rehabilitation and other
575 therapeutic health care setting.

576 [(19)] (20) "Final adverse determination" means an adverse
577 determination (A) that has been upheld by the health carrier at the
578 completion of its internal grievance process, or (B) for which the
579 internal grievance process has been deemed exhausted.

580 [(20)] (21) "Grievance" means a written complaint or, if the
581 complaint involves an urgent care request, an oral complaint,
582 submitted by or on behalf of a covered person regarding:

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

586 (B) Claims payment, handling or reimbursement for health care
587 services; or

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

590 [(21)] (22) (A) "Health benefit plan" means an insurance policy or
591 contract, certificate or agreement offered, delivered, issued for
592 delivery, renewed, amended or continued in this state to provide,
593 deliver, arrange for, pay for or reimburse any of the costs of health care
594 services;

595 (B) "Health benefit plan" does not include:

596 (i) Coverage of the type specified in subdivisions (5) to (9), inclusive,
597 (14) and (15) of section 38a-469 or any combination thereof;

598 (ii) Coverage issued as a supplement to liability insurance;

599 (iii) Liability insurance, including general liability insurance and
600 automobile liability insurance;

601 (iv) Workers' compensation insurance;

602 (v) Automobile medical payment insurance;

603 (vi) Credit insurance;

604 (vii) Coverage for on-site medical clinics;

605 (viii) Other insurance coverage similar to the coverages specified in
606 subparagraphs (B)(ii) to (B)(vii), inclusive, of this subdivision that are
607 specified in regulations issued pursuant to the Health Insurance
608 Portability and Accountability Act of 1996, P.L. 104-191, as amended
609 from time to time, under which benefits for health care services are
610 secondary or incidental to other insurance benefits;

611 (ix) (I) Limited scope dental or vision benefits, (II) benefits for long-
612 term care, nursing home care, home health care, community-based
613 care or any combination thereof, or (III) other similar, limited benefits
614 specified in regulations issued pursuant to the Health Insurance
615 Portability and Accountability Act of 1996, P.L. 104-191, as amended
616 from time to time, provided any benefits specified in subparagraphs
617 (B)(ix)(I) to (B)(ix)(III), inclusive, of this subdivision are provided
618 under a separate insurance policy, certificate or contract and are not
619 otherwise an integral part of a health benefit plan; or

620 (x) Coverage of the type specified in subdivisions (3) and (13) of
621 section 38a-469 or other fixed indemnity insurance if (I) they are
622 provided under a separate insurance policy, certificate or contract, (II)
623 there is no coordination between the provision of the benefits and any
624 exclusion of benefits under any group health plan maintained by the
625 same plan sponsor, and (III) the benefits are paid with respect to an
626 event without regard to whether benefits were also provided under
627 any group health plan maintained by the same plan sponsor.

628 [(22)] (23) "Health care center" has the same meaning as provided in
629 section 38a-175.

630 [(23)] (24) "Health care professional" means a physician or other
631 health care practitioner licensed, accredited or certified to perform
632 specified health care services consistent with state law.

633 [(24)] (25) "Health care services" has the same meaning as provided
634 in section 38a-478.

635 [(25)] (26) "Health carrier" means an entity subject to the insurance
636 laws and regulations of this state or subject to the jurisdiction of the
637 commissioner, that contracts or offers to contract to provide, deliver,
638 arrange for, pay for or reimburse any of the costs of health care
639 services, including a sickness and accident insurance company, a
640 health care center, a managed care organization, a hospital service
641 corporation, a medical service corporation or any other entity
642 providing a plan of health insurance, health benefits or health care
643 services.

644 [(26)] (27) "Health information" means information or data, whether
645 oral or recorded in any form or medium, and personal facts or
646 information about events or relationships that relate to (A) the past,
647 present or future physical, mental, or behavioral health or condition of
648 a covered person or a member of the covered person's family, (B) the
649 provision of health care services to a covered person, or (C) payment
650 for the provision of health care services to a covered person.

651 [(27)] (28) "Independent review organization" means an entity that
652 conducts independent external reviews of adverse determinations and
653 final adverse determinations. Such review entities include, but are not
654 limited to, medical peer review organizations, independent utilization
655 review companies, provided such organizations or companies are not
656 related to or associated with any health carrier, and nationally
657 recognized health experts or institutions approved by the Insurance
658 Commissioner.

659 [(28)] (29) "Medical or scientific evidence" means evidence found in
660 the following sources:

661 (A) Peer-reviewed scientific studies published in or accepted for
662 publication by medical journals that meet nationally recognized
663 requirements for scientific manuscripts and that submit most of their

664 published articles for review by experts who are not part of the
665 editorial staff;

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

672 (C) Medical journals recognized by the Secretary of the United
673 States Department of Health and Human Services under Section
674 1861(t)(2) of the Social Security Act;

675 (D) The following standard reference compendia: (i) The American
676 Hospital Formulary Service - Drug Information; (ii) Drug Facts and
677 Comparisons; (iii) The American Dental Association's Accepted Dental
678 Therapeutics; and (iv) The United States Pharmacopoeia - Drug
679 Information;

680 (E) Findings, studies or research conducted by or under the auspices
681 of federal government agencies and nationally recognized federal
682 research institutes, including: (i) The Agency for Healthcare Research
683 and Quality; (ii) the National Institutes of Health; (iii) the National
684 Cancer Institute; (iv) the National Academy of Sciences; (v) the Centers
685 for Medicare and Medicaid Services; (vi) the Food and Drug
686 Administration; and (vii) any national board recognized by the
687 National Institutes of Health for the purpose of evaluating the medical
688 value of health care services; or

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

692 [(29)] (30) "Medical necessity" has the same meaning as provided in
693 sections 38a-482a and 38a-513c.

694 [(30)] (31) "Participating provider" means a health care professional
695 who, under a contract with the health carrier, its contractor or
696 subcontractor, has agreed to provide health care services to covered
697 persons, with an expectation of receiving payment or reimbursement
698 directly or indirectly from the health carrier, other than coinsurance,
699 copayments or deductibles.

700 [(31)] (32) "Person" has the same meaning as provided in section
701 38a-1.

702 [(32)] (33) "Prospective review" means utilization review conducted
703 prior to an admission or the provision of a health care service or a
704 course of treatment, in accordance with a health carrier's requirement
705 that such service or treatment be approved, in whole or in part, prior
706 to such service's or treatment's provision.

707 [(33)] (34) "Protected health information" means health information
708 (A) that identifies an individual who is the subject of the information,
709 or (B) for which there is a reasonable basis to believe that such
710 information could be used to identify such individual.

711 [(34)] (35) "Randomized clinical trial" means a controlled,
712 prospective study of patients that have been randomized into an
713 experimental group and a control group at the beginning of the study,
714 with only the experimental group of patients receiving a specific
715 intervention, and that includes study of the groups for variables and
716 anticipated outcomes over time.

717 [(35)] (36) "Rescission" means a cancellation or discontinuance of
718 coverage under a health benefit plan that has a retroactive effect.
719 "Rescission" does not include a cancellation or discontinuance of
720 coverage under a health benefit plan if (A) such cancellation or
721 discontinuance has a prospective effect only, or (B) such cancellation or
722 discontinuance is effective retroactively to the extent it is attributable
723 to the covered person's failure to timely pay required premiums or
724 contributions towards the cost of such coverage.

725 [(36)] (37) "Retrospective review" means any review of a request for
726 a benefit that is not a prospective review or concurrent review.
727 "Retrospective review" does not include a review of a request that is
728 limited to the veracity of documentation or the accuracy of coding.

729 [(37)] (38) "Stabilize" means, with respect to an emergency medical
730 condition, that (A) no material deterioration of such condition is likely,
731 within reasonable medical probability, to result from or occur during
732 the transfer of the individual from a facility, or (B) with respect to a
733 pregnant woman, the woman has delivered, including the placenta.

734 [(38)] (39) "Urgent care request" means a request for a health care
735 service or course of treatment (A) for which the time period for making
736 a non-urgent care request determination (i) could seriously jeopardize
737 the life or health of the covered person or the ability of the covered
738 person to regain maximum function, or (ii) in the opinion of a health
739 care professional with knowledge of the covered person's medical
740 condition, would subject the covered person to severe pain that cannot
741 be adequately managed without the health care service or treatment
742 being requested, or (B) for a substance use disorder, as described in
743 section 17a-458, or for a co-occurring disorder.

744 [(39)] (40) "Utilization review" means the use of a set of formal
745 techniques designed to monitor the use of, or evaluate the medical
746 necessity, appropriateness, efficacy or efficiency of, health care
747 services, health care procedures or health care settings. Such
748 techniques may include the monitoring of or evaluation of (A) health
749 care services performed or provided in an outpatient setting, (B) the
750 formal process for determining, prior to discharge from a facility, the
751 coordination and management of the care that a patient receives
752 following discharge from a facility, (C) opportunities or requirements
753 to obtain a clinical evaluation by a health care professional other than
754 the one originally making a recommendation for a proposed health
755 care service, (D) coordinated sets of activities conducted for individual
756 patient management of serious, complicated, protracted or other health

757 conditions, or (E) prospective review, concurrent review, retrospective
758 review or certification.

759 [(40)] (41) "Utilization review company" means an entity that
760 conducts utilization review.

761 Sec. 7. Section 38a-591e of the general statutes, as amended by
762 section 3 of this act, is repealed and the following is substituted in lieu
763 thereof (*Effective January 1, 2015*):

764 (a) (1) Each health carrier shall establish and maintain written
765 procedures for (A) the review, by one or more clinical peers, of
766 grievances of adverse determinations that were based, in whole or in
767 part, on medical necessity, (B) the expedited review, by one or more
768 clinical peers, of grievances of adverse determinations of urgent care
769 requests, including concurrent review urgent care requests involving
770 an admission, availability of care, continued stay or health care service
771 for a covered person who has received emergency services but has not
772 been discharged from a facility, and (C) notifying covered persons or
773 covered persons' authorized representatives of such adverse
774 determinations.

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

778 (3) In addition to a copy of such procedures, each health carrier shall
779 file annually with the commissioner, as part of its annual report
780 required under subsection (e) of section 38a-591b, a certificate of
781 compliance stating that the health carrier has established and
782 maintains grievance procedures for each of its health benefit plans that
783 are fully compliant with the provisions of sections 38a-591a to 38a-
784 591n, inclusive, as amended by this act.

785 (b) (1) A covered person or a covered person's authorized
786 representative may file a grievance of an adverse determination that

787 was based, in whole or in part, on medical necessity with the health
788 carrier not later than one hundred eighty calendar days after the
789 covered person or the covered person's authorized representative, as
790 applicable, receives the notice of an adverse determination.

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

794 (c) (1) (A) When conducting a review of an adverse determination
795 under this section, the health carrier shall ensure that such review is
796 conducted in a manner to ensure the independence and impartiality of
797 the clinical peer or peers involved in making the review decision.

798 (B) If the adverse determination involves utilization review, the
799 health carrier shall designate an appropriate clinical peer or peers to
800 review such adverse determination. Such clinical peer or peers shall
801 not have been involved in the initial adverse determination.

802 (C) The clinical peer or peers conducting a review under this section
803 shall take into consideration all comments, documents, records and
804 other information relevant to the covered person's benefit request that
805 is the subject of the adverse determination under review, that are
806 submitted by the covered person or the covered person's authorized
807 representative, regardless of whether such information was submitted
808 or considered in making the initial adverse determination.

809 (D) Prior to issuing a decision, the health carrier shall provide free
810 of charge, by facsimile, electronic means or any other expeditious
811 method available, to the covered person or the covered person's
812 authorized representative, as applicable, any new or additional
813 documents, communications, information and evidence relied upon
814 and any new or additional scientific or clinical rationale used by the
815 health carrier in connection with the grievance. Such documents,
816 communications, information, evidence and rationale shall be
817 provided sufficiently in advance of the date the health carrier is

818 required to issue a decision to permit the covered person or the
819 covered person's authorized representative, as applicable, a reasonable
820 opportunity to respond prior to such date.

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

827 (3) If the review under subdivision (1) of this subsection is an
828 expedited review of a grievance involving an adverse determination of
829 a concurrent review urgent care request, the treatment shall be
830 continued without liability to the covered person until the covered
831 person has been notified of the review decision.

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

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

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

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

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

846 (e) (1) The notice required under subsection (d) of this section shall

847 set forth, in a manner calculated to be understood by the covered
848 person or the covered person's authorized representative:

849 (A) The titles and qualifying credentials of the clinical peer or peers
850 participating in the review process;

851 (B) Information sufficient to identify the claim involved with respect
852 to the grievance, including the date of service, if applicable, the health
853 care professional and the claim amount;

854 (C) A statement of such clinical peer's or peers' understanding of the
855 covered person's grievance;

856 (D) The clinical peer's or peers' decision in clear terms and the
857 health benefit plan contract basis or scientific or clinical rationale for
858 such decision in sufficient detail for the covered person to respond
859 further to the health carrier's position;

860 (E) Reference to the evidence or documentation used as the basis for
861 the decision;

862 (F) For a decision that upholds the adverse determination:

863 (i) The specific reason or reasons for the final adverse
864 determination, including the denial code and its corresponding
865 meaning, as well as a description of the health carrier's standard, if
866 any, that was used in reaching the denial;

867 (ii) Reference to the specific health benefit plan provisions on which
868 the decision is based;

869 (iii) A statement that the covered person may receive from the
870 health carrier, free of charge and upon request, reasonable access to
871 and copies of, all documents, records, communications and other
872 information and evidence not previously provided regarding the
873 adverse determination under review;

874 (iv) If the final adverse determination is based on a health carrier's
875 internal rule, guideline, protocol or other similar criterion, (I) the
876 specific rule, guideline, protocol or other similar criterion, or (II) a
877 statement that a specific rule, guideline, protocol or other similar
878 criterion of the health carrier was relied upon to make the final adverse
879 determination and that a copy of such rule, guideline, protocol or other
880 similar criterion will be provided to the covered person free of charge
881 upon request and instructions for requesting such copy;

882 (v) If the final adverse determination is based on medical necessity
883 or an experimental or investigational treatment or similar exclusion or
884 limit, the written statement of the scientific or clinical rationale for the
885 final adverse determination and (I) an explanation of the scientific or
886 clinical rationale used to make the determination that applies the terms
887 of the health benefit plan to the covered person's medical
888 circumstances, or (II) a statement that an explanation will be provided
889 to the covered person free of charge upon request and instructions for
890 requesting a copy of such explanation;

891 (vi) A statement describing the procedures for obtaining an external
892 review of the final adverse determination;

893 (G) If applicable, the following statement: "You and your plan may
894 have other voluntary alternative dispute resolution options such as
895 mediation. One way to find out what may be available is to contact
896 your state Insurance Commissioner."; and

897 (H) A statement disclosing the covered person's right to contact the
898 commissioner's office or the Office of the Healthcare Advocate at any
899 time. Such disclosure shall include the contact information for said
900 offices.

901 (2) Upon request pursuant to subparagraph (F)(iii) of subdivision (1)
902 of this subsection, the health carrier shall provide such copies in
903 accordance with subsection (b) of section 38a-591n.

904 (f) (1) Whenever a health carrier fails to strictly adhere to the
905 requirements of this section with respect to receiving and resolving
906 grievances involving an adverse determination, the covered person
907 shall be deemed to have exhausted the internal grievance process of
908 such health carrier and may file a request for an external review,
909 regardless of whether the health carrier asserts that it substantially
910 complied with the requirements of this section, or that any error it
911 committed was de minimis.

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

918 [(g) Notwithstanding subdivision (7) of section 38a-591a, for
919 purposes of this section, on and after September 1, 2013, and prior to
920 January 1, 2015:

921 (1) "Clinical peer" means:

922 (A) A licensed health care professional who (i) holds a nonrestricted
923 license in a state of the United States, (ii) holds a doctoral or medical
924 degree, and (iii) (I) holds an appropriate national board certification
925 including at the subspecialty level where available, or (II) actively
926 practices and typically manages the medical condition under review or
927 provides the procedure or treatment under review; or

928 (B) For a review of an adverse determination under this section
929 concerning an adolescent substance use disorder treatment, as such
930 disorder is described in section 17a-458, a licensed health care
931 professional who (i) holds a nonrestricted license in a state of the
932 United States, (ii) holds a doctoral or medical degree, and (iii) (I) holds
933 a national board certification in child and adolescent psychiatry or
934 child and adolescent psychology, and (II) has training or clinical

935 experience in the treatment of adolescent substance use disorder.

936 (2) "Appropriate national board certification" means, for a clinical
937 peer who conducts any reviews of adverse determinations under this
938 section concerning adult substance use disorder treatment, as such
939 disorder is described in section 17a-458, certification by a national
940 addiction board.]

941 Sec. 8. Section 38a-591c of the general statutes is repealed and the
942 following is substituted in lieu thereof (*Effective January 1, 2014*):

943 (a) (1) Each health carrier shall contract with (A) health care
944 professionals to administer such health carrier's utilization review
945 program and oversee utilization review determinations, and (B) [with]
946 clinical peers to evaluate the clinical appropriateness of an adverse
947 determination.

948 (2) (A) Each utilization review program shall use documented
949 clinical review criteria that are based on sound clinical evidence and
950 are evaluated periodically by the health carrier's organizational
951 mechanism specified in subparagraph (F) of subdivision (2) of
952 subsection (c) of section 38a-591b to assure such program's ongoing
953 effectiveness. A health carrier may develop its own clinical review
954 criteria or it may purchase or license clinical review criteria from
955 qualified vendors approved by the commissioner. Each health carrier
956 shall make its clinical review criteria available upon request to
957 authorized government agencies.

958 (B) Notwithstanding subparagraph (A) of this subdivision, for any
959 utilization review or benefit determination for the treatment of a
960 substance use disorder, as described in section 17a-458, or a co-
961 occurring disorder, the clinical review criteria used shall be: (i) The
962 most recent edition of the American Society of Addiction Medicine's
963 Patient Placement Criteria; or (ii) clinical review criteria that are (I)
964 developed as required under state law, and (II) reviewed and accepted
965 by the Department of Mental Health and Addiction Services for adults

966 and the Department of Children and Families for children and
967 adolescents, as adhering to the prevailing standard of care.

968 (C) A health carrier that uses clinical review criteria as set forth in
969 subparagraph (B)(ii) of this subdivision shall create and maintain a
970 document that (i) compares each aspect of such clinical review criteria
971 with the relevant provision of the American Society of Addiction
972 Medicine's Patient Placement Criteria, and (ii) provides citations to
973 peer-reviewed medical literature generally recognized by the relevant
974 medical community or to professional society guidelines that justify
975 each deviation from the American Society of Addiction Medicine's
976 Patient Placement Criteria.

977 (b) Each health carrier shall:

978 (1) Have procedures in place to ensure that the health care
979 professionals administering such health carrier's utilization review
980 program are applying the clinical review criteria consistently in
981 utilization review determinations;

982 (2) Have data systems sufficient to support utilization review
983 program activities and to generate management reports to enable the
984 health carrier to monitor and manage health care services effectively;

985 (3) Provide covered persons and participating providers with access
986 to its utilization review staff through a toll-free telephone number or
987 any other free calling option or by electronic means;

988 (4) Coordinate the utilization review program with other medical
989 management activity conducted by the health carrier, such as quality
990 assurance, credentialing, contracting with health care professionals,
991 data reporting, grievance procedures, processes for assessing member
992 satisfaction and risk management; and

993 (5) Routinely assess the effectiveness and efficiency of its utilization
994 review program.

995 (c) If a health carrier delegates any utilization review activities to a
996 utilization review company, the health carrier shall maintain adequate
997 oversight, which shall include (1) a written description of the
998 utilization review company's activities and responsibilities, including
999 such company's reporting requirements, (2) evidence of the health
1000 carrier's formal approval of the utilization review company program,
1001 and (3) a process by which the health carrier shall evaluate the
1002 utilization review company's performance.

1003 (d) When conducting utilization review, the health carrier shall (1)
1004 collect only the information necessary, including pertinent clinical
1005 information, to make the utilization review or benefit determination,
1006 and (2) ensure that such review is conducted in a manner to ensure the
1007 independence and impartiality of the individual or individuals
1008 involved in making the utilization review or benefit determination. No
1009 health carrier shall make decisions regarding the hiring, compensation,
1010 termination, promotion or other similar matters of such individual or
1011 individuals based on the likelihood that the individual or individuals
1012 will support the denial of benefits.

1013 Sec. 9. Subdivision (1) of subsection (a) of section 38a-591c of the
1014 general statutes, as amended by section 8 of this act, is repealed and
1015 the following is substituted in lieu thereof (*Effective January 1, 2015*):

1016 (a) (1) Each health carrier shall contract with (A) health care
1017 professionals to administer such health carrier's utilization review
1018 program and oversee utilization review determinations, and (B)
1019 clinical peers to [evaluate the clinical appropriateness of an] oversee
1020 and perform all reviews of adverse [determination] determinations.

1021 Sec. 10. Subsections (h) and (i) of section 38a-591g of the general
1022 statutes are repealed and the following is substituted in lieu thereof
1023 (*Effective January 1, 2015*):

1024 (h) In addition to the documents and information received pursuant
1025 to subsection (f) of this section, the independent review organization

1026 shall consider, to the extent the documents or information are available
1027 and the independent review organization considers them appropriate,
1028 the following in reaching a decision:

1029 (1) The covered person's medical records;

1030 (2) The attending health care professional's recommendation;

1031 (3) Consulting reports from appropriate health care professionals
1032 and other documents submitted by the health carrier, the covered
1033 person, the covered person's authorized representative or the covered
1034 person's treating health care professional;

1035 (4) The terms of coverage under the covered person's health benefit
1036 plan to ensure that the independent review organization's decision is
1037 not contrary to the terms of coverage under such health benefit plan;

1038 (5) The most appropriate practice guidelines, which shall include
1039 applicable evidence-based standards and may include any other
1040 practice guidelines developed by the federal government, national or
1041 professional medical societies, medical boards or medical associations;

1042 (6) Any applicable clinical review criteria developed and used by
1043 the health carrier or its designee utilization review company; and

1044 (7) The opinion or opinions of the independent review
1045 organization's clinical [peer or peers] reviewer or reviewers, as
1046 described in subdivision (4) of subsection (c) of section 38a-591l, as
1047 amended by this act, who conducted the review after considering
1048 subdivisions (1) to (6), inclusive, of this subsection.

1049 (i) (1) The independent review organization shall notify the
1050 commissioner, the health carrier, the covered person and, if applicable,
1051 the covered person's authorized representative in writing of its
1052 decision to uphold, reverse or revise the adverse determination or the
1053 final adverse determination, not later than:

1054 (A) For external reviews, forty-five calendar days after such
1055 organization receives the assignment from the commissioner to
1056 conduct such review;

1057 (B) For external reviews involving a determination that the
1058 recommended or requested health care service or treatment is
1059 experimental or investigational, twenty calendar days after such
1060 organization receives the assignment from the commissioner to
1061 conduct such review;

1062 (C) For expedited external reviews, as expeditiously as the covered
1063 person's medical condition requires, but not later than seventy-two
1064 hours after such organization receives the assignment from the
1065 commissioner to conduct such review; and

1066 (D) For expedited external reviews involving a determination that
1067 the recommended or requested health care service or treatment is
1068 experimental or investigational, as expeditiously as the covered
1069 person's medical condition requires, but not later than five calendar
1070 days after such organization receives the assignment from the
1071 commissioner to conduct such review.

1072 (2) Such notice shall include:

1073 (A) A general description of the reason for the request for the
1074 review;

1075 (B) The date the independent review organization received the
1076 assignment from the commissioner to conduct the review;

1077 (C) The date the review was conducted;

1078 (D) The date the organization made its decision;

1079 (E) The principal reason or reasons for its decision, including what
1080 applicable evidence-based standards, if any, were used as a basis for its
1081 decision;

1082 (F) The rationale for the organization's decision;

1083 (G) Reference to the evidence or documentation, including any
1084 evidence-based standards, considered by the organization in reaching
1085 its decision; and

1086 (H) For a review involving a determination that the recommended
1087 or requested health care service or treatment is experimental or
1088 investigational:

1089 (i) A description of the covered person's medical condition;

1090 (ii) A description of the indicators relevant to determining whether
1091 there is sufficient evidence to demonstrate that (I) the recommended or
1092 requested health care service or treatment is likely to be more
1093 beneficial to the covered person than any available standard health
1094 care services or treatments, and (II) the adverse risks of the
1095 recommended or requested health care service or treatment would not
1096 be substantially increased over those of available standard health care
1097 services or treatments;

1098 (iii) A description and analysis of any medical or scientific evidence
1099 considered in reaching the opinion;

1100 (iv) A description and analysis of any evidence-based standard; and

1101 (v) Information on whether the clinical [peer's] reviewer's rationale
1102 for the opinion is based on the documents and information set forth in
1103 subsection (f) of this section.

1104 (3) Upon the receipt of a notice of the independent review
1105 organization's decision to reverse or revise an adverse determination
1106 or a final adverse determination, the health carrier shall immediately
1107 approve the coverage that was the subject of the adverse determination
1108 or the final adverse determination.

1109 Sec. 11. Subsection (c) of section 38a-591l of the general statutes is

1110 repealed and the following is substituted in lieu thereof (*Effective*
1111 *January 1, 2015*):

1112 (c) To be eligible for approval by the commissioner, an independent
1113 review organization shall:

1114 (1) Have and maintain written policies and procedures that govern
1115 all aspects of both the standard external review process and the
1116 expedited external review process set forth in section 38a-591g, as
1117 amended by this act, that include, at a minimum:

1118 (A) A quality assurance mechanism in place that ensures:

1119 (i) That external reviews and expedited external reviews are
1120 conducted within the specified time frames and required notices are
1121 provided in a timely manner;

1122 (ii) (I) The selection of qualified and impartial clinical [peers]
1123 reviewers to conduct such reviews on behalf of the independent
1124 review organization and the suitable matching of such [peers]
1125 reviewers to specific cases, and (II) the employment of or the
1126 contracting with an adequate number of clinical [peers] reviewers to
1127 meet this objective;

1128 (iii) The confidentiality of medical and treatment records and
1129 clinical review criteria;

1130 (iv) That any person employed by or under contract with the
1131 independent review organization adheres to the requirements of
1132 section 38a-591g, as amended by this act; and

1133 (B) A toll-free telephone number to receive information twenty-four
1134 hours a day, seven days a week, related to external reviews and
1135 expedited external reviews and that is capable of accepting, recording
1136 or providing appropriate instruction to incoming telephone callers
1137 during other than normal business hours;

1138 (2) Agree to maintain and provide to the commissioner the
1139 information set forth in section 38a-591m, as amended by this act;

1140 (3) Not own or control, be a subsidiary of, be owned or controlled in
1141 any way by, or exercise control with a health benefit plan, a national,
1142 state or local trade association of health benefit plans, or a national,
1143 state or local trade association of health care professionals; and

1144 (4) Assign as a clinical [peer] reviewer a health care professional
1145 who meets the following minimum qualifications:

1146 (A) Holds a nonrestricted license in a state of the United States and
1147 in the same or similar specialty as typically manages the medical
1148 condition, procedure or treatment under review;

1149 ~~[(A)]~~ (B) Is an expert in the treatment of the covered person's
1150 medical condition that is the subject of the review;

1151 ~~[(B)]~~ (C) Is knowledgeable about the recommended health care
1152 service or treatment through recent or current actual clinical
1153 experience treating patients with the same or similar medical condition
1154 of the covered person;

1155 ~~[(C) Holds a nonrestricted license in a state of the United States and,~~
1156 ~~for]~~ (D) For physicians, a current certification by a recognized
1157 American medical specialty board in the area or areas appropriate to
1158 the subject of the review; and

1159 ~~[(D)]~~ (E) Has no history of disciplinary actions or sanctions,
1160 including loss of staff privileges or participation restrictions, that have
1161 been taken or are pending by any hospital, governmental agency or
1162 unit or regulatory body that raise a substantial question as to the
1163 clinical [peer's] reviewer's physical, mental or professional competence
1164 or moral character.

1165 Sec. 12. Subsections (a) to (d), inclusive, of section 38a-591m of the
1166 general statutes are repealed and the following is substituted in lieu

1167 thereof (*Effective January 1, 2015*):

1168 (a) The commissioner shall not assign an independent review
1169 organization, and no independent review organization shall assign a
1170 clinical [peer] reviewer, as described in subdivision (4) of subsection
1171 (c) of section 38a-591l, as amended by this act, to conduct an external
1172 review or an expedited external review of a specified case if such
1173 organization or clinical [peer] reviewer has a material professional,
1174 familial or financial conflict of interest with any of the following:

1175 (1) The health carrier that is the subject of such review;

1176 (2) The covered person whose treatment is the subject of such
1177 review or the covered person's authorized representative;

1178 (3) Any officer, director or management employee of the health
1179 carrier that is the subject of such review;

1180 (4) The health care provider, the health care provider's medical
1181 group or independent practice association recommending the health
1182 care service or treatment that is the subject of such review;

1183 (5) The facility at which the recommended health care service or
1184 treatment would be provided; or

1185 (6) The developer or manufacturer of the principal drug, device,
1186 procedure or other therapy being recommended for the covered
1187 person whose treatment is the subject of such review.

1188 (b) To determine whether an independent review organization or a
1189 clinical [peer] reviewer of the independent review organization has a
1190 material professional, familial or financial conflict of interest for
1191 purposes of subsection (a) of this section, the commissioner shall
1192 consider situations in which the independent review organization to
1193 be assigned to conduct an external review or an expedited external
1194 review of a specified case or a clinical [peer] reviewer to be assigned by
1195 the independent review organization to conduct such review of a

1196 specified case may have an apparent professional, familial or financial
 1197 relationship or connection with a person described in subsection (a) of
 1198 this section, but the characteristics of such relationship or connection
 1199 are such that they are not a material professional, familial or financial
 1200 conflict of interest that results in the disapproval of the independent
 1201 review organization or the clinical [peer] reviewer from conducting
 1202 such review.

1203 (c) An independent review organization shall be unbiased. In
 1204 addition to any other written procedures required under section 38a-
 1205 591l, as amended by this act, an independent review organization shall
 1206 establish and maintain written procedures to ensure that it is unbiased.

1207 (d) No independent review organization or clinical [peer] reviewer
 1208 working on behalf of an independent review organization or an
 1209 employee, agent or contractor of an independent review organization
 1210 shall be liable in damages to any person for any opinions rendered or
 1211 acts or omissions performed within the scope of the organization's or
 1212 person's duties during or upon completion of an external review or an
 1213 expedited external review conducted pursuant to section 38a-591g, as
 1214 amended by this act, unless such opinion was rendered or act or
 1215 omission performed in bad faith or involved gross negligence.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>September 1, 2013</i>	38a-591a(38)
Sec. 2	<i>September 1, 2013</i>	38a-591d
Sec. 3	<i>September 1, 2013</i>	38a-591e
Sec. 4	<i>September 1, 2013</i>	38a-591a(7)
Sec. 5	<i>September 1, 2013</i>	38a-591f(d)
Sec. 6	<i>January 1, 2015</i>	38a-591a
Sec. 7	<i>January 1, 2015</i>	38a-591e
Sec. 8	<i>January 1, 2014</i>	38a-591c
Sec. 9	<i>January 1, 2015</i>	38a-591c(a)(1)
Sec. 10	<i>January 1, 2015</i>	38a-591g(h) and (i)
Sec. 11	<i>January 1, 2015</i>	38a-591l(c)

Sec. 12	January 1, 2015	38a-591m(a) to (d)
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Statement of Purpose:

To implement the recommendations of the Legislative Program Review and Investigations Committee concerning the health carrier utilization review and grievance process.

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