



General Assembly

Substitute Bill No. 6557

January Session, 2013



**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2 is repealed and the following is substituted in lieu thereof (*Effective*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 Section 38a-591d of the general statutes is repealed and the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 treatment for a substance use disorder or detoxification in an
82 inpatient or residential treatment setting, the health carrier shall make
83 a determination as soon as possible, taking into account the covered
84 person's medical condition, but not later than twelve hours after the
85 health carrier receives such request, provided, if the urgent care
86 request is a concurrent review request to extend a course of treatment
87 beyond the initial period of time or the number of treatments, such
88 request is made at least twelve hours prior to the expiration of the
89 prescribed period of time or number of treatments.

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

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

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

109 (d) (1) Whenever a health carrier receives a review request from a

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

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

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

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

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

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

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

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

140 necessary to perfect the request or claim;

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

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

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

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

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

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

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

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

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

206 (3) A disclosure that the covered person or the covered person's
207 authorized representative may file immediately, without waiting for
208 the date such advance notice of the proposed rescission ends, a
209 grievance with the health carrier to request a review of the adverse
210 determination to rescind coverage, pursuant to sections 38a-591e and
211 38a-591f, as amended by this act;

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

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

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

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

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

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

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

249 (3) In addition to a copy of such procedures, each health carrier shall
250 file annually with the commissioner, as part of its annual report
251 required under subsection (e) of section 38a-591b, a certificate of
252 compliance stating that the health carrier has established and
253 maintains grievance procedures for each of its health benefit plans that
254 are fully compliant with the provisions of sections 38a-591a to 38a-
255 591n, inclusive, as amended by this act.

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

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

265 (c) (1) (A) When conducting a review of an adverse determination

266 under this section, the health carrier shall ensure that such review is
267 conducted in a manner to ensure the independence and impartiality of
268 the [individual or individuals] clinical peer or peers involved in
269 making the review decision.

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

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

282 (D) Prior to issuing a decision, the health carrier shall provide free
283 of charge, by facsimile, electronic means or any other expeditious
284 method available, to the covered person or the covered person's
285 authorized representative, as applicable, any new or additional
286 documents, communications, information and evidence relied upon
287 and any new or additional scientific or clinical rationale used by the
288 health carrier in connection with the grievance. Such documents,
289 communications, information, evidence and rationale shall be
290 provided sufficiently in advance of the date the health carrier is
291 required to issue a decision to permit the covered person or the
292 covered person's authorized representative, as applicable, a reasonable
293 opportunity to respond prior to such date.

294 (2) If the review under subdivision (1) of this subsection is an
295 expedited review, all necessary information, including the health
296 carrier's decision, shall be transmitted between the health carrier and
297 the covered person or the covered person's authorized representative,

298 as applicable, by telephone, facsimile, electronic means or any other
299 expeditious method available.

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

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

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

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

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

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

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

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

324 (B) Information sufficient to identify the claim involved with respect
325 to the grievance, including the date of service, if applicable, the health

326 care professional and the claim amount;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

385 (2) A covered person who has exhausted the internal grievance

386 process of a health carrier may, in addition to filing a request for an
387 external review, pursue any available remedies under state or federal
388 law on the basis that the health carrier failed to provide a reasonable
389 internal grievance process that would yield a decision on the merits of
390 the claim.

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

394 (1) "Clinical peer" means:

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

401 (B) For a review of an adverse determination under this section
402 concerning an adolescent substance use disorder treatment, as such
403 disorder is described in section 17a-458, a licensed health care
404 professional who (i) holds a nonrestricted license in a state of the
405 United States, (ii) holds a doctoral or medical degree, and (iii) (I) holds
406 a national board certification in child and adolescent psychiatry or
407 child and adolescent psychology, and (II) has training or clinical
408 experience in the treatment of adolescent substance use disorder.

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

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

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

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

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

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

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

432 (C) The individual's or individuals' decision in clear terms and the
433 health benefit plan contract basis for such decision in sufficient detail
434 for the covered person to respond further to the health carrier's
435 position;

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

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

447 disclosure shall include the contact information for said offices.

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

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

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

455 (1) "Adverse determination" means:

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

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

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

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

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

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

479 [(2)] (3) "Authorized representative" means:

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

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

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

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

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

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

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

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

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

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

514 (8) "Clinical peer" means:

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

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

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

533 [(9)] (10) "Cohort study" means a prospective evaluation of two

534 groups of patients with only one group of patients receiving a specific
535 intervention or specific interventions.

536 [(10)] (11) "Commissioner" means the Insurance Commissioner.

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

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

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

546 [(14)] (15) "Emergency medical condition" means a medical
547 condition manifesting itself by acute symptoms of sufficient severity,
548 including severe pain, such that a prudent layperson with an average
549 knowledge of health and medicine, acting reasonably, would have
550 believed that the absence of immediate medical attention would result
551 in serious impairment to bodily functions or serious dysfunction of a
552 bodily organ or part, or would place the person's health or, with
553 respect to a pregnant woman, the health of the woman or her unborn
554 child, in serious jeopardy.

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

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

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

563 hospital, to stabilize a patient.

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

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

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

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

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

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

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

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

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

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

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

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

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

602 (iv) Workers' compensation insurance;

603 (v) Automobile medical payment insurance;

604 (vi) Credit insurance;

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

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

612 (ix) (I) Limited scope dental or vision benefits, (II) benefits for long-
613 term care, nursing home care, home health care, community-based
614 care or any combination thereof, or (III) other similar, limited benefits
615 specified in regulations issued pursuant to the Health Insurance
616 Portability and Accountability Act of 1996, P.L. 104-191, as amended
617 from time to time, provided any benefits specified in subparagraphs
618 (B)(ix)(I) to (B)(ix)(III), inclusive, of this subdivision are provided

619 under a separate insurance policy, certificate or contract and are not
620 otherwise an integral part of a health benefit plan; or

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

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

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

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

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

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

650 provision of health care services to a covered person, or (C) payment
651 for the provision of health care services to a covered person.

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

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

662 (A) Peer-reviewed scientific studies published in or accepted for
663 publication by medical journals that meet nationally recognized
664 requirements for scientific manuscripts and that submit most of their
665 published articles for review by experts who are not part of the
666 editorial staff;

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

673 (C) Medical journals recognized by the Secretary of the United
674 States Department of Health and Human Services under Section
675 1861(t)(2) of the Social Security Act;

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

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

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

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

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

701 [(31)] (32) "Person" has the same meaning as provided in section
702 38a-1.

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

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

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

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

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

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

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

744 section 17a-458, or for a co-occurring disorder.

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

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

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

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

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

779 (3) In addition to a copy of such procedures, each health carrier shall
780 file annually with the commissioner, as part of its annual report
781 required under subsection (e) of section 38a-591b, a certificate of
782 compliance stating that the health carrier has established and
783 maintains grievance procedures for each of its health benefit plans that
784 are fully compliant with the provisions of sections 38a-591a to 38a-
785 591n, inclusive, as amended by this act.

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

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

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

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

803 (C) The clinical peer or peers conducting a review under this section
804 shall take into consideration all comments, documents, records and
805 other information relevant to the covered person's benefit request that
806 is the subject of the adverse determination under review, that are

807 submitted by the covered person or the covered person's authorized
808 representative, regardless of whether such information was submitted
809 or considered in making the initial adverse determination.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

864 (i) The specific reason or reasons for the final adverse

865 determination, including the denial code and its corresponding
866 meaning, as well as a description of the health carrier's standard, if
867 any, that was used in reaching the denial;

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

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

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

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

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

894 (G) If applicable, the following statement: "You and your plan may
895 have other voluntary alternative dispute resolution options such as

896 mediation. One way to find out what may be available is to contact
897 your state Insurance Commissioner."; and

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

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

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

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

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

922 (1) "Clinical peer" means:

923 (A) A licensed health care professional who (i) holds a nonrestricted
924 license in a state of the United States, (ii) holds a doctoral or medical
925 degree, and (iii) (I) holds an appropriate national board certification

926 including at the subspecialty level where available, or (II) actively
927 practices and typically manages the medical condition under review or
928 provides the procedure or treatment under review; or

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

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

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

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

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

957 shall make its clinical review criteria available upon request to
958 authorized government agencies.

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

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

978 (b) Each health carrier shall:

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

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

986 (3) Provide covered persons and participating providers with access
987 to its utilization review staff through a toll-free telephone number or

988 any other free calling option or by electronic means;

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

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

996 (c) If a health carrier delegates any utilization review activities to a
997 utilization review company, the health carrier shall maintain adequate
998 oversight, which shall include (1) a written description of the
999 utilization review company's activities and responsibilities, including
1000 such company's reporting requirements, (2) evidence of the health
1001 carrier's formal approval of the utilization review company program,
1002 and (3) a process by which the health carrier shall evaluate the
1003 utilization review company's performance.

1004 (d) When conducting utilization review, the health carrier shall (1)
1005 collect only the information necessary, including pertinent clinical
1006 information, to make the utilization review or benefit determination,
1007 and (2) ensure that such review is conducted in a manner to ensure the
1008 independence and impartiality of the individual or individuals
1009 involved in making the utilization review or benefit determination. No
1010 health carrier shall make decisions regarding the hiring, compensation,
1011 termination, promotion or other similar matters of such individual or
1012 individuals based on the likelihood that the individual or individuals
1013 will support the denial of benefits.

1014 Sec. 9. Subdivision (1) of subsection (a) of section 38a-591c of the
1015 general statutes, as amended by section 8 of this act, is repealed and
1016 the following is substituted in lieu thereof (*Effective January 1, 2015*):

1017 (a) (1) Each health carrier shall contract with (A) health care
1018 professionals to administer such health carrier's utilization review

1019 program and oversee utilization review determinations, and (B)
1020 clinical peers to [evaluate the clinical appropriateness of an] oversee
1021 and perform all reviews of adverse [determination] determinations.

1022 Sec. 10. Subsections (h) and (i) of section 38a-591g of the general
1023 statutes are repealed and the following is substituted in lieu thereof
1024 (*Effective January 1, 2015*):

1025 (h) In addition to the documents and information received pursuant
1026 to subsection (f) of this section, the independent review organization
1027 shall consider, to the extent the documents or information are available
1028 and the independent review organization considers them appropriate,
1029 the following in reaching a decision:

1030 (1) The covered person's medical records;

1031 (2) The attending health care professional's recommendation;

1032 (3) Consulting reports from appropriate health care professionals
1033 and other documents submitted by the health carrier, the covered
1034 person, the covered person's authorized representative or the covered
1035 person's treating health care professional;

1036 (4) The terms of coverage under the covered person's health benefit
1037 plan to ensure that the independent review organization's decision is
1038 not contrary to the terms of coverage under such health benefit plan;

1039 (5) The most appropriate practice guidelines, which shall include
1040 applicable evidence-based standards and may include any other
1041 practice guidelines developed by the federal government, national or
1042 professional medical societies, medical boards or medical associations;

1043 (6) Any applicable clinical review criteria developed and used by
1044 the health carrier or its designee utilization review company; and

1045 (7) The opinion or opinions of the independent review
1046 organization's clinical [peer or peers] reviewer or reviewers, as

1047 described in subdivision (4) of subsection (c) of section 38a-591l, as
1048 amended by this act, who conducted the review after considering
1049 subdivisions (1) to (6), inclusive, of this subsection.

1050 (i) (1) The independent review organization shall notify the
1051 commissioner, the health carrier, the covered person and, if applicable,
1052 the covered person's authorized representative in writing of its
1053 decision to uphold, reverse or revise the adverse determination or the
1054 final adverse determination, not later than:

1055 (A) For external reviews, forty-five calendar days after such
1056 organization receives the assignment from the commissioner to
1057 conduct such review;

1058 (B) For external reviews involving a determination that the
1059 recommended or requested health care service or treatment is
1060 experimental or investigational, twenty calendar days after such
1061 organization receives the assignment from the commissioner to
1062 conduct such review;

1063 (C) For expedited external reviews, as expeditiously as the covered
1064 person's medical condition requires, but not later than seventy-two
1065 hours after such organization receives the assignment from the
1066 commissioner to conduct such review; and

1067 (D) For expedited external reviews involving a determination that
1068 the recommended or requested health care service or treatment is
1069 experimental or investigational, as expeditiously as the covered
1070 person's medical condition requires, but not later than five calendar
1071 days after such organization receives the assignment from the
1072 commissioner to conduct such review.

1073 (2) Such notice shall include:

1074 (A) A general description of the reason for the request for the
1075 review;

1076 (B) The date the independent review organization received the
1077 assignment from the commissioner to conduct the review;

1078 (C) The date the review was conducted;

1079 (D) The date the organization made its decision;

1080 (E) The principal reason or reasons for its decision, including what
1081 applicable evidence-based standards, if any, were used as a basis for its
1082 decision;

1083 (F) The rationale for the organization's decision;

1084 (G) Reference to the evidence or documentation, including any
1085 evidence-based standards, considered by the organization in reaching
1086 its decision; and

1087 (H) For a review involving a determination that the recommended
1088 or requested health care service or treatment is experimental or
1089 investigational:

1090 (i) A description of the covered person's medical condition;

1091 (ii) A description of the indicators relevant to determining whether
1092 there is sufficient evidence to demonstrate that (I) the recommended or
1093 requested health care service or treatment is likely to be more
1094 beneficial to the covered person than any available standard health
1095 care services or treatments, and (II) the adverse risks of the
1096 recommended or requested health care service or treatment would not
1097 be substantially increased over those of available standard health care
1098 services or treatments;

1099 (iii) A description and analysis of any medical or scientific evidence
1100 considered in reaching the opinion;

1101 (iv) A description and analysis of any evidence-based standard; and

1102 (v) Information on whether the clinical [peer's] reviewer's rationale

1103 for the opinion is based on the documents and information set forth in
1104 subsection (f) of this section.

1105 (3) Upon the receipt of a notice of the independent review
1106 organization's decision to reverse or revise an adverse determination
1107 or a final adverse determination, the health carrier shall immediately
1108 approve the coverage that was the subject of the adverse determination
1109 or the final adverse determination.

1110 Sec. 11. Subsection (c) of section 38a-591l of the general statutes is
1111 repealed and the following is substituted in lieu thereof (*Effective*
1112 *January 1, 2015*):

1113 (c) To be eligible for approval by the commissioner, an independent
1114 review organization shall:

1115 (1) Have and maintain written policies and procedures that govern
1116 all aspects of both the standard external review process and the
1117 expedited external review process set forth in section 38a-591g, as
1118 amended by this act, that include, at a minimum:

1119 (A) A quality assurance mechanism in place that ensures:

1120 (i) That external reviews and expedited external reviews are
1121 conducted within the specified time frames and required notices are
1122 provided in a timely manner;

1123 (ii) (I) The selection of qualified and impartial clinical [peers]
1124 reviewers to conduct such reviews on behalf of the independent
1125 review organization and the suitable matching of such [peers]
1126 reviewers to specific cases, and (II) the employment of or the
1127 contracting with an adequate number of clinical [peers] reviewers to
1128 meet this objective;

1129 (iii) The confidentiality of medical and treatment records and
1130 clinical review criteria;

1131 (iv) That any person employed by or under contract with the
1132 independent review organization adheres to the requirements of
1133 section 38a-591g, as amended by this act; and

1134 (B) A toll-free telephone number to receive information twenty-four
1135 hours a day, seven days a week, related to external reviews and
1136 expedited external reviews and that is capable of accepting, recording
1137 or providing appropriate instruction to incoming telephone callers
1138 during other than normal business hours;

1139 (2) Agree to maintain and provide to the commissioner the
1140 information set forth in section 38a-591m, as amended by this act;

1141 (3) Not own or control, be a subsidiary of, be owned or controlled in
1142 any way by, or exercise control with a health benefit plan, a national,
1143 state or local trade association of health benefit plans, or a national,
1144 state or local trade association of health care professionals; and

1145 (4) Assign as a clinical [peer] reviewer a health care professional
1146 who meets the following minimum qualifications:

1147 (A) Holds a nonrestricted license in a state of the United States and
1148 in the same or similar specialty as typically manages the medical
1149 condition, procedure or treatment under review;

1150 [(A)] (B) Is an expert in the treatment of the covered person's
1151 medical condition that is the subject of the review;

1152 [(B)] (C) Is knowledgeable about the recommended health care
1153 service or treatment through recent or current actual clinical
1154 experience treating patients with the same or similar medical condition
1155 of the covered person;

1156 [(C)] (D) [Holds a nonrestricted license in a state of the United States
1157 and, for] For physicians, a current certification by a recognized
1158 American medical specialty board in the area or areas appropriate to
1159 the subject of the review; and

1160 [(D)] (E) Has no history of disciplinary actions or sanctions,
1161 including loss of staff privileges or participation restrictions, that have
1162 been taken or are pending by any hospital, governmental agency or
1163 unit or regulatory body that raise a substantial question as to the
1164 clinical [peer's] reviewer's physical, mental or professional competence
1165 or moral character.

1166 Sec. 12. Subsections (a) to (d), inclusive, of section 38a-591m of the
1167 general statutes are repealed and the following is substituted in lieu
1168 thereof (*Effective January 1, 2015*):

1169 (a) The commissioner shall not assign an independent review
1170 organization, and no independent review organization shall assign a
1171 clinical [peer] reviewer, as described in subdivision (4) of subsection
1172 (c) of section 38a-591l, as amended by this act, to conduct an external
1173 review or an expedited external review of a specified case if such
1174 organization or clinical [peer] reviewer has a material professional,
1175 familial or financial conflict of interest with any of the following:

1176 (1) The health carrier that is the subject of such review;

1177 (2) The covered person whose treatment is the subject of such
1178 review or the covered person's authorized representative;

1179 (3) Any officer, director or management employee of the health
1180 carrier that is the subject of such review;

1181 (4) The health care provider, the health care provider's medical
1182 group or independent practice association recommending the health
1183 care service or treatment that is the subject of such review;

1184 (5) The facility at which the recommended health care service or
1185 treatment would be provided; or

1186 (6) The developer or manufacturer of the principal drug, device,
1187 procedure or other therapy being recommended for the covered
1188 person whose treatment is the subject of such review.

1189 (b) To determine whether an independent review organization or a
 1190 clinical [peer] reviewer of the independent review organization has a
 1191 material professional, familial or financial conflict of interest for
 1192 purposes of subsection (a) of this section, the commissioner shall
 1193 consider situations in which the independent review organization to
 1194 be assigned to conduct an external review or an expedited external
 1195 review of a specified case or a clinical [peer] reviewer to be assigned by
 1196 the independent review organization to conduct such review of a
 1197 specified case may have an apparent professional, familial or financial
 1198 relationship or connection with a person described in subsection (a) of
 1199 this section, but the characteristics of such relationship or connection
 1200 are such that they are not a material professional, familial or financial
 1201 conflict of interest that results in the disapproval of the independent
 1202 review organization or the clinical [peer] reviewer from conducting
 1203 such review.

1204 (c) An independent review organization shall be unbiased. In
 1205 addition to any other written procedures required under section 38a-
 1206 591l, as amended by this act, an independent review organization shall
 1207 establish and maintain written procedures to ensure that it is unbiased.

1208 (d) No independent review organization or clinical [peer] reviewer
 1209 working on behalf of an independent review organization or an
 1210 employee, agent or contractor of an independent review organization
 1211 shall be liable in damages to any person for any opinions rendered or
 1212 acts or omissions performed within the scope of the organization's or
 1213 person's duties during or upon completion of an external review or an
 1214 expedited external review conducted pursuant to section 38a-591g, as
 1215 amended by this act, unless such opinion was rendered or act or
 1216 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	<i>January 1, 2015</i>	38a-591m(a) to (d)

PRI *Joint Favorable Subst.*