

---

---

## **OLR Bill Analysis**

### **sHB 6557**

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

#### **SUMMARY:**

This bill (1) reduces the time that insurers and other health carriers have to make benefit determinations for a service or treatment for substance use disorder or co-occurring disorder and (2) entitles the covered person to an expedited review of an adverse determination (e.g., a claim denial). By law, an insured can grieve a benefit determination in a multi-step process that can involve reviews by the carrier and independent review organization.

The bill establishes additional notice requirements when a carrier makes or upholds any adverse determination.

The bill (1) expands the role of health professionals who are “clinical peers” that review carriers’ decisions and (2) requires that clinical peers have additional qualifications.

The bill phases in its major provisions, with some taking effect September 1, 2013 and the rest January 1, 2015.

**EFFECTIVE DATE:** September 1, 2013 for the provisions concerning substance use or co-occurring disorder determinations and expedited reviews, the notice requirements, and some of the provisions concerning clinical peers, January 1, 2014 for the clinical review criteria for substance use and co-occurring disorders, and January 1, 2015 for the remaining provisions.

#### **REQUEST FOR SUBSTANCE USE OR CO-OCCURRING DISORDER TREATMENT**

#### ***Benefit Determination (§§1 and 2(c))***

By law, the amount of time a carrier has to make a benefit determination depends on whether or not it is an urgent request. In general, carriers must make a determination within 15 calendar days for non-urgent requests but within 72 hours for urgent requests.

The bill treats as urgent requests those for a service or treatment for substance use disorder or a co-occurring disorder. It requires the carrier to make its determination as soon as possible, but no more than 12 hours after it receives a request for inpatient treatment for a substance use disorder or detoxification in an inpatient or residential setting. If the request is to extend a course of treatment beyond the initial period or number of treatments, the request must be made at least 12 hours before the initial authorization runs out. The 12 hour deadline for the carrier does not apply if the covered person or his or her representative fails to provide the information the carrier needs to make its determination.

### ***Expedited Reviews***

By classifying requests for these services and treatments as urgent, the bill entitles the covered person to an expedited review of an adverse determination. By law, the carrier or independent review organization must notify the covered person and his or her representative of its decision regarding an expedited review within 72 hours of receiving a grievance.

### ***Utilization Review (§ 8)***

By law, each carrier must contract with health care professionals to administer its utilization review program. Utilization review is the use of formal techniques to monitor the use of health care services or evaluate their medical necessity, appropriateness, efficacy, or efficiency.

Under current law, each program must use documented clinical review criteria based on sound clinical evidence. The bill requires that, for any utilization review or benefit determination for treating a substance use or co-occurring disorder, the program use the following criteria:

1. the most recent edition of the American Society of Addiction Medicine's Patient Placement Criteria or
2. clinical review criteria that are developed as required under state law and reviewed and accepted by the Department of Mental Health and Addiction Services for adults and the Department of Children and Families for children and adolescents, as adhering to the prevailing standard of care.

The bill requires carriers that use clinical review criteria developed pursuant to state law to create and maintain a document that:

1. compares each aspect of these criteria with the society's patient placement criteria and
2. provides citations to peer-reviewed medical literature generally recognized by the relevant medical community or to professional society guidelines that justify each deviation from those criteria.

## **ADVERSE DETERMINATIONS**

### ***Notice (§§ 2(e)(1)(I) and 5)***

By law, each carrier must promptly provide notice of any adverse determination to a covered person and, if applicable, his or her authorized representative. The notice must describe the carrier's internal grievance procedures. The bill requires the notice to include a statement that, if the covered person or his or her representative chooses to file a grievance of an adverse determination, that:

1. such appeals sometimes succeed;
2. the covered person or his or her representative may benefit from free assistance from the Office of the Healthcare Advocate (OHA), which can help with a grievance under federal law;
3. the covered person or representative is entitled and encouraged to submit supporting documentation for the health carrier's clinical peers to consider during the review of an adverse

determination, including their narratives describing the problem, when the problem arose, the covered person's symptoms, and letters and treatment notes from such covered person's health care professional; and

4. the covered person or representative has the right to ask his or her health care professional for these letters and treatment notes.

The law imposes additional notice requirements when a carrier's internal review process upholds an adverse determination not based on medical necessity. The bill further requires that the decision in such cases disclose:

1. the covered person's right to contact the commissioner's office or OHA at any time and
2. that he or she may benefit from free assistance from OHA.

The disclosure must include the contact information for the offices. By law, the notice must include a statement informing the covered person that he or she can contact the commissioner's office or OHA or file a lawsuit after completing the carrier's internal grievance process.

#### **CLINICAL PEERS (§§ 3, 4, 6, 7, & 9)**

By law, carriers must have written policies for (1) reviewing adverse determinations that are based at least in part on medical necessity and (2) expedited reviews of urgent care requests. The bill requires, starting September 1, 2013, that these internal reviews performed pursuant to these policies be conducted by clinical peers and makes conforming changes.

Under current law, carriers must contract with clinical peers to evaluate the clinical appropriateness of adverse determinations. Starting January 1, 2015, the bill requires carriers to contract with clinical peers to oversee and perform all reviews of adverse determinations.

Under current law, a clinical peer must be a health care professional who holds a nonrestricted license in a state in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review. The bill defines clinical peers, starting September 1, 2013, as a licensed health care professional who:

1. holds a nonrestricted license in a state,
2. holds a doctoral or medical degree, and
3. (a) holds an appropriate national board certification including at the subspecialty level where available or (b) actively practices and typically manages the medical condition under review or provides the procedure or treatment under review.

Starting September 1, 2013, for an internal review of an adverse determination based on medical necessity concerning an adolescent substance use disorder treatment, the bill requires that the health care professional meet the above license and degree requirements and (1) hold a national board certification in child and adolescent psychiatry or child and adolescent psychology, and (2) have training or clinical experience in the treatment of adolescent substance use disorder. Starting January 1, 2015, this requirement applies to all reviews and benefit determinations regarding treatments of this disorder.

Starting September 1, 2013, for internal reviews of adverse determinations concerning treatment for adult substance use disorder, "appropriate national board certification" means certification by a national addiction board. Starting January 1, 2015, the bill extends this definition to a clinical peer who reviews any benefit determination or review for such treatments.

The bill retains the current qualifications for a clinical peer who conducts external reviews of determinations for an independent review organization that conducts the reviews, but renames these individuals "clinical reviewers."

## **BACKGROUND**

**Related Bills**

SB 599, reported favorably by the Insurance and Real Estate Committee (File 5), requires health insurers to authorize an insured's pharmacy to fill a prescription if the insured or his or her authorized representative files a grievance or requests a review of an adverse determination or final adverse determination related to dispensing a drug prescribed by a licensed participating provider.

HB 6517, reported favorably by the Program Review and Investigations Committee, among other things requires the Insurance Department to request the U.S. Department of Health and Human Services to rule on whether external appeal applicants must provide either an adverse determination notice, an insurance identification card, or both, and act accordingly in response.

HB 6612, reported favorably by the Insurance and Real Estate Committee, makes various changes to the health insurance grievance process for adverse determinations. Among other things, it:

1. treats as urgent requests for certain services or treatments for mental or substance use disorders,
2. specifies the clinical review criteria that must be used in any benefit determination or utilization review regarding the treatment or provision of services for these disorders,
3. modifies the standard for determining whether other benefit requests should be considered urgent,
4. expands the role of clinical peers and notice requirements for carriers, and
5. establishes requirements for the implementation of the law that requires parity of treatment of mental health insurance coverage.

**COMMITTEE ACTION**

Program Review and Investigations Committee

Joint Favorable Substitute

Yea 9 Nay 1 (03/14/2013)