OLR Bill Analysis

SB 180

AN ACT CONCERNING ADVERSE DETERMINATION AND UTILIZATION REVIEWS.

SUMMARY

For insurance utilization or adverse determination reviews, this bill establishes a rebuttable presumption that a health care service is medically necessary if it was ordered by a health professional acting within his or her scope of practice (see BACKGROUND). For utilization reviews, the bill imposes on health carriers or utilization review companies the burden of proving a health care service is not medically necessary. For adverse determination reviews, a carrier may rebut the presumption by reasonably substantiating to the clinical peers doing the review that the service is not medically necessary. (Utilization and adverse determination reviews are steps in determining whether a specific service is covered and reimbursed.)

The bill generally increases the requirements to qualify as a "clinical peer" for adverse determination reviews, by requiring the person to be licensed in the same specialty, rather than a similar one, as the professional under review. (It does not change existing, generally comparable requirements that apply in cases involving the urgent treatment of substance use or mental disorders.)

The bill also requires health carriers to authorize clinical peers to reverse initial adverse determinations that were based on medical necessity. This applies when the carrier, as required by law, offers a covered person's health care professional the opportunity to confer with a clinical peer of the carrier following the adverse determination (see BACKGROUND).

EFFECTIVE DATE: January 1, 2025

§ 1 — CLINICAL PEER QUALIFICATIONS

Under current law, clinical peers doing adverse determination reviews generally must have a nonrestricted license (in any U.S. state) in the same or similar specialty that typically manages the medical condition, procedures, or treatment under review. The bill instead generally requires these clinical peers to have a nonrestricted license in the same specialty as the treating physician or other health care professional under review.

By law, unchanged by the bill, for urgent care requests of substance use or mental health disorders under certain circumstances, the clinical peer must be a (1) psychologist with relevant training and clinical experience or (2) psychiatrist.

BACKGROUND

Utilization and Adverse Determination Reviews

Generally, reviews have up to three steps: (1) an initial utilization review to determine if the procedure is covered; (2) a grievance review (i.e., internal review), which occurs when a covered person appeals a benefit denial (i.e., adverse determination); and (3) an external review, which is done when a covered person exhausts a health carrier's internal process and appeals the carrier's adverse determination to the Insurance Department. External reviews, also called final adverse determination reviews, are done by an independent review organization assigned by the department.

Medically Necessary

State law specifies the definition of "medically necessary" that health policies must include. In general, a health care service is medically necessary if it would be provided by a physician exercising prudent clinical judgment for the purposes of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and it is:

1. in keeping with generally accepted medical standards;

2. clinically appropriate and considered effective for the illness,

injury, or disease;

3. not primarily for the convenience of the patient, physician, or other health care provider; and

4. not more costly than therapeutically equivalent alternative treatments (CGS §§ 38a-482a and 38a-513c).

Conference With Clinical Peer Following Adverse Determination

The law requires a carrier to offer a covered person's health care professional an opportunity to confer with a clinical peer of the carrier under certain circumstances. This applies:

1. after a covered person or his or her representative or health care professional is notified of an initial adverse determination of a concurrent or prospective utilization review, or of a benefit request, that was at least partially based on medical necessity and

2. as long as the covered person, representative, or health care professional has not already filed a grievance of the initial adverse determination.

COMMITTEE ACTION

Public Health Committee

Joint Favorable
Yea 30 Nay 7 (03/04/2024)