

LEGISLATURE OF NEBRASKA  
ONE HUNDRED THIRD LEGISLATURE  
FIRST SESSION  
**LEGISLATIVE BILL 147**

Introduced by Gloor, 35.

Read first time January 11, 2013

Committee: Banking, Commerce and Insurance

A BILL

1 FOR AN ACT relating to insurance; to adopt the Health Carrier  
2 External Review Act; to eliminate certain grievance  
3 review provisions; and to outright repeal section  
4 44-7309, Reissue Revised Statutes of Nebraska.  
5 Be it enacted by the people of the State of Nebraska,

1           Section 1. Sections 1 to 18 of this act shall be known  
2 and may be cited as the Health Carrier External Review Act.

3           Sec. 2. The purpose of the Health Carrier External Review  
4 Act is to provide uniform standards for the establishment and  
5 maintenance of external review procedures to assure that covered  
6 persons have the opportunity for an independent review of an adverse  
7 determination or final adverse determination.

8           Sec. 3. For purposes of the Health Carrier External  
9 Review Act:

10           (1) Adverse determination means a determination by a  
11 health carrier or its designee utilization review organization that  
12 an admission, the availability of care, a continued stay, or other  
13 health care service that is a covered benefit has been reviewed and,  
14 based upon the information provided, does not meet the health  
15 carrier's requirements for medical necessity, appropriateness, health  
16 care setting, level of care, or effectiveness, and the requested  
17 service or payment for the service is therefor denied, reduced, or  
18 terminated;

19           (2) Ambulatory review means the utilization review of  
20 health care services performed or provided in an outpatient setting;

21           (3) Authorized representative means:

22           (a) A person to whom a covered person has given express  
23 written consent to represent the covered person in an external  
24 review;

25           (b) A person authorized by law to provide substituted

1 consent for a covered person; or

2 (c) A family member of the covered person or the covered  
3 person's treating health care professional only when the covered  
4 person is unable to provide consent;

5 (4) Benefits or covered benefits means those health care  
6 services to which a covered person is entitled under the terms of a  
7 health benefit plan;

8 (5) Best evidence means evidence based on:

9 (a) Randomized clinical trials;

10 (b) If randomized clinical trials are not available,  
11 cohort studies or case-control studies;

12 (c) If the criteria described in subdivisions (5)(a) and  
13 (b) of this section are not available, case-series; or

14 (d) If the criteria described in subdivisions (5)(a),  
15 (b), and (c) of this section are not available, expert opinions;

16 (6) Case-control study means a retrospective evaluation  
17 of two groups of patients with different outcomes to determine which  
18 specific interventions the patients received;

19 (7) Case management means a coordinated set of activities  
20 conducted for individual patient management of serious, complicated,  
21 protracted, or other health conditions;

22 (8) Case-series means an evaluation of a series of  
23 patients with a particular outcome, without the use of a control  
24 group;

25 (9) Certification means a determination by a health

1 carrier or its designee utilization review organization that an  
2 admission, the availability of care, a continued stay, or other  
3 health care service has been reviewed and, based upon the information  
4 provided, satisfies the health carrier's requirements for medical  
5 necessity, appropriateness, health care setting, level of care, and  
6 effectiveness;

7 (10) Clinical review criteria means the written screening  
8 procedures, decision abstracts, clinical protocols, and practice  
9 guidelines used by a health carrier to determine the necessity and  
10 appropriateness of health care services;

11 (11) Cohort study means a prospective evaluation of two  
12 groups of patients with only one group of patients receiving a  
13 specific intervention;

14 (12) Concurrent review means a utilization review  
15 conducted during a patient's hospital stay or course of treatment;

16 (13) Covered person means a policyholder, subscriber,  
17 enrollee, or other individual participating in a health benefit plan;

18 (14) Director means the Director of Insurance;

19 (15) Discharge planning means the formal process for  
20 determining, prior to discharge from a facility, the coordination and  
21 management of the care that a patient receives following discharge  
22 from a facility;

23 (16) Disclose means to release, transfer, or otherwise  
24 divulge protected health information to any person other than the  
25 individual who is the subject of the protected health information;

1           (17) Emergency medical condition means the sudden and, at  
2 the time, unexpected onset of a health condition or illness that  
3 requires immediate medical attention and failure to provide such  
4 medical attention would result in a serious impairment to bodily  
5 functions, serious dysfunction of a bodily organ or part, or would  
6 place the person's health in serious jeopardy;

7           (18) Emergency services means health care items and  
8 services furnished or required to evaluate and treat an emergency  
9 medical condition;

10           (19) Evidence-based standard means the conscientious,  
11 explicit, and judicious use of the current best evidence based on the  
12 overall systematic review of the research in making decisions about  
13 the care of an individual patient;

14           (20) Expert opinion means a belief or an interpretation  
15 by a specialist with experience in a specific area about the  
16 scientific evidence pertaining to a particular service, intervention,  
17 or therapy;

18           (21) Facility means an institution providing health care  
19 services or a health care setting, including, but not limited to,  
20 hospitals and other licensed inpatient centers, ambulatory surgical  
21 or treatment centers, skilled nursing centers, residential treatment  
22 centers, diagnostic, laboratory and imaging centers, and  
23 rehabilitation and other therapeutic health settings;

24           (22) Final adverse determination means an adverse  
25 determination involving a covered benefit that has been upheld by a

1 health carrier, or its designee utilization review organization, at  
2 the completion of the health carrier's internal grievance process  
3 procedures as set forth in the Health Carrier Grievance Procedure  
4 Act;

5 (23) Health benefit plan means a policy, contract,  
6 certificate, or agreement offered or issued by a health carrier to  
7 provide, deliver, arrange for, pay for, or reimburse any of the costs  
8 of health care services;

9 (24) Health care professional means a physician or other  
10 health care practitioner licensed, accredited, or certified to  
11 perform specified health care services consistent with state law;

12 (25) Health care provider or provider means a health care  
13 professional or a facility;

14 (26) Health care services means services for the  
15 diagnosis, prevention, treatment, cure, or relief of a health  
16 condition, illness, injury, or disease;

17 (27) Health carrier means an entity subject to the  
18 insurance laws and regulations of this state, or subject to the  
19 jurisdiction of the director, that contracts or offers to contract to  
20 provide, deliver, arrange for, pay for, or reimburse any of the costs  
21 of health care services, including a sickness and accident insurance  
22 company, a health maintenance organization, a nonprofit hospital and  
23 health service corporation, or any other entity providing a plan of  
24 health insurance, health benefits, or health care services;

25 (28) Health information means information or data,

1 whether oral or recorded in any form or medium, and personal facts or  
2 information about events or relationships that relates to:

3 (a) The past, present, or future physical, mental, or  
4 behavioral health or condition of an individual or a member of the  
5 individual's family;

6 (b) The provision of health care services to an  
7 individual; or

8 (c) Payment for the provision of health care services to  
9 an individual;

10 (29) Independent review organization means an entity that  
11 conducts independent external reviews of adverse determinations and  
12 final adverse determinations;

13 (30) Medical or scientific evidence means evidence found  
14 in the following sources:

15 (a) Peer-reviewed scientific studies published in or  
16 accepted for publication by medical journals that meet nationally  
17 recognized requirements for scientific manuscripts and that submit  
18 most of its published articles for review by experts who are not part  
19 of the editorial staff;

20 (b) Peer-reviewed medical literature, including  
21 literature relating to therapies reviewed and approved by a qualified  
22 institutional review board, biomedical compendia, and other medical  
23 literature that meet the criteria of the National Institutes of  
24 Health's United States National Library of Medicine for indexing in  
25 Index Medicus, known as Medline, and Elsevier Science Ltd. for

- 1 indexing in Excerpta Medica, known as Embase;
- 2 (c) Medical journals recognized by the Secretary of  
3 Health and Human Services under section 1861(t)(2) of the federal  
4 Social Security Act;
- 5 (d) The following standard reference compendia:
- 6 (i) The AHFS Drug Information;
- 7 (ii) Drug Facts and Comparisons;
- 8 (iii) The American Dental Association Guide to Dental  
9 Therapeutics; and
- 10 (iv) The United States Pharmacopoeia Drug Information;
- 11 (e) Findings, studies, or research conducted by or under  
12 the auspices of federal government agencies and nationally recognized  
13 federal research institutes, including:
- 14 (i) The federal Agency for Healthcare Research and  
15 Quality of the United States Department of Health and Human Services;
- 16 (ii) The National Institutes of Health;
- 17 (iii) The National Cancer Institute;
- 18 (iv) The National Academy of Sciences;
- 19 (v) The Centers for Medicare and Medicaid Services of the  
20 United States Department of Health and Human Services;
- 21 (vi) The federal Food and Drug Administration; and
- 22 (vii) Any national board recognized by the National  
23 Institutes of Health for the purpose of evaluating the medical value  
24 of health care services; or
- 25 (f) Any other medical or scientific evidence that is



1 comparable to the sources listed in subdivisions (30)(a) through (e)  
2 of this section;

3 (31) Prospective review means a utilization review  
4 conducted prior to an admission or a course of treatment;

5 (32) Protected health information means health  
6 information:

7 (a) That identifies an individual who is the subject of  
8 the information; or

9 (b) With respect to which there is a reasonable basis to  
10 believe that the information could be used to identify an individual;

11 (33) Randomized clinical trial means a controlled,  
12 prospective study of patients that have been randomized into an  
13 experimental group and a control group at the beginning of the study  
14 with only the experimental group of patients receiving a specific  
15 intervention, which includes study of the groups for variables and  
16 anticipated outcomes over time;

17 (34) Retrospective review means a review of medical  
18 necessity conducted after services have been provided to a patient,  
19 but does not include the review of a claim that is limited to an  
20 evaluation of reimbursement levels, veracity of documentation,  
21 accuracy of coding, or adjudication for payment;

22 (35) Second opinion means an opportunity or requirement  
23 to obtain a clinical evaluation by a provider other than the one  
24 originally making a recommendation for a proposed health care service  
25 to assess the clinical necessity and appropriateness of the initial

1 proposed health care service;

2 (36) Utilization review means a set of formal techniques  
3 designed to monitor the use or evaluate the clinical necessity,  
4 appropriateness, efficacy, or efficiency of health care services,  
5 procedures, or settings. Techniques may include ambulatory review,  
6 prospective review, second opinion, certification, concurrent review,  
7 case management, discharge planning, or retrospective review; and

8 (37) Utilization review organization means an entity that  
9 conducts a utilization review, other than a health carrier performing  
10 a review for its own health benefit plans.

11 Sec. 4. (1) Except as provided in subsection (2) of this  
12 section, the Health Carrier External Review Act shall apply to all  
13 health carriers.

14 (2)(a) The act shall not apply to a policy or certificate  
15 that provides coverage for:

16 (i) A specified disease, specified accident, or accident-  
17 only coverage;

18 (ii) Credit;

19 (iii) Dental;

20 (iv) Disability income;

21 (v) Hospital indemnity;

22 (vi) Long-term care insurance, as defined in section  
23 44-4509;

24 (vii) Vision care; or

25 (viii) Any other limited supplemental benefit.

- 1                   (b) The act shall not apply to:
- 2                   (i) A medicare supplement policy of insurance as defined  
3 in section 44-3602;
- 4                   (ii) Coverage under a plan through medicare, medicaid, or  
5 the Federal Employees Health Benefits Program;
- 6                   (iii) Any coverage issued under Chapter 55 of Title 10 of  
7 the United States Code and any coverage issued as a supplement to  
8 that coverage;
- 9                   (iv) Any coverage issued as supplemental to liability  
10 insurance;
- 11                   (v) Workers' compensation or similar insurance;
- 12                   (vi) Automobile medical-payment insurance; or
- 13                   (vii) Any insurance under which benefits are payable with  
14 or without regard to fault, whether written on a group blanket or  
15 individual basis.
- 16                   Sec. 5. (1)(a) A health carrier shall notify the covered  
17 person in writing of the covered person's right to request an  
18 external review to be conducted pursuant to section 8, 9, or 10 of  
19 this act and include the appropriate statements and information as  
20 set forth in subsection (2) of this section at the same time that the  
21 health carrier sends written notice of:
- 22                   (i) An adverse determination upon completion of the  
23 health carrier's utilization review process set forth in the  
24 Utilization Review Act; and
- 25                   (ii) A final adverse determination.

1           (b) As part of the written notice required under  
2 subdivision (1)(a) of this section, a health carrier shall include  
3 the following, or substantially equivalent, language: We have denied  
4 your request for the provision of or payment for a health care  
5 service or course of treatment. You may have the right to have our  
6 decision reviewed by health care professionals who have no  
7 association with us if our decision involved making a judgment as to  
8 the medical necessity, appropriateness, health care setting, level of  
9 care, or effectiveness of the health care service or treatment you  
10 requested by submitting a request for external review to the Director  
11 of Insurance (insert address and telephone number of the office of  
12 the director).

13           (c) The director may prescribe by rule and regulation the  
14 form and content of the notice required under this section.

15           (2)(a) The health carrier shall include in the notice  
16 required under subsection (1) of this section:

17           (i) For a notice related to an adverse determination, a  
18 statement informing the covered person that:

19           (A) If the covered person has a medical condition in  
20 which the timeframe for completion of an expedited review of a  
21 grievance involving an adverse determination as set forth in section  
22 44-7311 would seriously jeopardize the life or health of the covered  
23 person or would jeopardize the covered person's ability to regain  
24 maximum function, the covered person or the covered person's  
25 authorized representative may file a request for an expedited

1 external review to be conducted pursuant to section 9 or 10 of this  
2 act if the adverse determination involves a denial of coverage based  
3 on a determination that the recommended or requested health care  
4 service or treatment is experimental or investigational and the  
5 covered person's treating physician certifies in writing that the  
6 recommended or requested health care service or treatment that is the  
7 subject of the adverse determination would be significantly less  
8 effective if not promptly initiated, at the same time the covered  
9 person or the covered person's authorized representative files a  
10 request for an expedited review of a grievance involving an adverse  
11 determination as set forth in section 44-7311, but that the  
12 independent review organization assigned to conduct the expedited  
13 external review will determine whether the covered person shall be  
14 required to complete the expedited review of the grievance prior to  
15 conducting the expedited external review; and

16 (B) The covered person or the covered person's authorized  
17 representative may file a grievance under the health carrier's  
18 internal grievance process as set forth in section 44-7308, but if  
19 the health carrier has not issued a written decision to the covered  
20 person or his or her authorized representative within thirty days  
21 following the date that the covered person or his or her authorized  
22 representative files the grievance with the health carrier and the  
23 covered person or his or her authorized representative has not  
24 requested or agreed to a delay, the covered person or his or her  
25 authorized representative may file a request for external review

1 pursuant to section 6 of this act and shall be considered to have  
2 exhausted the health carrier's internal grievance process for  
3 purposes of section 7 of this act; and

4 (ii) For a notice related to a final adverse  
5 determination, a statement informing the covered person that:

6 (A) If the covered person has a medical condition in  
7 which the timeframe for completion of a standard external review  
8 pursuant to section 8 of this act would seriously jeopardize the life  
9 or health of the covered person or would jeopardize the covered  
10 person's ability to regain maximum function, the covered person or  
11 the covered person's authorized representative may file a request for  
12 an expedited external review pursuant to section 9 of this act; or

13 (B) If the final adverse determination concerns:

14 (I) An admission, availability of care, continued stay,  
15 or health care service for which the covered person received  
16 emergency services, but has not been discharged from a facility, the  
17 covered person or the covered person's authorized representative may  
18 request an expedited external review pursuant to section 9 of this  
19 act; or

20 (II) A denial of coverage based on a determination that  
21 the recommended or requested health care service or treatment is  
22 experimental or investigational, the covered person or the covered  
23 person's authorized representative may file a request for a standard  
24 external review to be conducted pursuant to section 10 of this act or  
25 if the covered person's treating physician certifies in writing that

1 the recommended or requested health care service or treatment that is  
2 the subject of the request would be significantly less effective if  
3 not promptly initiated, the covered person or his or her authorized  
4 representative may request an expedited external review to be  
5 conducted under section 10 of this act.

6 (b) In addition to the information to be provided  
7 pursuant to subdivision (2)(a) of this section, the health carrier  
8 shall include a copy of the description of both the standard and  
9 expedited external review procedures that the health carrier is  
10 required to provide pursuant to section 17 of this act and shall  
11 highlight the provisions in the external review procedures that give  
12 the covered person or the covered person's authorized representative  
13 the opportunity to submit additional information and include any  
14 forms used to process an external review.

15 (c) As part of any forms provided under subdivision (2)  
16 (b) of this section, the health carrier shall include an  
17 authorization form or other document approved by the director that  
18 complies with the requirements of 45 C.F.R. 164.508, by which the  
19 covered person, for purposes of conducting an external review under  
20 the Health Carrier External Review Act, authorizes the health carrier  
21 and the covered person's treating health care provider to disclose  
22 protected health information, including medical records, concerning  
23 the covered person that are pertinent to the external review.

24 Sec. 6. (1)(a) Except for a request for an expedited  
25 external review as set forth in section 9 of this act, all requests

1 for external review shall be made in writing to the director.

2 (b) The director may prescribe by rule and regulation the  
3 form and content of external review requests required to be submitted  
4 under this section.

5 (2) A covered person or the covered person's authorized  
6 representative may make a request for an external review of an  
7 adverse determination or final adverse determination.

8 Sec. 7. (1)(a) Except as provided in subsection (2) of  
9 this section, a request for an external review pursuant to section 8,  
10 9, or 10 of this act shall not be made until the covered person has  
11 exhausted the health carrier's internal grievance process as set  
12 forth in the Health Carrier Grievance Procedure Act.

13 (b) A covered person shall be considered to have  
14 exhausted the health carrier's internal grievance process for  
15 purposes of this section if the covered person or the covered  
16 person's authorized representative:

17 (i) Has filed a grievance involving an adverse  
18 determination pursuant to section 44-7308; and

19 (ii) Except to the extent that the covered person or the  
20 covered person's authorized representative requested or agreed to a  
21 delay, has not received a written decision on the grievance from the  
22 health carrier within thirty days following the date that the covered  
23 person or the covered person's authorized representative filed the  
24 grievance with the health carrier.

25 (c) Notwithstanding subdivision (1)(b) of this section, a



1 covered person or the covered person's authorized representative may  
2 not make a request for an external review of an adverse determination  
3 involving a retrospective review determination made pursuant to the  
4 Utilization Review Act until the covered person has exhausted the  
5 health carrier's internal grievance process.

6 (2)(a)(i) At the same time that a covered person or the  
7 covered person's authorized representative files a request for an  
8 expedited review of a grievance involving an adverse determination as  
9 set forth in section 44-7311, the covered person or his or her  
10 authorized representative may file a request for an expedited  
11 external review of the adverse determination:

12 (A) Under section 9 of this act if the covered person has  
13 a medical condition in which the timeframe for completion of an  
14 expedited review of the grievance involving an adverse determination  
15 set forth in section 44-7311 would seriously jeopardize the life or  
16 health of the covered person or would jeopardize the covered person's  
17 ability to regain maximum function; or

18 (B) Under section 10 of this act if the adverse  
19 determination involves a denial of coverage based upon a  
20 determination that the recommended or requested health care service  
21 or treatment is experimental or investigational and the covered  
22 person's treating physician certifies in writing that the recommended  
23 or requested health care service or treatment that is the subject of  
24 the adverse determination would be significantly less effective if  
25 not promptly initiated.

1           (ii) Upon receipt of a request for an expedited external  
2 review under subdivision (2)(a)(i) of this section, the independent  
3 review organization conducting the external review in accordance with  
4 the provisions of section 9 or 10 of this act shall determine whether  
5 the covered person shall be required to complete the expedited  
6 grievance review process set forth in section 44-7311 before it  
7 conducts the expedited external review.

8           (iii) Upon a determination made pursuant to subdivision  
9 (2)(a)(ii) of this section that the covered person must first  
10 complete the expedited grievance review process set forth in section  
11 44-7311, the independent review organization shall immediately notify  
12 the covered person and, if applicable, the covered person's  
13 authorized representative of such determination and the fact that it  
14 will not proceed with the expedited external review set forth in  
15 section 9 of this act until completion of the expedited grievance  
16 review process and the covered person's grievance at the completion  
17 of the expedited grievance review process remains unresolved.

18           (b) A request for an external review of an adverse  
19 determination may be made before the covered person has exhausted the  
20 health carrier's internal grievance procedures as set forth in  
21 section 44-7308 if the health carrier agrees to waive the exhaustion  
22 requirement.

23           (3) If the requirement to exhaust the health carrier's  
24 internal grievance procedures is waived under subdivision (2)(b) of  
25 this section, the covered person or the covered person's authorized

1 representative may file a request in writing for a standard external  
2 review as set forth in section 8 or 10 of this act.

3           Sec. 8. (1)(a) Within four months after the date of  
4 receipt of a notice of an adverse determination or final adverse  
5 determination pursuant to section 5 of this act, a covered person or  
6 the covered person's authorized representative may file a request for  
7 an external review with the director.

8           (b) Within one business day after the date of receipt of  
9 a request for an external review pursuant to subdivision (1)(a) of  
10 this section, the director shall send a copy of the request to the  
11 health carrier.

12           (2) Within five business days following the date of  
13 receipt of the copy of the external review request from the director  
14 under subdivision (1)(b) of this section, the health carrier shall  
15 complete a preliminary review of the request to determine whether:

16           (a) The individual is or was a covered person in the  
17 health benefit plan at the time that the health care service was  
18 requested or, in the case of a retrospective review, was a covered  
19 person in the health benefit plan at the time that the health care  
20 service was provided;

21           (b) The health care service that is the subject of the  
22 adverse determination or the final adverse determination is a covered  
23 service under the covered person's health benefit plan, but for a  
24 determination by the health carrier that the health care service is  
25 not covered because it does not meet the health carrier's

1 requirements for medical necessity, appropriateness, health care  
2 setting, level of care, or effectiveness;

3 (c) The covered person has exhausted the health carrier's  
4 internal grievance process as set forth in the Health Carrier  
5 Grievance Procedure Act unless the covered person is not required to  
6 exhaust the health carrier's internal grievance process pursuant to  
7 section 7 of this act; and

8 (d) The covered person has provided all the information  
9 and forms required to process an external review, including the  
10 release form provided under subsection (2) of section 5 of this act.

11 (3)(a) Within one business day after completion of the  
12 preliminary review, the health carrier shall notify the director and  
13 covered person and, if applicable, the covered person's authorized  
14 representative, in writing whether:

15 (i) The request is complete; and

16 (ii) The request is eligible for external review.

17 (b) If the request:

18 (i) Is not complete, the health carrier shall inform the  
19 covered person and, if applicable, the covered person's authorized  
20 representative and the director in writing and include in the notice  
21 what information or materials are needed to make the request  
22 complete; or

23 (ii) Is not eligible for external review, the health  
24 carrier shall inform the covered person and, if applicable, the  
25 covered person's authorized representative and the director in

1 writing and include in the notice the reasons for its ineligibility.

2 (c)(i) The director may specify the form for the health  
3 carrier's notice of initial determination under this subsection and  
4 any supporting information to be included in the notice.

5 (ii) The notice of initial determination shall include a  
6 statement informing the covered person and, if applicable, the  
7 covered person's authorized representative that a health carrier's  
8 initial determination that the external review request is ineligible  
9 for review may be appealed to the director.

10 (d)(i) The director may determine that a request is  
11 eligible for external review under subsection (2) of this section  
12 notwithstanding a health carrier's initial determination that the  
13 request is ineligible and require that it be referred for external  
14 review.

15 (ii) In making a determination under subdivision (3)(d)  
16 (i) of this section, the director's decision shall be made in  
17 accordance with the terms of the covered person's health benefit plan  
18 and shall be subject to all applicable provisions of the Health  
19 Carrier External Review Act.

20 (4)(a) Whenever the director receives a notice that a  
21 request is eligible for external review following the preliminary  
22 review conducted pursuant to subsection (3) of this section, the  
23 director shall, within one business day after the date of receipt of  
24 the notice:

25 (i) Assign an independent review organization from the

1 list of approved independent review organizations compiled and  
2 maintained by the director pursuant to section 12 of this act to  
3 conduct the external review and notify the health carrier of the name  
4 of the assigned independent review organization; and

5 (ii) Notify in writing the covered person and, if  
6 applicable, the covered person's authorized representative of the  
7 request's eligibility and acceptance for external review.

8 (b) In reaching a decision, the assigned independent  
9 review organization is not bound by any decisions or conclusions  
10 reached during the health carrier's utilization review process as set  
11 forth in the Utilization Review Act or the health carrier's internal  
12 grievance process as set forth in the Health Carrier Grievance  
13 Procedure Act.

14 (c) The director shall include in the notice provided to  
15 the covered person and, if applicable, the covered person's  
16 authorized representative, a statement that the covered person or his  
17 or her authorized representative may submit in writing to the  
18 assigned independent review organization within five business days  
19 following the date of receipt of the notice provided pursuant to  
20 subdivision (4)(a) of this section additional information that the  
21 independent review organization shall consider when conducting the  
22 external review. The independent review organization is not required  
23 to but may accept and consider additional information submitted after  
24 five business days.

25 (5)(a) Within five business days after the date of

1 receipt of the notice provided pursuant to subdivision (4)(a) of this  
2 section, the health carrier or its designee utilization review  
3 organization shall provide to the assigned independent review  
4 organization the documents and any information considered in making  
5 the adverse determination or final adverse determination.

6 (b) Except as provided in subdivision (5)(c) of this  
7 section, failure by the health carrier or its utilization review  
8 organization to provide the documents and information within the time  
9 specified in subdivision (5)(a) of this section shall not delay the  
10 conduct of the external review.

11 (c)(i) If the health carrier or its utilization review  
12 organization fails to provide the documents and information within  
13 the time specified in subdivision (5)(a) of this section, the  
14 assigned independent review organization may terminate the external  
15 review and make a decision to reverse the adverse determination or  
16 final adverse determination.

17 (ii) Within one business day after making the decision  
18 under subdivision (5)(c)(i) of this section, the independent review  
19 organization shall notify the covered person and, if applicable, the  
20 covered person's authorized representative, the health carrier, and  
21 the director.

22 (6)(a) The assigned independent review organization shall  
23 review all of the information and documents received pursuant to  
24 subsection (5) of this section and any other information submitted in  
25 writing to the independent review organization by the covered person

1 or the covered person's authorized representative pursuant to  
2 subdivision (4)(c) of this section.

3 (b) Upon receipt of any information submitted by the  
4 covered person or the covered person's authorized representative  
5 pursuant to subdivision (4)(c) of this section, the assigned  
6 independent review organization shall forward the information to the  
7 health carrier within one business day.

8 (7)(a) Upon receipt of the information, if any, required  
9 to be forwarded pursuant to subdivision (6)(b) of this section, the  
10 health carrier may reconsider its adverse determination or final  
11 adverse determination that is the subject of the external review.

12 (b) Reconsideration by the health carrier of its adverse  
13 determination or final adverse determination pursuant to subdivision  
14 (7)(a) of this section shall not delay or terminate the external  
15 review.

16 (c) The external review may only be terminated if the  
17 health carrier decides, upon completion of its reconsideration, to  
18 reverse its adverse determination or final adverse determination and  
19 provide coverage or payment for the health care service that is the  
20 subject of the adverse determination or final adverse determination.

21 (d)(i) Within one business day after making the decision  
22 to reverse its adverse determination or final adverse determination  
23 as provided in subdivision (7)(c) of this section, the health carrier  
24 shall notify the covered person and, if applicable, the covered  
25 person's authorized representative, the assigned independent review



1 organization, and the director in writing of its decision.

2 (ii) The assigned independent review organization shall  
3 terminate the external review upon receipt of the notice from the  
4 health carrier sent pursuant to subdivision (7)(d)(i) of this  
5 section.

6 (8) In addition to the documents and information provided  
7 pursuant to subsection (5) of this section, the assigned independent  
8 review organization, to the extent the information or documents are  
9 available and the independent review organization considers them  
10 appropriate, shall consider the following in reaching a decision:

11 (a) The covered person's medical records;

12 (b) The attending health care professional's  
13 recommendation;

14 (c) Consulting reports from appropriate health care  
15 professionals and other documents submitted by the health carrier,  
16 covered person, the covered person's authorized representative, or  
17 the covered person's treating provider;

18 (d) The terms of coverage under the covered person's  
19 health benefit plan with the health carrier to ensure that the  
20 independent review organization's decision is not contrary to the  
21 terms of coverage under the covered person's health benefit plan with  
22 the health carrier;

23 (e) The most appropriate practice guidelines, which shall  
24 include applicable evidence-based standards and may include any other  
25 practice guidelines developed by the federal government, national or

1 professional medical societies, boards, or associations;

2 (f) Any applicable clinical review criteria developed and  
3 used by the health carrier or its designee utilization review  
4 organization; and

5 (g) The opinion of the independent review organization's  
6 clinical reviewer or reviewers after considering subdivisions (8)(a)  
7 through (f) of this section to the extent that the information or  
8 documents are available and the clinical reviewer or reviewers  
9 consider it appropriate.

10 (9)(a) Within forty-five days after the date of receipt  
11 of the request for an external review, the assigned independent  
12 review organization shall provide written notice of its decision to  
13 uphold or reverse the adverse determination or the final adverse  
14 determination to the covered person, if applicable, the covered  
15 person's authorized representative, the health carrier, and the  
16 director.

17 (b) The independent review organization shall include in  
18 the notice sent pursuant to subdivision (9)(a) of this section:

19 (i) A general description of the reason for the request  
20 for external review;

21 (ii) The date that the independent review organization  
22 received the assignment from the director to conduct the external  
23 review;

24 (iii) The date that the external review was conducted;

25 (iv) The date of its decision;

1           (v) The principal reason or reasons for its decision,  
2 including what applicable, if any, evidence-based standards were a  
3 basis for its decision;

4           (vi) The rationale for its decision; and

5           (vii) References to the evidence or documentation,  
6 including the evidence-based standards, considered in reaching its  
7 decision.

8           (c) Upon receipt of a notice of a decision pursuant to  
9 subdivision (9)(a) of this section reversing the adverse  
10 determination or final adverse determination, the health carrier  
11 shall immediately approve the coverage that was the subject of the  
12 adverse determination or final adverse determination.

13           (10) The assignment by the director of an approved  
14 independent review organization to conduct an external review in  
15 accordance with this section shall be done on a random basis among  
16 those approved independent review organizations qualified to conduct  
17 the particular external review based on the nature of the health care  
18 service that is the subject of the adverse determination or final  
19 adverse determination and other circumstances, including conflict of  
20 interest concerns pursuant to subsection (4) of section 13 of this  
21 act.

22           Sec. 9. (1) Except as provided in subsection (6) of this  
23 section, a covered person or the covered person's authorized  
24 representative may make a request for an expedited external review  
25 with the director at the time that the covered person receives:

1           (a) An adverse determination if:

2           (i) The adverse determination involves a medical  
3 condition of the covered person for which the timeframe for  
4 completion of an expedited internal review of a grievance involving  
5 an adverse determination set forth in section 44-7311 would seriously  
6 jeopardize the life or health of the covered person or would  
7 jeopardize the covered person's ability to regain maximum function;  
8 and

9           (ii) The covered person or the covered person's  
10 authorized representative has filed a request for an expedited review  
11 of a grievance involving an adverse determination as set forth in  
12 section 44-7311; or

13           (b) A final adverse determination:

14           (i) If the covered person has a medical condition in  
15 which the timeframe for completion of a standard external review  
16 pursuant to section 8 of this act would seriously jeopardize the life  
17 or health of the covered person or would jeopardize the covered  
18 person's ability to regain maximum function; or

19           (ii) If the final adverse determination concerns an  
20 admission, availability of care, continued stay, or health care  
21 service for which the covered person received emergency services, but  
22 has not been discharged from a facility.

23           (2)(a) Upon receipt of a request for an expedited  
24 external review, the director shall immediately send a copy of the  
25 request to the health carrier.

1           (b) Immediately upon receipt of the request pursuant to  
2 subdivision (2)(a) of this section, the health carrier shall  
3 determine whether the request meets the reviewability requirements  
4 set forth in subsection (2) of section 8 of this act. The health  
5 carrier shall immediately notify the director and the covered person  
6 and, if applicable, the covered person's authorized representative of  
7 its eligibility determination.

8           (c)(i) The director may specify the form for the health  
9 carrier's notice of initial determination under this subsection and  
10 any supporting information to be included in the notice.

11           (ii) The notice of initial determination shall include a  
12 statement informing the covered person and, if applicable, the  
13 covered person's authorized representative that a health carrier's  
14 initial determination that an external review request is ineligible  
15 for review may be appealed to the director.

16           (d)(i) The director may determine that a request is  
17 eligible for external review under subsection (2) of section 8 of  
18 this act notwithstanding a health carrier's initial determination  
19 that the request is ineligible and require that it be referred for  
20 external review.

21           (ii) In making a determination under subdivision (2)(d)  
22 (i) of this section, the director's decision shall be made in  
23 accordance with the terms of the covered person's health benefit plan  
24 and shall be subject to all applicable provisions of the Health  
25 Carrier External Review Act.

1           (e) Upon receipt of the notice that the request meets the  
2 reviewability requirements, the director shall immediately assign an  
3 independent review organization to conduct the expedited external  
4 review from the list of approved independent review organizations  
5 compiled and maintained by the director pursuant to section 12 of  
6 this act. The director shall immediately notify the health carrier of  
7 the name of the assigned independent review organization.

8           (f) In reaching a decision in accordance with subsection  
9 (5) of this section, the assigned independent review organization is  
10 not bound by any decisions or conclusions reached during the health  
11 carrier's utilization review process as set forth in the Utilization  
12 Review Act or the Health Carrier Grievance Procedure Act.

13           (3) Upon receipt of the notice from the director of the  
14 name of the independent review organization assigned to conduct the  
15 expedited external review pursuant to subdivision (2)(e) of this  
16 section, the health carrier or its designee utilization review  
17 organization shall provide or transmit all necessary documents and  
18 information considered in making the adverse determination or final  
19 adverse determination to the assigned independent review organization  
20 electronically or by telephone or facsimile or any other available  
21 expeditious method.

22           (4) In addition to the documents and information provided  
23 or transmitted pursuant to subsection (3) of this section, the  
24 assigned independent review organization, to the extent that the  
25 information or documents are available and the independent review

1 organization considers them appropriate, shall consider the following  
2 in reaching a decision:

3 (a) The covered person's pertinent medical records;

4 (b) The attending health care professional's  
5 recommendation;

6 (c) Consulting reports from appropriate health care  
7 professionals and other documents submitted by the health carrier,  
8 covered person, the covered person's authorized representative, or  
9 the covered person's treating provider;

10 (d) The terms of coverage under the covered person's  
11 health benefit plan with the health carrier to ensure that the  
12 independent review organization's decision is not contrary to the  
13 terms of coverage under the covered person's health benefit plan with  
14 the health carrier;

15 (e) The most appropriate practice guidelines, which shall  
16 include evidence-based standards, and may include any other practice  
17 guidelines developed by the federal government, national or  
18 professional medical societies, boards, or associations;

19 (f) Any applicable clinical review criteria developed and  
20 used by the health carrier or its designee utilization review  
21 organization in making adverse determinations; and

22 (g) The opinion of the independent review organization's  
23 clinical reviewer or reviewers after considering subdivisions (4)(a)  
24 through (f) of this section to the extent that the information and  
25 documents are available and the clinical reviewer or reviewers

1 consider it appropriate.

2 (5)(a) As expeditiously as the covered person's medical  
3 condition or circumstances requires, but in no event more than  
4 seventy-two hours after the date of receipt of the request for an  
5 expedited external review that meets the reviewability requirements  
6 set forth in subsection (2) of section 8 of this act, the assigned  
7 independent review organization shall:

8 (i) Make a decision to uphold or reverse the adverse  
9 determination or final adverse determination; and

10 (ii) Notify the covered person and, if applicable, the  
11 covered person's authorized representative, the health carrier, and  
12 the director of the decision.

13 (b) If the notice provided pursuant to subdivision (5)(a)  
14 of this section was not in writing, within forty-eight hours after  
15 the date of providing that notice, the assigned independent review  
16 organization shall:

17 (i) Provide written confirmation of the decision to the  
18 covered person and, if applicable, the covered person's authorized  
19 representative, the health carrier, and the director; and

20 (ii) Include the information set forth in subdivision (9)  
21 (b) of section 8 of this act.

22 (c) Upon receipt of the notice of a decision pursuant to  
23 subdivision (5)(a) of this section reversing the adverse  
24 determination or final adverse determination, the health carrier  
25 shall immediately approve the coverage that was the subject of the



1 adverse determination or final adverse determination.

2 (6) An expedited external review may not be provided for  
3 retrospective adverse or final adverse determinations.

4 (7) The assignment by the director of an approved  
5 independent review organization to conduct an external review in  
6 accordance with this section shall be done on a random basis among  
7 those approved independent review organizations qualified to conduct  
8 the particular external review based on the nature of the health care  
9 service that is the subject of the adverse determination or final  
10 adverse determination and other circumstances, including conflict of  
11 interest concerns pursuant to subsection (4) of section 13 of this  
12 act.

13 Sec. 10. (1)(a) Within four months after the date of  
14 receipt of a notice of an adverse determination or final adverse  
15 determination pursuant to section 5 of this act that involves a  
16 denial of coverage based on a determination that the health care  
17 service or treatment recommended or requested is experimental or  
18 investigational, a covered person or the covered person's authorized  
19 representative may file a request for external review with the  
20 director.

21 (b)(i) A covered person or the covered person's  
22 authorized representative may make an oral request for an expedited  
23 external review of the adverse determination or final adverse  
24 determination pursuant to subdivision (1)(a) of this section if the  
25 covered person's treating physician certifies, in writing, that the

1 recommended or requested health care service or treatment that is the  
2 subject of the request would be significantly less effective if not  
3 promptly initiated.

4 (ii) Upon receipt of a request for an expedited external  
5 review, the director shall immediately notify the health carrier.

6 (iii)(A) Upon notice of the request for expedited  
7 external review, the health carrier shall immediately determine  
8 whether the request meets the reviewability requirements of  
9 subdivision (2)(b) of this section. The health carrier shall  
10 immediately notify the director and the covered person and, if  
11 applicable, the covered person's authorized representative of its  
12 eligibility determination.

13 (B) The director may specify the form for the health  
14 carrier's notice of initial determination under subdivision (1)(b)  
15 (iii)(A) of this section and any supporting information to be  
16 included in the notice.

17 (C) The notice of initial determination under subdivision  
18 (1)(b)(iii)(A) of this section shall include a statement informing  
19 the covered person and, if applicable, the covered person's  
20 authorized representative that a health carrier's initial  
21 determination that the external review request is ineligible for  
22 review may be appealed to the director.

23 (iv)(A) The director may determine that a request is  
24 eligible for external review under subdivision (2)(b) of this section  
25 notwithstanding a health carrier's initial determination that the

1 request is ineligible and require that it be referred for external  
2 review.

3 (B) In making a determination under subdivision (1)(b)  
4 (iii)(A) of this section, the director's decision shall be made in  
5 accordance with the terms of the covered person's health benefit plan  
6 and shall be subject to all applicable provisions of the Health  
7 Carrier External Review Act.

8 (v) Upon receipt of the notice that the expedited  
9 external review request meets the reviewability requirements of  
10 subdivision (2)(b) of this section, the director shall immediately  
11 assign an independent review organization to review the expedited  
12 request from the list of approved independent review organizations  
13 compiled and maintained by the director pursuant to section 12 of  
14 this act and notify the health carrier of the name of the assigned  
15 independent review organization.

16 (vi) At the time the health carrier receives the notice  
17 of the assigned independent review organization pursuant to  
18 subdivision (1)(b)(v) of this section, the health carrier or its  
19 designee utilization review organization shall provide or transmit  
20 all necessary documents and information considered in making the  
21 adverse determination or final adverse determination to the assigned  
22 independent review organization electronically or by telephone or  
23 facsimile or any other available expeditious method.

24 (2)(a) Except for a request for an expedited external  
25 review made pursuant to subdivision (1)(b) of this section, within

1 one business day after the date of receipt of the request the  
2 director receives a request for an external review, the director  
3 shall notify the health carrier.

4 (b) Within five business days following the date of  
5 receipt of the notice sent pursuant to subdivision (2)(a) of this  
6 section, the health carrier shall conduct and complete a preliminary  
7 review of the request to determine whether:

8 (i) The individual is or was a covered person in the  
9 health benefit plan at the time that the health care service or  
10 treatment was recommended or requested or, in the case of a  
11 retrospective review, was a covered person in the health benefit plan  
12 at the time that the health care service or treatment was provided;

13 (ii) The recommended or requested health care service or  
14 treatment that is the subject of the adverse determination or final  
15 adverse determination:

16 (A) Is a covered benefit under the covered person's  
17 health benefit plan except for the health carrier's determination  
18 that the service or treatment is experimental or investigational for  
19 a particular medical condition; and

20 (B) Is not explicitly listed as an excluded benefit under  
21 the covered person's health benefit plan with the health carrier;

22 (iii) The covered person's treating physician has  
23 certified that one of the following situations is applicable:

24 (A) Standard health care services or treatments have not  
25 been effective in improving the condition of the covered person;

1           (B) Standard health care services or treatments are not  
2 medically appropriate for the covered person; or

3           (C) There is no available standard health care service or  
4 treatment covered by the health carrier that is more beneficial than  
5 the recommended or requested health care service or treatment  
6 described in subdivision (2)(b)(iv) of this section;

7           (iv) The covered person's treating physician:

8           (A) Has recommended a health care service or treatment  
9 that the physician certifies, in writing, is likely to be more  
10 beneficial to the covered person, in the physician's opinion, than  
11 any available standard health care service or treatment; or

12           (B) Who is a licensed, board-certified or board-eligible  
13 physician qualified to practice in the area of medicine appropriate  
14 to treat the covered person's condition, has certified in writing  
15 that scientifically valid studies using accepted protocols  
16 demonstrate that the health care service or treatment requested by  
17 the covered person that is the subject of the adverse determination  
18 or final adverse determination is likely to be more beneficial to the  
19 covered person than any available standard health care service or  
20 treatment;

21           (v) The covered person has exhausted the health carrier's  
22 internal grievance process as set forth in the Health Carrier  
23 Grievance Procedure Act unless the covered person is not required to  
24 exhaust the health carrier's internal grievance process pursuant to  
25 section 7 of this act; and

1           (vi) The covered person has provided all the information  
2 and forms required by the director that are necessary to process an  
3 external review, including the release form provided under subsection  
4 (2) of section 5 of this act.

5           (3)(a) Within one business day after completion of the  
6 preliminary review, the health carrier shall notify the director and  
7 the covered person and, if applicable, the covered person's  
8 authorized representative in writing whether the request is complete  
9 and the request is eligible for external review.

10           (b) If the request:

11           (i) Is not complete, the health carrier shall inform, in  
12 writing, the director and the covered person and, if applicable, the  
13 covered person's authorized representative and include in the notice  
14 what information or materials are needed to make the request  
15 complete; or

16           (ii) Is not eligible for external review, the health  
17 carrier shall inform the covered person, the covered person's  
18 authorized representative, if applicable, and the director in writing  
19 and include in the notice the reasons for its ineligibility.

20           (c)(i) The director may specify the form for the health  
21 carrier's notice of initial determination under subdivision (3)(b) of  
22 this section and any supporting information to be included in the  
23 notice.

24           (ii) The notice of initial determination provided under  
25 subdivision (3)(b) of this section shall include a statement

1 informing the covered person and, if applicable, the covered person's  
2 authorized representative that a health carrier's initial  
3 determination that the external review request is ineligible for  
4 review may be appealed to the director.

5 (d)(i) The director may determine that a request is  
6 eligible for external review under subdivision (2)(b) of this section  
7 notwithstanding a health carrier's initial determination that the  
8 request is ineligible and require that it be referred for external  
9 review.

10 (ii) In making a determination under subdivision (3)(d)  
11 (i) of this section, the director's decision shall be made in  
12 accordance with the terms of the covered person's health benefit plan  
13 and shall be subject to all applicable provisions of the Health  
14 Carrier External Review Act.

15 (e) Whenever a request for external review is determined  
16 eligible for external review, the health carrier shall notify the  
17 director and the covered person and, if applicable, the covered  
18 person's authorized representative.

19 (4)(a) Within one business day after the receipt of the  
20 notice from the health carrier that the external review request is  
21 eligible for external review pursuant to subdivision (1)(b)(iv) of  
22 this section or subdivision (3)(e) of this section, the director  
23 shall:

24 (i) Assign an independent review organization to conduct  
25 the external review from the list of approved independent review

1 organizations compiled and maintained by the director pursuant to  
2 section 12 of this act and notify the health carrier of the name of  
3 the assigned independent review organization; and

4 (ii) Notify in writing the covered person and, if  
5 applicable, the covered person's authorized representative of the  
6 request's eligibility and acceptance for external review.

7 (b) The director shall include in the notice provided to  
8 the covered person and, if applicable, the covered person's  
9 authorized representative a statement that the covered person or the  
10 covered person's authorized representative may submit in writing to  
11 the assigned independent review organization within five business  
12 days following the date of receipt of the notice provided pursuant to  
13 subdivision (4)(a) of this section additional information that the  
14 independent review organization shall consider when conducting the  
15 external review. The independent review organization may accept and  
16 consider additional information submitted after five business days.

17 (c) Within one business day after the receipt of the  
18 notice of assignment to conduct the external review pursuant to  
19 subdivision (4)(a) of this section, the assigned independent review  
20 organization shall:

21 (i) Select one or more clinical reviewers, as it  
22 determines is appropriate, pursuant to subdivision (4)(d) of this  
23 section to conduct the external review; and

24 (ii) Based upon the opinion of the clinical reviewer, or  
25 opinions if more than one clinical reviewer has been selected to



1 conduct the external review, make a decision to uphold or reverse the  
2 adverse determination or final adverse determination.

3 (d)(i) In selecting clinical reviewers pursuant to  
4 subdivision (4)(c)(i) of this section, the assigned independent  
5 review organization shall select physicians or other health care  
6 professionals who meet the minimum qualifications described in  
7 section 13 of this act and, through clinical experience in the past  
8 three years, are experts in the treatment of the covered person's  
9 condition and knowledgeable about the recommended or requested health  
10 care service or treatment.

11 (ii) Neither the covered person, the covered person's  
12 authorized representative, if applicable, nor the health carrier  
13 shall choose or control the choice of the physicians or other health  
14 care professionals to be selected to conduct the external review.

15 (e) In accordance with subsection (8) of this section,  
16 each clinical reviewer shall provide a written opinion to the  
17 assigned independent review organization on whether the recommended  
18 or requested health care service or treatment should be covered.

19 (f) In reaching an opinion, a clinical reviewer is not  
20 bound by any decisions or conclusions reached during the health  
21 carrier's utilization review process as set forth in the Utilization  
22 Review Act or the health carrier's internal grievance process as set  
23 forth in the Health Carrier Grievance Procedure Act.

24 (5)(a) Within five business days after the date of  
25 receipt of the notice provided pursuant to subdivision (4)(a) of this

1 section, the health carrier or its designee utilization review  
2 organization shall provide to the assigned independent review  
3 organization the documents and any information considered in making  
4 the adverse determination or the final adverse determination.

5 (b) Except as provided in subdivision (5)(c) of this  
6 section, failure by the health carrier or its designee utilization  
7 review organization to provide the documents and information within  
8 the time specified in subdivision (5)(a) of this section shall not  
9 delay the conduct of the external review.

10 (c)(i) If the health carrier or its designee utilization  
11 review organization has failed to provide the documents and  
12 information within the time specified in subdivision (5)(a) of this  
13 section, the assigned independent review organization may terminate  
14 the external review and make a decision to reverse the adverse  
15 determination or final adverse determination.

16 (ii) Immediately upon making the decision under  
17 subdivision (5)(c)(i) of this section, the independent review  
18 organization shall notify the covered person, the covered person's  
19 authorized representative, if applicable, the health carrier, and the  
20 director.

21 (6)(a) Each clinical reviewer selected pursuant to  
22 subsection (4) of this section shall review all of the information  
23 and documents received pursuant to subsection (5) of this section and  
24 any other information submitted in writing by the covered person or  
25 the covered person's authorized representative pursuant to

1 subdivision (4)(b) of this section.

2 (b) Upon receipt of any information submitted by the  
3 covered person or the covered person's authorized representative  
4 pursuant to subdivision (4)(b) of this section, within one business  
5 day after the receipt of the information, the assigned independent  
6 review organization shall forward the information to the health  
7 carrier.

8 (7)(a) Upon receipt of the information required to be  
9 forwarded pursuant to subdivision (6)(b) of this section, the health  
10 carrier may reconsider its adverse determination or final adverse  
11 determination that is the subject of the external review.

12 (b) Reconsideration by the health carrier of its adverse  
13 determination or final adverse determination pursuant to subdivision  
14 (7)(a) of this section shall not delay or terminate the external  
15 review.

16 (c) The external review may be terminated only if the  
17 health carrier decides, upon completion of its reconsideration, to  
18 reverse its adverse determination or final adverse determination and  
19 provide coverage or payment for the recommended or requested health  
20 care service or treatment that is the subject of the adverse  
21 determination or final adverse determination.

22 (d)(i) Immediately upon making the decision to reverse  
23 its adverse determination or final adverse determination as provided  
24 in subdivision (7)(c) of this section, the health carrier shall  
25 notify the covered person, the covered person's authorized

1 representative, if applicable, the assigned independent review  
2 organization, and the director in writing of its decision.

3 (ii) The assigned independent review organization shall  
4 terminate the external review upon receipt of the notice from the  
5 health carrier sent pursuant to subdivision (7)(d)(i) of this  
6 section.

7 (8)(a) Except as provided in subdivision (8)(c) of this  
8 section, within twenty days after being selected in accordance with  
9 subsection (4) of this section to conduct the external review, each  
10 clinical reviewer shall provide an opinion to the assigned  
11 independent review organization pursuant to subsection (9) of this  
12 section on whether the recommended or requested health care service  
13 or treatment should be covered.

14 (b) Except for an opinion provided pursuant to  
15 subdivision (8)(c) of this section, each clinical reviewer's opinion  
16 shall be in writing and include the following information:

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

19 (ii) A description of the indicators relevant to  
20 determining whether there is sufficient evidence to demonstrate that  
21 the recommended or requested health care service or treatment is more  
22 likely than not to be beneficial to the covered person than any  
23 available standard health care service or treatment and the adverse  
24 risk of the recommended or requested health care service or treatment  
25 would not be substantially increased over that of available standard

1 health care service or treatment;

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

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

6 (v) Information on whether the reviewer's rationale for  
7 the opinion is based on subdivision (9)(e)(i) or (ii) of this  
8 section.

9 (c) For an expedited external review, each clinical  
10 reviewer shall provide an opinion orally or in writing to the  
11 assigned independent review organization as expeditiously as the  
12 covered person's medical condition or circumstances requires, but in  
13 no event more than five calendar days after being selected in  
14 accordance with subsection (4) of this section.

15 (d) If the opinion provided pursuant to subdivision (8)  
16 (a) of this section was not in writing, within forty-eight hours  
17 following the date that the opinion was provided, the clinical  
18 reviewer shall provide written confirmation of the opinion to the  
19 assigned independent review organization and include the information  
20 required under subdivision (8)(b) of this section.

21 (9) In addition to the documents and information provided  
22 pursuant to subdivision (1)(b) of this section or subsection (5) of  
23 this section, each clinical reviewer selected pursuant to subsection  
24 (4) of this section, to the extent the information or documents are  
25 available and the reviewer considers appropriate, shall consider the

1 following in reaching an opinion pursuant to subsection (8) of this  
2 section:

3 (a) The covered person's pertinent medical records;

4 (b) The attending physician or health care professional's  
5 recommendation;

6 (c) Consulting reports from appropriate health care  
7 professionals and other documents submitted by the health carrier,  
8 covered person, the covered person's authorized representative, if  
9 applicable, or the covered person's treating physician or health care  
10 professional;

11 (d) The terms of coverage under the covered person's  
12 health benefit plan with the health carrier to ensure that, but for  
13 the health carrier's determination that the recommended or requested  
14 health care service or treatment that is the subject of the opinion  
15 is experimental or investigational, the reviewer's opinion is not  
16 contrary to the terms of coverage under the covered person's health  
17 benefit plan with the health carrier; and

18 (e) Whether:

19 (i) The recommended or requested health care service or  
20 treatment has been approved by the federal Food and Drug  
21 Administration, if applicable, for the condition; or

22 (ii) Medical or scientific evidenced or evidence-based  
23 standards demonstrate that the expected benefits of the recommended  
24 or requested health care service or treatment is more likely than not  
25 to be beneficial to the covered person than any available standard

1 health care service or treatment and the adverse risks of the  
2 recommended or requested health care service or treatment would not  
3 be substantially increased over those of available standard health  
4 care service or treatment.

5 (10)(a)(i) Except as provided in subdivision (10)(a)(ii)  
6 of this section, within twenty days after the date it receives the  
7 opinion of each clinical reviewer pursuant to subsection (9) of this  
8 section, the assigned independent review organization, in accordance  
9 with subdivision (10)(b) of this section, shall make a decision and  
10 provide written notice of the decision to the covered person, if  
11 applicable, the covered person's authorized representative, the  
12 health carrier, and the director.

13 (ii)(A) For an expedited external review, within forty-  
14 eight hours after the date it receives the opinion of each clinical  
15 reviewer pursuant to subsection (9) of this section, the assigned  
16 independent review organization, in accordance with subdivision (10)  
17 (b) of this section shall make a decision and provide notice of the  
18 decision orally or in writing to the persons listed in subdivision  
19 (10)(a)(i) of this section.

20 (B) If the notice provided under subdivision (10)(a)(ii)  
21 (A) of this section was not in writing, within forty-eight hours  
22 after the date of providing that notice, the assigned independent  
23 review organization shall provide written confirmation of the  
24 decision to the persons listed in subdivision (10)(a)(i) of this  
25 section and include the information set forth in subdivision (10)(a)

1 (iii) of this section.

2 (b)(i) If a majority of the clinical reviewers recommend  
3 that the recommended or requested health care service or treatment  
4 should be covered, the independent review organization shall make a  
5 decision to reverse the health carrier's adverse determination or  
6 final adverse determination.

7 (ii) If a majority of the clinical reviewers recommend  
8 that the recommended or requested health care service or treatment  
9 should not be covered, the independent review organization shall make  
10 a decision to uphold the health carrier's adverse determination or  
11 final adverse determination.

12 (iii)(A) If the clinical reviewers are evenly split as to  
13 whether the recommended or requested health care service or treatment  
14 should be covered, the independent review organization shall obtain  
15 the opinion of an additional clinical reviewer in order for the  
16 independent review organization to make a decision based on the  
17 opinions of a majority of the clinical reviewers pursuant to  
18 subdivision (10)(b)(i) or (ii) of this section.

19 (B) The additional clinical reviewer selected under  
20 subdivision (10)(b)(iii)(A) of this section shall use the same  
21 information to reach an opinion as the clinical reviewers who have  
22 already submitted their opinions pursuant to subsection (9) of this  
23 section.

24 (C) The selection of the additional clinical reviewer  
25 shall not extend the time within which the assigned independent



1 review organization is required to make a decision based on the  
2 opinions of the clinical reviewers selected under subsection (4) of  
3 this section pursuant to subdivision (4)(a) of this section.

4 (c) The independent review organization shall include in  
5 the notice provided pursuant to subdivision (10)(a) of this section:

6 (i) A general description of the reason for the request  
7 for external review;

8 (ii) The written opinion of each clinical reviewer,  
9 including the recommendation of each clinical reviewer as to whether  
10 the recommended or requested health care service or treatment should  
11 be covered and the rationale for the reviewer's recommendation;

12 (iii) The date the independent review organization was  
13 assigned by the director to conduct the external review;

14 (iv) The date the external review was conducted;

15 (v) The date of its decision;

16 (vi) The principal reason or reasons for its decision;

17 and

18 (vii) The rationale for its decision.

19 (d) Upon receipt of a notice of a decision pursuant to  
20 subdivision (10)(a) of this section reversing the adverse  
21 determination or final adverse determination, the health carrier  
22 shall immediately approve coverage of the recommended or requested  
23 health care service or treatment that was the subject of the adverse  
24 determination or final adverse determination.

25 (11) The assignment by the director of an approved

1 independent review organization to conduct an external review in  
2 accordance with this section shall be done on a random basis among  
3 those approved independent review organizations qualified to conduct  
4 the particular external review based on the nature of the health care  
5 service that is the subject of the adverse determination or final  
6 adverse determination and other circumstances, including conflict of  
7 interest concerns pursuant to subsection (4) of section 13 of this  
8 act.

9           Sec. 11. (1) An external review decision is binding on  
10 the health carrier except to the extent the health carrier has other  
11 remedies available under applicable state law.

12           (2) An external review decision is binding on the covered  
13 person except to the extent the covered person has other remedies  
14 available under applicable federal or state law.

15           (3) A covered person or the covered person's authorized  
16 representative, if applicable, shall not file a subsequent request  
17 for external review involving the same adverse determination or final  
18 adverse determination for which the covered person has already  
19 received an external review decision pursuant to the Health Carrier  
20 External Review Act.

21           Sec. 12. (1) The director shall approve independent  
22 review organizations eligible to be assigned to conduct external  
23 reviews under the Health Carrier External Review Act.

24           (2) In order to be eligible for approval by the director  
25 under this section to conduct external reviews under the act, an

1 independent review organization:

2 (a) Except as otherwise provided in this section, shall  
3 be accredited by a nationally recognized private accrediting entity  
4 that the director has determined has independent review organization  
5 accreditation standards that are equivalent to or exceed the minimum  
6 qualifications for independent review organizations established under  
7 section 13 of this act; and

8 (b) Shall submit an application for approval in  
9 accordance with subsection (4) of this section.

10 (3) The director shall develop an application form for  
11 initially approving and for reapproving independent review  
12 organizations to conduct external reviews.

13 (4)(a) Any independent review organization wishing to be  
14 approved to conduct external reviews under the act shall submit the  
15 application form and include with the form all documentation and  
16 information necessary for the director to determine if the  
17 independent review organization satisfies the minimum qualifications  
18 established under section 13 of this act.

19 (b)(i) Subject to subdivision (4)(b)(ii) of this section,  
20 an independent review organization is eligible for approval under  
21 this section only if it is accredited by a nationally recognized  
22 private accrediting entity that the director has determined has  
23 independent review organization accreditation standards that are  
24 equivalent to or exceed the minimum qualifications for independent  
25 review organizations under section 13 of this act.

1           (ii) The director may approve independent review  
2 organizations that are not accredited by a nationally recognized  
3 private accrediting entity if there are no acceptable nationally  
4 recognized private accrediting entities providing independent review  
5 organization accreditation.

6           (c) The director may charge an application fee that  
7 independent review organizations shall submit to the director with an  
8 application for approval and reapproval.

9           (5)(a) An approval is effective for two years, unless the  
10 director determines before its expiration that the independent review  
11 organization is not satisfying the minimum qualifications established  
12 under section 13 of this act.

13           (b) Whenever the director determines that an independent  
14 review organization has lost its accreditation or no longer satisfies  
15 the minimum requirements established under section 13 of this act,  
16 the director shall terminate the approval of the independent review  
17 organization and remove the independent review organization from the  
18 list of independent review organizations approved to conduct external  
19 reviews under this act that is maintained by the director pursuant to  
20 subsection (6) of this section.

21           (6) The director shall maintain and periodically update a  
22 list of approved independent review organizations.

23           (7) The director may adopt and promulgate rules and  
24 regulations to carry out the provisions of this section.

25           Sec. 13. (1) To be approved under section 12 of this act

1 to conduct external reviews, an independent review organization shall  
2 have and maintain written policies and procedures that govern all  
3 aspects of both the standard external review process and the  
4 expedited external review process set forth in the Health Carrier  
5 External Review Act that include, at a minimum:

6 (a) A quality assurance mechanism in place that:

7 (i) Ensures that external reviews are conducted within  
8 the specified time frames and that required notices are provided in a  
9 timely manner;

10 (ii) Ensures the selection of qualified and impartial  
11 clinical reviewers to conduct external reviews on behalf of the  
12 independent review organization and suitable matching of reviewers to  
13 specific cases and that the independent review organization employs  
14 or contracts with an adequate number of clinical reviewers to meet  
15 this objective;

16 (iii) Ensures the confidentiality of medical and  
17 treatment records and clinical review criteria; and

18 (iv) Ensures that any person employed by or under  
19 contract with the independent review organization adheres to the  
20 requirements of the act;

21 (b) A toll-free telephone service to receive information  
22 on a twenty-four hours per day, seven-days-per-week basis related to  
23 external reviews that is capable of accepting, recording, or  
24 providing appropriate instruction to incoming telephone callers  
25 during other than normal business hours; and

1           (c) An agreement to maintain and provide to the director  
2 the information set out in section 15 of this act.

3           (2) All clinical reviewers assigned by an independent  
4 review organization to conduct external reviews shall be physicians  
5 or other appropriate health care providers who meet the following  
6 minimum qualifications:

7           (a) Be an expert in the treatment of the covered person's  
8 medical condition that is the subject of the external review;

9           (b) Be knowledgeable about the recommended health care  
10 service or treatment through recent or current actual clinical  
11 experience treating patients with the same or similar medical  
12 condition of the covered person;

13           (c) Hold a nonrestricted license in a state of the United  
14 States and, for physicians, a current certification by a recognized  
15 medical specialty board in the United States in the area or areas  
16 appropriate to the subject of the external review; and

17           (d) Have no history of disciplinary actions or sanctions,  
18 including loss of staff privileges or participation restrictions,  
19 that have been taken or are pending by any hospital, governmental  
20 agency or unit, or regulatory body that raise a substantial question  
21 as to the clinical reviewer's physical, mental, or professional  
22 competence or moral character.

23           (3) In addition to the requirements set forth in  
24 subsection (1) of this section, an independent review organization  
25 may not own or control, be a subsidiary of, in any way be owned or

1 controlled by, or exercise control with a health benefit plan, a  
2 national, state, or local trade association of health benefit plans,  
3 or a national, state, or local trade association of health care  
4 providers.

5 (4)(a) In addition to the requirements set forth in  
6 subsections (1), (2), and (3) of this section, to be approved  
7 pursuant to section 12 of this act to conduct an external review of a  
8 specified case, neither the independent review organization selected  
9 to conduct the external review nor any clinical reviewer assigned by  
10 the independent organization to conduct the external review may have  
11 a material professional, familial, or financial conflict of interest  
12 with any of the following:

13 (i) The health carrier that is the subject of the  
14 external review;

15 (ii) The covered person whose treatment is the subject of  
16 the external review or the covered person's authorized  
17 representative, if applicable;

18 (iii) Any officer, director, or management employee of  
19 the health carrier that is the subject of the external review;

20 (iv) The health care provider or the health care  
21 provider's medical group or independent practice association  
22 recommending the health care service or treatment that is the subject  
23 of the external review;

24 (v) The facility at which the recommended health care  
25 service or treatment would be provided; or

1           (vi) The developer or manufacturer of the principal drug,  
2 device, procedure, or other therapy being recommended for the covered  
3 person whose treatment is the subject of the external review.

4           (b) In determining whether an independent review  
5 organization or a clinical reviewer of the independent review  
6 organization has a material professional, familial, or financial  
7 conflict of interest for purposes of subdivision (4)(a) of this  
8 section, the director shall take into consideration situations in  
9 which the independent review organization to be assigned to conduct  
10 an external review of a specified case or a clinical reviewer to be  
11 assigned by the independent review organization to conduct an  
12 external review of a specified case may have an apparent  
13 professional, familial, or financial relationship or connection with  
14 a person described in subdivision (4)(a) of this section, but that  
15 the characteristics of that relationship or connection are such that  
16 they are not a material professional, familial, or financial conflict  
17 of interest that results in the disapproval of the independent review  
18 organization or the clinical reviewer from conducting the external  
19 review.

20           (5)(a) An independent review organization that is  
21 accredited by a nationally recognized private accrediting entity that  
22 has independent review accreditation standards that the director has  
23 determined are equivalent to or exceed the minimum qualifications of  
24 this section shall be presumed in compliance with this section to be  
25 eligible for approval under section 12 of this act.



1           (b) The director shall initially review and periodically  
2 review the independent review organization accreditation standards of  
3 a nationally recognized private accrediting entity to determine  
4 whether the entity's standards are, and continue to be, equivalent to  
5 or exceed the minimum qualifications established under this section.  
6 The director may accept a review conducted by the National  
7 Association of Insurance Commissioners for the purpose of the  
8 determination under this subdivision.

9           (c) Upon request, a nationally recognized private  
10 accrediting entity shall make its current independent review  
11 organization accreditation standards available to the director or the  
12 National Association of Insurance Commissioners in order for the  
13 director to determine if the entity's standards are equivalent to or  
14 exceed the minimum qualifications established under this section. The  
15 director may exclude any private accrediting entity that is not  
16 reviewed by the National Association of Insurance Commissioners.

17           (6) An independent review organization shall be unbiased.  
18 An independent review organization shall establish and maintain  
19 written procedures to ensure that it is unbiased in addition to any  
20 other procedures required under this section.

21           Sec. 14. No independent review organization, clinical  
22 reviewer working on behalf of an independent review organization, or  
23 an employee, agent, or contractor of an independent review  
24 organization shall be liable in damages to any person for any  
25 opinions rendered or acts or omissions performed within the scope of

1 the organization's or person's duties under the law during or upon  
2 completion of an external review conducted pursuant to the Health  
3 Carrier External Review Act, unless the opinion was rendered or act  
4 or omission performed in bad faith or involved gross negligence.

5           Sec. 15. (1)(a) An independent review organization  
6 assigned pursuant to section 8, 9, or 10 of this act to conduct an  
7 external review shall maintain written records in the aggregate by  
8 state and by health carrier on all requests for external review for  
9 which it conducted an external review during a calendar year and,  
10 upon request, submit a report to the director as required under  
11 subdivision (1)(b) of this section.

12           (b) Each independent review organization required to  
13 maintain written records on all requests for external review pursuant  
14 to subdivision (1)(a) of this section for which it was assigned to  
15 conduct an external review shall submit to the director, upon  
16 request, a report in the format specified by the director.

17           (c) The report shall include in the aggregate by state,  
18 and for each health carrier:

19           (i) The total number of requests for external review;

20           (ii) The number of requests for external review resolved  
21 and, of those resolved, the number resolved upholding the adverse  
22 determination or final adverse determination and the number resolved  
23 reversing the adverse determination or final adverse determination;

24           (iii) The average length of time for resolution;

25           (iv) A summary of the types of coverages or cases for

1 which an external review was sought, as provided in the format  
2 required by the director;

3 (v) The number of external reviews pursuant to section 8  
4 of this act that were terminated as the result of a reconsideration  
5 by the health carrier of its adverse determination or final adverse  
6 determination after the receipt of additional information from the  
7 covered person or the covered person's authorized representative; and

8 (vi) Any other information the director may request or  
9 require.

10 (d) The independent review organization shall retain the  
11 written records required pursuant to this subsection for at least  
12 three years.

13 (2)(a) Each health carrier shall maintain written records  
14 in the aggregate, by state and for each type of health benefit plan  
15 offered by the health carrier, on all requests for external review  
16 that the health carrier receives notice of from the director pursuant  
17 to the Health Carrier External Review Act.

18 (b) Each health carrier required to maintain written  
19 records on all requests for external review pursuant to subdivision  
20 (2)(a) of this section shall submit to the director, upon request, a  
21 report in the format specified by the director.

22 (c) The report shall include in the aggregate, by state,  
23 and by type of health benefit plan:

24 (i) The total number of requests for external review;

25 (ii) From the total number of requests for external

1 review reported under subdivision (2)(c)(i) of this section, the  
2 number of requests determined eligible for a full external review;  
3 and

4 (iii) Any other information the director may request or  
5 require.

6 (3) The health carrier shall retain the written records  
7 required pursuant to this section for at least three years.

8 Sec. 16. The health carrier against which a request for a  
9 standard external review or an expedited external review is filed  
10 shall pay the cost of the independent review organization for  
11 conducting the external review.

12 Sec. 17. (1)(a) Each health carrier shall include a  
13 description of the external review procedures in or attached to the  
14 policy, certificate, membership booklet, outline of coverage, or  
15 other evidence of coverage it provides to covered persons.

16 (b) The disclosure required by subdivision (1)(a) of this  
17 section shall be in a format prescribed by the director.

18 (2) The description required under subsection (1) of this  
19 section shall include a statement that informs the covered person of  
20 the right of the covered person to file a request for an external  
21 review of an adverse determination or final adverse determination  
22 with the director. The statement may explain that external review is  
23 available when the adverse determination or final adverse  
24 determination involves an issue of medical necessity,  
25 appropriateness, health care setting, level of care, or

1 effectiveness. The statement shall include the telephone number and  
2 address of the director.

3 (3) In addition to the contents required by subsection  
4 (2) of this section, the statement shall inform the covered person  
5 that, when filing a request for an external review, the covered  
6 person will be required to authorize the release of any medical  
7 records of the covered person that may be required to be reviewed for  
8 the purpose of reaching a decision on the external review.

9 Sec. 18. The Health Carrier External Review Act applies  
10 to any claim submitted on and after January 1, 2014.

11 Sec. 19. The following section is outright repealed:  
12 Section 44-7309, Reissue Revised Statutes of Nebraska.