State of Idaho

DEPARTMENT OF INSURANCE

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WILLIAM W. DEAL
Director

BULLETIN NO. 11-04

DATE: June 13, 2011

TO: Disability/Health Insurance Carriers, Independent Review Organizations and Single Employer Self-funded Plan Administrators

FROM: William W. Deal, Director

SUBJECT: Idaho Health Carrier External Review Act Amendments

The purpose of this bulletin is to alert health insurance carriers, independent review organizations, and administrators for single employer self-funded ERISA employee benefit plans to important changes to the Idaho Health Carrier External Review Act (Title 41, Chapter 59 of the Idaho Code). House Bills 131 and 299 amended the following sections of the act for health benefit plans in Idaho effective July 1, 2011:

1. **Section 41-5903(2):** The definition of "adverse benefit determination" was revised to include denials based on **"appropriateness, health care setting, level of care, effectiveness,"** in addition to denials based on medical necessity and investigational services.

2. **Section 41-5903(39):** The definition of "urgent care request" was revised to include **"a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility,"** in addition to the existing language in that definition.

3. **Section 41-5904:** Subsection (1) was revised to remove unnecessary language. The revisions to subsection (2) provide that an administrator or designee of a single employer self-funded ERISA employee benefit plan may voluntarily elect to comply with Idaho's external review act. The administrator or designee must give timely and appropriate written notice to the director. The election may be for a single plan beneficiary or for a specific period of time.

4. **Section 41-5905:** Language in this section was updated to be consistent with the inclusion of additional reasons for denial in the definition of an adverse benefit determination referenced above.

5. **Sections 41-5906 and 41-5915:** The sections were changed to delete the director's authority to establish by rule a filing fee to be paid by the covered person for an external review request filed with the department.

6. **Section 41-5907:** The requirements for what constitutes exhaustion of the health carrier's internal grievance process now include:

    - When a carrier fails to give a timely, full and fair opportunity for the covered person to take advantage of the carrier's internal grievance process.
    - A covered person may file for an internal grievance with the carrier and an expedited external review with the department at the same time for an urgent care request involving a medical condition where any delay would jeopardize the person's life, health, or the ability to regain maximum function.

7. **Section 41-5908(22):** When a health carrier receives notice from an independent review organization reversing an adverse benefit determination for a standard external review request, the carrier must approve coverage as soon as practicable but not later than one business day after receipt of notice.

8. **Section 41-5909:** For expedited external review requests:
    - In subsection (1), a covered person may request an expedited review at exhaustion of the health carrier's internal grievance process or at the same time as filing an internal appeal as provided in Section 41-5907.
    - In subsection (11), when a health carrier receives notice from an independent review organization reversing an adverse benefit determination, the carrier must notify the director and covered person of its intent to pay the covered benefit as soon as practicable but not later than one business day after receipt of notice.

The department will revise its Health Carrier External Review rule, IDAPA 18.01.05, to comply with the amended act. Health carriers must file revised forms with the department's Rates and Forms section. Attached are language changes required for these notices (Note: the language changes include strike-through and are underlined for your information only. The filed forms do not need to include strike-through or underlining.):

- Appendix A, "Your Right to an Independent External Review" as required by Section 41-5916; and
- Appendix B, "Notice of Your Right to an Independent External Review" as required by Section 41-5905.

As part of the revisions to IDAPA 18.01.05, the department will delete the annual reporting requirements for health carriers and independent review organizations in Section 024 of that rule. Section 024 will be replaced with the requirements for "Voluntary Election by ERISA Plan Administrator," explaining the written notice requirements for plan administrators or designees.

The department will revise the external review request forms and other information posted on its website for these changes effective July 1, 2011. Any questions regarding

this bulletin may be directed to Eileen Mundorff, Consumer Affairs Officer, 208-334-4326 or by email to: eileen.mundorff@doi.idaho.gov

Appendix A

The summary description below provides an acceptable format approved by the director as meeting the requirements of Section 41-5916, Idaho Code. A health carrier may change the terms "you, your" to "covered person" and "we, our" to the health carrier's name, or similar references consistent with the health carrier's typical terminology.

YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final. Except in limited circumstances, you will have no further right to have your claim reviewed by a court, arbitrator, mediator or other dispute resolution entity.

If we issue a final adverse benefit determination of your request to provide or pay for a health care service or supply, you may have the right to have our decision reviewed by health care professionals who have no association with us. You have this right only if our denial decision involved:

- The medical necessity, appropriateness, health care setting, level of care, or effectiveness of your health care service or supply, or
- Our determination your health care service or supply was investigational.

You must first exhaust our internal grievance and appeal process. Exhaustion of that process includes completing all levels of appeal, or unless you requested or agreed to a delay, our failure to respond to a standard appeal within 35 days in writing or to an urgent appeal within three business days of the date you filed your appeal. We may also agree to waive the exhaustion requirement for an external review request. You may file for an internal urgent appeal with us and for an expedited external review with the Idaho Department of Insurance at the same time if any delay would seriously jeopardize your life, health or ability to regain maximum function.

You may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St., 3rd Floor
Boise ID 83720-0043

For more information and for an external review request form:

- See the department's web site, www.doi.idaho.gov, or
- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

You may represent yourself in your request or you may name another person, including your treating health care provider, to act as your authorized representative for your request. If you want someone else to represent you, you must include a signed "Appointment of an Authorized Representative" form with your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records the independent review organization may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The department will not act on an external review request without your completed authorization form.

If your request qualifies for external review, our final adverse benefit determination will be reviewed by an independent review organization selected by the department. We will pay the costs of the review.

Standard External Review Request: You must file your written external review request with the department within four months after the date we issue a final notice of denial.

1. Within seven days after the department receives your request, the department will send a copy to us.
2. Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may appeal that determination to the department.
3. If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
4. Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to you, to us and to the department within 42 days after receipt of an external review request.

Expedited External Review Request: You may file a written "urgent care request" with the department for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

"Urgent care request" means a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
2. In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of ~~the approval of coverage~~our intent to pay the covered benefit as soon as reasonably practicable, but not later than one business day after ~~making the determination~~receiving notice of the decision.

Binding Nature of the External Review Decision: If your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees), the external review decision by the independent review organization will be final and binding on us. You may have additional review rights provided under federal ERISA laws.

If your plan is not subject to ERISA requirements, the external review decision by the independent review organization will be final and binding on both you and us. **This means that if you elect to request external review, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of our denial after the independent review organization issues its final decision.** If you choose not to use the external review process, other options for resolving a

disputed claim may include mediation, arbitration or filing an action in court.

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

Appendix B

The notice below provides an acceptable format approved by the director as meeting the requirements of Idaho Code Section 41-5905. A health carrier may change the terms "you, your" to "covered person" and "we, our" to the health carrier's name, or similar references consistent with the health carrier's typical terminology.

NOTICE OF YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final. Except in limited circumstances, you will have no further right to have your claim reviewed by a court, arbitrator, mediator or other dispute resolution entity.

We have denied your request to provide or pay for a health care service or supply. You may have the right to have our decision reviewed by health care professionals who have no association with us. You have this right only if our denial decision involved:

- The medical necessity, appropriateness, health care setting, level of care or effectiveness of your health care service or supply, or
- Our determination your health care service or supply was investigational.

No later than four months from the date of this denial, you may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St., 3rd Floor
Boise ID 83720-0043

For more information and for an external review request form:
- See the department's web site, www.doi.idaho.gov, or
- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

You may represent yourself in your request or you may name another person, including your treating health care provider, to act as your authorized representative for your request. If you want someone else to represent you, you must include a signed "Appointment of an Authorized Representative" form with your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records the independent review organization may require for review to reach a decision on the external review. The department will not act on an external review request without your completed authorization form.

If your request qualifies for external review, our decision will be reviewed by an independent review organization selected by the department. We will pay the costs of the review.

Standard External Review Request: You must file your written external review request with the department **within four months** after the date we issued this notice of denial.

1. Within seven days after the department receives your request, the department will send a copy to us.
2. Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may appeal that determination to the department.
3. If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
4. Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to you, to us and to the department within 42 days after receipt of an external review request.

Expedited External Review Request: You may file a written "urgent care request" with the department for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

"Urgent care request" means a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
2. In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of ~~the approval of coverage~~ our intent to pay the covered benefit as soon as reasonably practicable, but not later than one business day after ~~making the determination~~ receiving notice of the decision.

Binding Nature of the External Review Decision: *[NOTE TO HEALTH CARRIERS: The carrier must include one of the applicable paragraphs below for the covered person's health benefit plan.]*

*[*Your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees). The external review decision by the independent review organization will be final and binding on the health insurer, but you may have additional review rights provided under federal ERISA laws.*]*

*[*The external review decision by the independent review organization will be final and binding on both you and us. **This means that if you elect to request external review of your claim, you will be bound by the decision of the independent review organization. You will not have any further opportunity for**

review of your claim after the independent review organization issues its final decision. If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.*]*

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.