H-2042.1

SUBSTITUTE HOUSE BILL 1956

State of Washington 64th Legislature 2015 Regular Session

By House Health Care & Wellness (originally sponsored by Representative Moeller)

READ FIRST TIME 02/20/15.

AN ACT Relating to independent review organizations; and amending RCW 48.43.535.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 48.43.535 and 2012 c 211 s 21 are each amended to read as follows:

(1) There is a need for a process for the fair consideration of disputes relating to decisions by carriers that offer a health plan to deny, modify, reduce, or terminate coverage of or payment for health care services for an enrollee. For purposes of this section, "carrier" also applies to a health plan if the health plan administers the appeal process directly or through a third party.

(2) An enrollee may seek review by a certified independent review organization of a carrier's decision to deny, modify, reduce, or terminate coverage of or payment for a health care service, after exhausting the carrier's grievance process and receiving a decision that is unfavorable to the enrollee, or after the carrier has exceeded the timelines for grievances provided in RCW 48.43.530, without good cause and without reaching a decision.

(3) The commissioner must establish and use a rotational registry system for the assignment of a certified independent review organization to each dispute. The system should be flexible enough to

ensure that an independent review organization has the expertise necessary to review the particular medical condition or service at issue in the dispute, and that any approved independent review organization does not have a conflict of interest that will influence its independence.

(4) Carriers must provide to the appropriate certified independent review organization, not later than the third business day after the date the carrier receives a request for review, a copy of:

(a) Any medical records of the enrollee that are relevant to the review;

(b) Any documents used by the carrier in making the determination to be reviewed by the certified independent review organization;

(c) Any documentation and written information submitted to the carrier in support of the appeal; and

(d) A list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal. Health information or other confidential or proprietary information in the custody of a carrier may be provided to an independent review organization, subject to rules adopted by the commissioner.

(5) Enrollees must be provided with at least five business days to submit to the independent review organization in writing additional information that the independent review organization must consider when conducting the external review. The independent review organization must forward any additional information submitted by an enrollee to the plan or carrier within one business day of receipt by the independent review organization.

(6) The medical reviewers from a certified independent review organization will make determinations regarding the medical necessity or appropriateness of, and the application of health plan coverage provisions to, health care services for an enrollee. The medical reviewers' determinations must be based upon their expert medical judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice in the state of Washington. Except as provided in this subsection, the certified independent review organization must ensure that determinations are consistent with the scope of covered benefits as outlined in the medical coverage agreement. Medical reviewers may override the health plan's medical necessity or appropriateness

standards if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based medical practice.

(7) Once a request for an independent review determination has been made, the independent review organization must proceed to a final determination, unless requested otherwise by both the carrier and the enrollee or the enrollee's representative.

(a) An enrollee or carrier may request an expedited external review if the adverse benefit determination or internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services but has not been discharged from a facility; or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum function. The independent review organization must make its decision to uphold or reverse the adverse benefit determination or final internal adverse benefit determination and notify the enrollee and the carrier or health plan of the determination as expeditiously as possible but within not more than seventy-two hours after the receipt of the request for expedited external review. If the notice is not in writing, the independent review organization must provide written confirmation of the decision within forty-eight hours after the date of the notice of the decision.

(b) For claims involving experimental or investigational treatments, the independent review organization must ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process.

(8) Carriers must timely implement the certified independent review organization's determination, and must pay the certified independent review organization's charges.

(9) When an enrollee requests independent review of a dispute under this section, and the dispute involves a carrier's decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving at the time the request for review is submitted and the carrier's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier must continue to provide the health service if requested by the enrollee until a determination is made under this section. If the determination affirms the carrier's

decision, the enrollee may be responsible for the cost of the continued health service.

(10) Each certified independent review organization must maintain written records and make them available upon request to the commissioner.

(11) A certified independent review organization may notify the office of the insurance commissioner if, based upon its review of disputes under this section, it finds a pattern of substandard or egregious conduct by a carrier.

(12)(a) The commissioner shall adopt rules to implement this section after considering relevant standards adopted by national managed care accreditation organizations and the national association of insurance commissioners.

(b) This section is not intended to supplant any existing authority of the office of the insurance commissioner under this title to oversee and enforce carrier compliance with applicable statutes and rules.

(13) A certified independent review organization shall submit an annual statistical report with the department of health with the information identified in (a) through (k) of this subsection. The department of health shall transmit the reports to the commissioner. The commissioner shall make the reports available to the public in a database on the commissioner's internet web site, taking into consideration laws governing disclosure of public records, confidentiality, and personal privacy, including but not limited to chapter 70.02 RCW and the federal health insurance portability and accountability act of 1996 and its implementing regulations. Information for certified independent review organization determinations in the database must include and be searchable by the following:

(a) Enrollee demographic profile information, including age, race, and gender;

(b) Enrollee diagnosis or condition and disputed health care service;

(c) Name of the carrier;

(d) Whether the independent review was for medically necessary services, experimental or investigational treatments, or a contractual coverage dispute;

(e) Whether the external review was standard or expedited;

(f) The length of time from the certified independent review organization's receipt of a request for external review and supporting documentation until the certified independent review organization notified the enrollee of its determination;

(g) The credentials and qualifications of the reviewer or reviewers;

(h) The nature of the criteria that the reviewer or reviewers used to make the determination;

(i) The final result of the determination and the date the determination was made;

(j) A detailed case summary that includes the specific standards, criteria, and medical and scientific evidence, if any, that led to the determination; and

(k) If the enrollee was limited English proficient, whether the independent review organization's notices and determinations were translated and provided to the enrollee in a timely manner.

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