[27 R.I. Gen. Laws §§ 27-18.9-1 through 27-18.9-15.]

§§ 27-18.9-1 through 27-18.9-15: Benefit Determination and Utilization Review Act

§ 27-18.9-1. Purpose of chapter.

(a) The purpose of this chapter is to:

(1) Promote the delivery of quality health care in a cost-effective manner;

(2) Foster greater coordination between health care providers, patients, health care entities, health benefit plans and utilization-review entities to ensure public health well-being;

(3) Protect beneficiaries, businesses, and providers by ensuring that review agents are qualified to perform review activities and to make informed decisions on the medical necessity and appropriateness of medical care;

(4) Ensure that review agents maintain the confidentiality of medical records in accordance with applicable state and federal laws; and

(5) Interface and maintain compliance with federal benefit determination and adverse benefit determination requirements.

(b) Nothing in this chapter is intended to prohibit or discourage the health insurance commissioner from consulting or collaborating with the department of health, or any other state or federal agency, to the extent the commissioner in his or her discretion determines such consultation and/or collaboration is necessary and/or appropriate for the administration and enforcement of this chapter.

§ 27-18.9-2. Definitions.

As used in this chapter, the following terms are defined as follows:

(1) "Adverse benefit determination" means a decision not to authorize a health-care service, including a denial, reduction, or termination of, or a failure to provide or make a payment, in whole or in part, for a benefit. A decision by a utilization-review agent to authorize a health-care service in an alternative setting, a modified extension of stay, or an alternative treatment shall not constitute an adverse determination if the review agent and provider are in agreement regarding the decision. Adverse benefit determinations include:

(i) "Administrative adverse benefit determinations," meaning any adverse benefit determination that does not require the use of medical judgment or clinical criteria such as a determination of an individual's eligibility to participate in coverage, a determination that a benefit is not a covered benefit, or any rescission of coverage; and

(ii) "Non-administrative adverse benefit determinations," meaning any adverse benefit determination that requires or involves the use of medical judgement or clinical criteria to determine whether the service being reviewed is medically necessary and/or appropriate. This includes the denial of treatments determined to be experimental or investigational, and any denial of coverage of a prescription drug because that drug is not on the health-care entity's formulary.

(2) "Appeal" or "internal appeal" means a subsequent review of an adverse benefit determination upon request by a claimant to include the beneficiary or provider to reconsider all or part of the original adverse benefit determination.

(3) "Authorization" means a review by a review agent, performed according to this chapter, concluding that the allocation of health-care services ordered by a provider, given or proposed to be given to a beneficiary, was approved or authorized.

(4) "Authorized representative" means an individual acting on behalf of the beneficiary and shall include: the ordering provider; any individual to whom the beneficiary has given express written consent to act on his or her behalf; a person authorized by law to provide substituted consent for the beneficiary; and, when the beneficiary is unable to provide consent, a family member of the beneficiary.

(5) "Beneficiary" means a policy-holder subscriber, enrollee, or other individual participating in a health-benefit plan.

(6) "Benefit determination" means a decision to approve or deny a request to provide or make payment for a health-care service or treatment.

(7) "Certificate" means a certificate granted by the commissioner to a review agent meeting the requirements of this chapter.

(8) "Claim" means a request for plan benefit(s) made by a claimant in accordance with the health-care entity's reasonable procedures for filing benefit claims. This shall include pre-service, concurrent, and post-service claims.

(9) "Claimant" means a health-care entity participant, beneficiary, and/or authorized representative who makes a request for plan benefit(s).

(10) "Commissioner" means the health insurance commissioner.

(11) "Complaint" means an oral or written expression of dissatisfaction by a beneficiary, authorized representative, or a provider. The appeal of an adverse benefit determination is not considered a complaint.

(12) "Concurrent assessment" means an assessment of health-care services conducted during a beneficiary's hospital stay, course of treatment or services over a period of time, or for the number of treatments. If the

medical problem is ongoing, this assessment may include the review of services after they have been rendered and billed.

(13) "Concurrent claim" means a request for a plan benefit(s) by a claimant that is for an ongoing course of treatment or services over a period of time or for the number of treatments.

(14) "Delegate" means a person or entity authorized pursuant to a delegation of authority or re-delegation of authority, by a health-care entity or network plan to perform one or more of the functions and responsibilities of a health-care entity and/or network plan set forth in this chapter or regulations or guidance promulgated thereunder.

(15) "Emergency services" or "emergent services" means those resources provided in the event of the sudden onset of a medical, behavioral health, or other health condition that the absence of immediate medical attention could reasonably be expected, by a prudent layperson, to result in placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any bodily organ or part.

(16) "External review" means a review of a non-administrative adverse benefit determination (including final internal adverse benefit determination) conducted pursuant to an applicable external review process performed by an independent review organization.

(17) "External review decision" means a determination by an independent review organization at the conclusion of the external review.

(18) "Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by a plan or issuer at the completion of the internal appeals process or when the internal appeals process has been deemed exhausted as defined in § 27-18.9-7(b)(1).

(19) "Health-benefit plan" or "health plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health-care entity to provide, deliver, arrange for, pay for, or reimburse any of the costs of health-care services.

(20) "Health-care entity" means an insurance company licensed, or required to be licensed, by the state of Rhode Island or other entity subject to the jurisdiction of the commissioner or the jurisdiction of the department of business regulation pursuant to chapter 62 of title 42, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health-care services, including, without limitation: a for-profit or nonprofit hospital, medical or dental service corporation or plan, a health maintenance organization, a health insurance company, or any other entity providing a plan of health insurance, accident and sickness insurance, health benefits, or health-care services.

(21) "Health-care services" means and includes, but is not limited to: an admission, diagnostic procedure, therapeutic procedure, treatment, extension of stay, the ordering and/or filling of formulary or non-formulary medications, and any other medical, behavioral, dental, vision care services, activities, or supplies that are covered by the beneficiary's health-benefit plan.

(22) "Independent review organization" or "IRO" means an entity that conducts independent external reviews of adverse benefit determinations or final internal adverse benefit determinations.

(23) "Network" means the group or groups of participating providers providing health-care services under a network plan.

(24) "Network plan" means a health-benefit plan or health plan that either requires a beneficiary to use, or creates incentives, including financial incentives, for a beneficiary to use the providers managed, owned, under contract with, or employed by the health-care entity.

(25) "Office" means the office of the health insurance commissioner.

(26) "Pre-service claim" means the request for a plan benefit(s) by a claimant prior to a service being rendered and is not considered a concurrent claim.

(27) "Professional provider" means an individual provider or health-care professional licensed, accredited, or certified to perform specified health-care services consistent with state law and who provides health-care services and is not part of a separate facility or institutional contract.

(28) "Prospective assessment" or "pre-service assessment" means an assessment of health-care services prior to services being rendered.

(29) "Provider" means a physician, hospital, professional provider, pharmacy, laboratory, dental, medical, or behavioral health provider or other state-licensed or other state-recognized provider of health care or behavioral health services or supplies.

(30) "Retrospective assessment" or "post-service assessment" means an assessment of health-care services that have been rendered. This shall not include reviews conducted when the review agency has been obtaining ongoing information.

(31) "Retrospective claim" or "post-service claim" means any claim for a health-plan benefit that is not a pre-service or concurrent claim.

(32) "Review agent" means a person or health-care entity performing benefit determination reviews that is either employed by, affiliated with, under contract with, or acting on behalf of a health-care entity.

(33) "Same or similar specialty" means a practitioner who has the appropriate training and experience that is the same or similar as the attending provider in addition to experience in treating the same problems to include any potential complications as those under review.

(34) "Therapeutic interchange" means the interchange or substitution of a drug with a dissimilar chemical structure within the same therapeutic or pharmacological class that can be expected to have similar outcomes

and similar adverse reaction profiles when given in equivalent doses, in accordance with protocols approved by the president of the medical staff or medical director and the director of pharmacy.

(35) "Tiered network" means a network that identifies and groups some or all types of providers into specific groups to which different provider reimbursement, beneficiary cost-sharing, or provider access requirements, or any combination thereof, apply for the same services.

(36) "Urgent health-care services" includes those resources necessary to treat a symptomatic medical, mental health, substance use, or other health-care condition that a prudent layperson, acting reasonably, would believe necessitates treatment within a twenty-four hour (24) period of the onset of such a condition in order that the patient's health status not decline as a consequence. This does not include those conditions considered to be emergent health-care services as defined in this section.

(37) "Utilization review" means the prospective, concurrent, or retrospective assessment of the medical necessity and/or appropriateness of the allocation of health-care services of a provider, given or proposed to be given, to a beneficiary. Utilization review does not include:

(i) The therapeutic interchange of drugs or devices by a pharmacy operating as part of a licensed inpatient health-care facility; or

(ii) The assessment by a pharmacist licensed pursuant to the provisions of chapter 19.1 of title 5, and practicing in a pharmacy operating as part of a licensed inpatient health-care facility, in the interpretation, evaluation and implementation of medical orders, including assessments and/or comparisons involving formularies and medical orders.

(38) "Utilization review plan" means a description of the standards governing utilization review activities performed by a review agent.

§ 27-18.9-3. Certification and recertification of review agents.

(a) A review agent shall not conduct benefit determination reviews in the state unless the office has granted the review agent a certificate.

(b) Individuals shall not be required to hold a separate review agent certification under this chapter when acting as either an employee of, an affiliate of, a contractor for, or otherwise acting on behalf of a certified review agent.

(c) The commissioner shall establish a process for the certification of review agents meeting the requirements of certification.

(d) The commissioner shall establish procedures for the periodic review and recertification of review agents at least every three (3) years.

(e) A certificate issued under this chapter is not transferable, and the transfer of fifty percent (50%) or more of the ownership of a review agent shall be deemed a transfer.

(f) The office shall issue a review agent certificate to an applicant who or that has met the minimum standards defined in this chapter, and regulations promulgated in accordance with it, including the payment of any fees as required, and other applicable regulations of the office.

(g) In the event of any systemic changes in the review agent certification information on file with the office, the review agent shall submit notice and explanation of this change for approval by the commissioner at least thirty (30) calendar days prior to implementation of any such change.

(h) The total cost of obtaining and maintaining a review agent certification under this title and in compliance with the requirements of the applicable rules and regulations shall be borne by the applicant and shall include one hundred fifty percent (150%) of the total salaries paid to the personnel engaged in certifications and ensuring compliance with the requirements herein and applicable rules and regulations. These monies shall be paid to the commissioner to and for the use of the office and shall be in addition to any taxes and fees otherwise payable to the state.

(i) Notwithstanding any other provision of law, the review agent, the office, and all other parties privy to information that is the subject of this chapter shall comply with all state and federal confidentiality laws, including, but not limited to, chapter 37.3 of title 5 (confidentiality of health care communications and information act) and specifically § 5-37.3-4(c), which requires limitation on the distribution of information that is the subject of this chapter on a "need to know" basis, and § 40.1-5-26.

(j) The office may, in response to a complaint or inquiry, review a benefit determination or appeal and may request information of the review agent, provider, or beneficiary regarding the status, outcome, or rationale regarding any decision. The review agent shall promptly respond to any such requests by the office.

(k) The office shall adopt regulations necessary to implement the provisions of this chapter.

§ 27-18.9-4. Application requirements.

An application for review agent certification or recertification shall include, but is not limited to, documentation to evidence the following:

(a) Administrative and non-administrative benefit determinations:

(1) That the health care entity or its review agent provide beneficiaries and providers with a summary of its benefit determination review programs and adverse benefit determination criteria in a manner acceptable to the commissioner that includes a summary of the standards, procedures, and methods to be used in evaluating proposed, concurrent, or delivered health care services;

(2) The circumstances, if any, under which review agent may be delegated to and evidence that the delegated review agent is a certified review agent pursuant to the requirements of this chapter;

(3) A complaint resolution process acceptable to the commissioner, whereby beneficiaries or other health care providers may seek resolution of complaints and other matters of which the review agent has received notice;

(4) Policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

(5) Requirements that no employee of, or other individual rendering an adverse benefit determination or appeal decision may receive any financial or other incentives based upon the number of denials of certification made by that employee or individual;

(6) Evidence that the review agent has not entered into a compensation agreement or contract with its employees or agents whereby the compensation of its employees or its agents is based, directly or indirectly, upon a reduction of services or the charges for those services, the reduction of length of stay, or use of alternative treatment settings;

(7) An adverse benefit determination and internal appeals process consistent with chapter 18.9 of title 27 and acceptable to the office, whereby beneficiaries, their physicians, or other health care service providers may seek prompt reconsideration or appeal of adverse benefit determinations by the review agent according to all state and federal requirements; and

(8) That the health care entity or its review agent has a mechanism to provide the beneficiary or claimant with a description of its claims procedures and any procedures for obtaining approvals as a prerequisite for obtaining a benefit or for obtaining coverage for such benefit. This description should, at a minimum, be placed in the summary of benefits document and available on the review agent's or the relevant health care entity's website and upon request from the claimant, his/her authorized representative and ordering providers.

(b) Non-administrative benefit determinations general requirements:

(1) Type and qualifications of personnel (employed or under contract) authorized to perform utilization review, including a requirement that only a provider with the same license status as the ordering professional provider or a licensed physician or dentist is permitted to make a prospective or concurrent utilization review adverse benefit determination;

(2) Requirement that a representative of the utilization review agent is reasonably accessible to beneficiaries and providers at least five (5) days a week during normal business hours in Rhode Island and during the hours of the agency's operations when conducting utilization review;

(3) Policies and procedures regarding the notification and conduct of patient interviews by the utilization review agent to include a process and assurances that such interviews do not disrupt care; and

(4) Requirement that the utilization review agent shall not impede the provision of health care services for treatment and/or hospitalization or other use of a provider's services or facilities for any beneficiary.

§ 27-18.9-5. Administrative and non-administrative benefit determination procedural requirements.

(a) Procedural failure by claimant.

(1) In the event of the failure of claimant or an authorized representative to follow the health care entities claims procedures for a pre-service claim the health care entity or its review agent must:

(i) Notify claimant or the authorized representative, as appropriate, of this failure as soon as possible and no later than five (5) calendar days following the failure and this notification must also inform claimant of the proper procedures to file a pre-service claim; and

(ii) Notwithstanding the above, if the pre-service claim relates to urgent or emergent health care services, the health care entity or its review agent must notify and inform claimant or the authorized representative, as appropriate, of the failure and proper procedures within twenty-four (24) hours following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

(2) Claimant must have stated name, specific medical condition or symptom and specific treatment, service, or product for which approval is requested and submitted to proper claim processing unit.

(b) Utilization review agent procedural requirements:

(1) All initial, prospective, and concurrent non-administrative, adverse benefit determinations of a health care service that had been ordered by a physician, dentist, or other practitioner shall be made, documented, and signed by a licensed practitioner with the same licensure status as the ordering provider;

(2) Utilization review agents are not prohibited from allowing appropriately qualified review agency staff from engaging in discussions with the attending provider, the attending provider's designee or appropriate health care facility and office personnel regarding alternative service and/or treatment options. Such a discussion shall not constitute an adverse benefit determination; provided, however, that any change to the attending provider's original order and/or any decision for an alternative level of care must be made and/or appropriately consented to by the attending provider or the provider's designee responsible for treating the beneficiary and must be documented by the review agent; and

(3) A utilization review agent shall not retrospectively deny authorization for health care services provided to a covered person when an authorization has been obtained for that service from the review agent unless the approval was based upon inaccurate information material to the review or the health care services were not provided consistent with the provider's submitted plan of care and/or any restrictions included in the prior approval granted by the review agent.

§ 27-18.9-6. Non-administrative benefit determination notifications.

(a) Benefit determination notification timelines. A health care entity and/or its review agent shall comply with the following:

(1) For urgent or emergent health care services, benefit determinations (adverse or non-adverse) shall be made as soon as possible taking into account exigencies but not later than 72 hours after receipt of the claim.

(2) For concurrent claims (adverse or non-adverse), no later than twenty-four (24) hours after receipt of the claim and prior to the expiration of the period of time or number of treatments. The claim must have been made to the health care entity or review agent at least twenty-four (24) hours prior to the expiration of the period of time or number of treatments.

(3) For pre-service claims (adverse or non-adverse), within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) calendar days after the receipt of the claim. This may be extended up to fifteen (15) additional calendar days if required by special circumstances and claimant is noticed within the first fifteen (15) calendar-day period.

(4) For post-service claims adverse benefit determination no later than thirty (30) calendar days after the receipt of the claim. This may be extended for fifteen (15) calendar days if substantiated and claimant is noticed within the first thirty (30) calendar day period.

(5) Provision in the event of insufficient information from a claimant.

(i) For urgent or emergent care, the health care entity or review agent must notify claimant as soon as possible, depending on exigencies, but no later than twenty-four (24) hours after receipt of claim giving specifics as to what information is needed. The health care entity or review agent must allow claimant at least forty-eight (48) hours to send additional information. The health care entity or review agent must provide benefit determination as soon as possible and no later than forty-eight (48) hours after receipt of necessary additional information or end of period afforded to the claimant to provide additional information, whichever is earlier.

(ii) For pre-service and post-service claims, the notice by the health care entity or review agent must include what specific information is needed. The claimant has forty-five (45) calendar days from receipt of notice to provide information.

(iii) Timelines for decisions, in the event of insufficient information, are paused from the date on which notice is sent to the claimant and restarted when the claimant responds to the request for information.

(b) Adverse benefit determination notifications form and content requirements. Health care entities and review agents shall comply with form and content notification requirements, to include the following:

(1) Notices may be written or electronic with reasonable assurance of receipt by claimant unless urgent or emergent. When urgent or emergent, oral notification is acceptable, absent a specific request by claimant for written or electronic notice, followed by written or electronic notification within three (3) calendar days.

(2) Notification content shall:

(i) Be culturally and linguistically appropriate;

(ii) Provide details of a claim that is being denied to include date of service, provider, amount of claim, a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning as applicable;

(iii) Give specific reason or reasons for the adverse benefit determination;

(iv) Include the reference(s) to specific health benefit plan or review agent provisions, guideline, protocol, or criterion on which the adverse benefit determination is based;

(v) If the decision is based on medical necessity, clinical criteria or experimental treatment or similar exclusion or limit, then notice must include the scientific or clinical judgment for the adverse determination;

(vi) Provide information for the beneficiary as to how to obtain copies of any and all information relevant to the denied claim free of charge;

(vii) Describe the internal and external appeal processes, as applicable, to include all relevant review agency contacts and OHIC's consumer assistance program information;

(viii) Clearly state timeline that the claimant has at least one hundred eighty (180) calendar days following the receipt of notification of an adverse benefit determination to file an appeal; and

(ix) Be written in a manner to convey clinical rationale in layperson terms when appropriate based on clinical condition and age and in keeping with federal and state laws and regulations.

§ 27-18.9-7. Internal appeal procedural requirements.

(a) Administrative and non-administrative appeals. The review agent shall conform to the following for the internal appeal of administrative or non-administrative, adverse benefit determinations:

(1) The review agent shall maintain and make available a written description of its appeal procedures by which either the beneficiary or the provider of record may seek review of determinations not to authorize health-care services.

(2) The process established by each review agent may include a reasonable period within which an appeal must be filed to be considered and that period shall not be less than one hundred eighty (180) calendar days after receipt of the adverse benefit determination notice.

(3) During the appeal, a review agent may utilize a reconsideration process in assessing an adverse benefit determination. If utilized, the review agent shall develop a reasonable reconsideration and appeal process, in accordance with this section. For non-administrative, adverse benefit determinations, the period for the reconsideration may not exceed fifteen (15) days from the date the request for reconsideration or appeal is received. The review agent shall notify the beneficiary and/or provider of the reconsideration determination

with the form and content described in § 27-18.9-6(b), as appropriate. Following the decision on reconsideration, the beneficiary and/or provider shall have a period of forty-five (45) calendar days during which the beneficiary and/or provider may request an appeal of the reconsideration decision and/or submit additional information.

(4) Prior to a final internal appeal decision, the review agent must allow the claimant to review the entire adverse determination and appeal file and allow the claimant to present evidence and/or additional testimony as part of the internal appeal process.

(5) A review agent is only entitled to request and review information or data relevant to the benefit determination and utilization review processes.

(6) The review agent shall maintain records of written adverse benefit determinations, reconsiderations, appeals and their resolution, and shall provide reports as requested by the office.

(7)(i) The review agent shall notify, in writing, the beneficiary and/or provider of record of its decision on the administrative appeal in no case later than thirty (30) calendar days after receipt of the request for the review of an adverse benefit determination for pre-service claims, and sixty (60) days for post-service claims, commensurate with 29 C.F.R. § 2560.503-1(i)(2)(ii) and (iii).

(ii) The review agent shall notify, in writing, the beneficiary and provider of record of its decision on the non-administrative appeal as soon as practical considering medical circumstances, but in no case later than thirty (30) calendar days after receipt of the request for the review of an adverse benefit determination, inclusive of the period to conduct the reconsideration, if any. The timeline for decision on appeal is paused from the date on which the determination on reconsideration is sent to the beneficiary and/or provider and restarted when the beneficiary and/or provider submits additional information and/or a request for appeal of the reconsideration decision.

(8) The review agent shall also provide for an expedited appeal process for urgent and emergent situations taking into consideration medical exigencies. Notwithstanding any other provision of this chapter, each review agent shall complete the adjudication of expedited appeals, including notification of the beneficiary and provider of record of its decision on the appeal, not later than seventy-two (72) hours after receipt of the claimant's request for the appeal of an adverse benefit determination.

(9) Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The review agent or health-care entity is required to continue coverage pending the outcome of an appeal.

(10) A review agent may not disclose or publish individual medical records or any confidential information obtained in the performance of benefit determination or utilization review activities. A review agent shall be considered a third-party health insurer for the purposes of § 5-37.3-6(b)(6) and shall be required to maintain the security procedures mandated in § 5-37.3-4(c).

(b) Non-administrative appeals. In addition to subsection (a) of this section the utilization review agent shall conform to the following for its internal appeals adverse benefit determinations:

(1) A claimant is deemed to have exhausted the internal claims appeal process when the utilization review agent or health-care entity fails to strictly adhere to all benefit determination and appeal processes with respect to a claim. In this case the claimant may initiate an external appeal or remedies under section 502(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq., or other state and federal law, as applicable.

(2) No reviewer under this section, who has been involved in prior reviews or in the adverse benefit determination under appeal or who has participated in the direct care of the beneficiary, may participate in reviewing the case under appeal.

(3) All internal-level appeals of utilization review determinations not to authorize a health-care service that had been ordered by a physician, dentist, or other provider shall be made according to the following:

(i) The reconsideration decision of a non-administrative, adverse benefit determination shall not be made until the utilization review agent's professional provider with the same licensure status as typically manages the condition, procedure, treatment, or requested service under discussion has spoken to, or otherwise provided for, an equivalent two-way, direct communication with the beneficiary's attending physician, dentist, other professional provider, or other qualified professional provider responsible for treatment of the beneficiary concerning the services under review.

(ii) A review agent who does not utilize a reconsideration process must comply with the peer-review obligation described in subsection (b)(3)(i) of this section as part of the appeal process.

(iii) When the appeal of any adverse benefit determination, including an appeal of a reconsideration decision, is based in whole or in part on medical judgment, including determinations with regard to whether a particular service, treatment, drug, or other item is experimental, investigational or not medically necessary or appropriate, the reviewer making the appeal decision must be appropriately trained having the same licensure status as the ordering provider or be a physician or dentist and be in the same or similar specialty as typically manages the condition. These qualifications must be provided to the claimant upon request.

(iv) The utilization review agency reviewer must document and sign their decisions.

(4) The review agent must ensure that an appropriately licensed practitioner or licensed physician is reasonably available to review the case as required under this subsection (b) and shall conform to the following:

(i) Each agency peer reviewer shall have access to and review all necessary information as requested by the agency and/or submitted by the provider(s) and/or beneficiaries;

(ii) Each agency shall provide accurate peer review contact information to the provider at the time of service, if requested, and/or prior to such service, if requested. This contact information must provide a mechanism for direct communication with the agency's peer reviewer; and

(iii) Agency peer reviewers shall respond to the provider's request for a two-way, direct communication defined in this subsection (b) as follows:

(A) For a prospective review of non-urgent and non-emergent health-care services, a response within one business day of the request for a peer discussion;

(B) For concurrent and prospective reviews of urgent and emergent health-care services, a response within a reasonable period of time of the request for a peer discussion; and

(C) For retrospective reviews, prior to the internal-level appeal decision.

(5) The review agency will have met the requirements of a two-way, direct communication, when requested and/or as required prior to the internal level of appeal, when it has made two (2) reasonable attempts to contact the attending provider directly. Repeated violations of this section shall be deemed to be substantial violations pursuant to § 27-18.9-9 and shall be cause for the imposition of penalties under that section.

(6) For the appeal of an adverse benefit determination decision that a drug is not covered, the review agent shall complete the internal-appeal determination and notify the claimant of its determination:

(i) No later than seventy-two (72) hours following receipt of the appeal request; or

(ii) No later than twenty-four (24) hours following the receipt of the appeal request in cases where the beneficiary is suffering from a health condition that may seriously jeopardize the beneficiary's life, health, or ability to regain maximum function or when a beneficiary is undergoing a current course of treatment using a non-formulary drug.

(iii) And if approved on appeal, coverage of the non-formulary drug must be provided for the duration of the prescription, including refills unless expedited then for the duration of the exigency.

(7) The review agents using clinical criteria and medical judgment in making utilization review decisions shall comply with the following:

(i) The requirement that each review agent shall provide its clinical criteria to OHIC upon request;

(ii) Provide and use written clinical criteria and review procedures established according to nationally accepted standards, evidence-based medicine and protocols that are periodically evaluated and updated or other reasonable standards required by the commissioner;

(iii) Establish and employ a process to incorporate and consider local variations to national standards and criteria identified herein including without limitation, a process to incorporate input from local participating providers; and

(iv) Updated description of clinical decision criteria to be available to beneficiaries, providers, and the office upon request and readily available and accessible on the health-care entity or the review agent's website.

(8) The review agent shall maintain records of written, adverse benefit determination reconsiderations and appeals to include their resolution, and shall provide reports and other information as requested by the office.

§ 27-18.9-8. External appeal procedural requirements.

(a) General requirements.

(1) In cases where the non-administrative, adverse benefit determination or the final internal level of appeal to reverse a non-administrative, adverse benefit determination is unsuccessful, the health care entity or review agent shall provide for an external appeal by an independent review organization (IRO) approved by the commissioner and ensure that the external appeal complies with all applicable laws and regulations.

(2) In order to seek an external appeal, claimant must have exhausted the internal claims and appeal process unless the utilization review agent or health care entity has waived the internal appeal process by failing to comply with the internal appeal process or the claimant has applied for expedited external review at the same time as applying for expedited internal review.

(3) A claimant shall have at least four (4) months after receipt of a notice of the decision on a final internal appeal to request an external appeal by an IRO.

(4) Health care entities and review agents must use a rotational IRO registry system specified by the commissioner, and must select an IRO in the rotational manner described in the IRO registry system.

(5) A claimant requesting an external appeal may be charged no more than a twenty-five dollar ($25.00) external appeal fee by the review agent. The external appeal fee, if charged, must be refunded to the claimant if the adverse benefit determination is reversed through external review. The external appeal fee must be waived if payment of the fee would impose an undue financial hardship on the beneficiary. In addition, the annual limit on external appeal fees for any beneficiary within a single plan year (in the individual market, within a policy year) must not exceed seventy-five dollars ($75.00). Notwithstanding the aforementioned, this subsection shall not apply to excepted benefits as defined in 42 U.S.C. § 300gg-91(c).

(6) IRO and/or the review agent and/or the health care entity may not impose a minimum dollar amount of a claim for a claim to be eligible for external review by an IRO.

(7) The decision of the external appeal by the IRO shall be binding on the health care entity and/or review agent; however, any person who is aggrieved by a final decision of the external appeal agency is entitled to judicial review in a court of competent jurisdiction.

(8) The health care entity must provide benefits (including making payment on the claim) pursuant to an external review decision without delay regardless whether the health care entity or review agent intends to seek judicial review of the IRO decision.

(9) The commissioner shall promulgate rules and regulations including, but not limited to, criteria for designation, operation, policy, oversight, and termination of designation as an IRO. The IRO shall not be required to be certified under this chapter for activities conducted pursuant to its designation.

(b) The external appeal process shall include, but not be limited to, the following characteristics:

(1) The claimant must be noticed that he/she shall have at least five (5) business days from receipt of the external appeal notice to submit additional information to the IRO.

(2) The IRO must notice the claimant of its external appeal decision to uphold or overturn the review agency decision:

(i) No more than ten (10) calendar days from receipt of all the information necessary to complete the external review and not greater than forty-five (45) calendar days after the receipt of the request for external review; and

(ii) In the event of an expedited external appeal by the IRO for urgent or emergent care, as expeditiously as possible and no more than seventy-two (72) hours after the receipt of the request for the external appeal by the IRO. Notwithstanding provisions in this section to the contrary, this notice may be made orally but must be followed by a written decision within forty-eight (48) hours after oral notice is given.

(3) For an external appeal of an internal appeal decision that a drug is not covered, the IRO shall complete the external appeal determination and notify the claimant of its determination:

(i) No later than seventy-two (72) hours following receipt of the external appeal request; or

(ii) No later than twenty-four (24) hours following the receipt of the external appeal request if the original request was an expedited request; and

(iii) If approved on external appeal, coverage of the non-formulary drug must be provided for the duration of the prescription, including refills, unless expedited then for the duration of the exigencies.

(c) External appeal decision notifications. The health care entity and review agent must ensure that the IRO adheres to the following relative to decision notifications:

(1) May be written or electronic with reasonable assurance of receipt by claimant unless urgent or emergent. If urgent or emergent, oral notification is acceptable followed by written or electronic notification within three (3) calendar days;

(2) Must be culturally and linguistically appropriate;

(3) The details of claim that is being denied to include the date of service, provider name, amount of claim, diagnostic code, and treatment costs with corresponding meanings;

(4) Must include the specific reason or reasons for the external appeal decision;

(5) Must include information for claimant as to procedure to obtain copies of any and all information relevant to the external appeal which copies must be provided to the claimant free of charge; and

(6) Must not be written in a manner that could reasonably be expected to negatively impact the beneficiary.

§ 27-18.9-9. Reporting requirements.

The office shall establish reporting requirements to determine if adverse benefit determination and/or utilization review programs are in compliance with the provisions of this chapter and applicable regulations as well as in compliance with applicable federal law.

§ 27-18.9-10. Rules and regulations.

The health insurance commissioner may promulgate such rules and regulations as are necessary and proper to effectuate the purpose and for the efficient administration and enforcement of this chapter.

§ 27-18.9-11. Waiver of requirements.

(a) The office shall waive the requirements of this chapter only when a conflict exists with those activities of a review agent that are conducted pursuant to contracts with the state or the federal government or those activities under other state or federal jurisdictions.

(b) The office shall waive de minimus activity, in accordance with the regulations adopted by the commissioner.

§ 27-18.9-12. Variance of statutory requirements.

Statutory variances shall be issued for a period not to exceed one year and may be subject to such terms and conditions deemed necessary as determined by the commissioner. Prior to issuing a statutory variance, the office may provide notice and public hearing to ensure necessary beneficiary and health care provider protections in the process.

§ 27-18.9-13. Denial, suspension, or revocation of certificate – Penalties.

Adopted pursuant to this chapter;

(a) The office may deny a certificate or certification upon review of the application if, upon review of the application, it finds that the applicant proposing to conduct utilization review does not meet the standards required by this chapter or by any regulations promulgated pursuant to this chapter.

(b) The office may revoke or suspend a certificate or certification and/or impose monetary penalties not less than one hundred dollars ($100) and not to exceed fifty thousand dollars ($50,000) per violation and/or impose an order requiring a monetary restitution or disgorgement payment in an amount determined by the commissioner to reasonably reflect the amount of damages caused or monies improperly obtained in any case in which:

(1) The health care entity and/or review agent fails to comply with the requirements of this chapter or of regulations;

(2) The review agent/network plan and/or health care entity and/or review agent fails to comply with the criteria used by it in its application for a certificate or certification; or

(3) The health care entity and/or review agent refuses to permit or fails to reasonably cooperate with an examination by the commissioner to determine compliance with the requirements of this chapter and regulations promulgated pursuant to the authority granted to the commissioner in this chapter. These determinations may involve consideration of any written grievances filed with the office against the health care entity and/or review agent by patients or providers.

(c) Any applicant or certificate or certification holder aggrieved by an order or a decision of the commissioner made under this chapter without a hearing may, within thirty (30) days after notice of the order or decision, make a written request to the office for a hearing on the order or decision pursuant to § 42-35-15.

(d) The procedure governing hearings authorized by this section shall be in accordance with §§ 42-35-9 through 42-35-13 as stipulated in § 42-35-14(a). A full and complete record shall be kept of all proceedings, and all testimony shall be recorded but need not be transcribed unless the decision is appealed pursuant to § 42-35-15. A copy or copies of the transcript may be obtained by any interested party upon payment of the cost of preparing the copy or copies. Witnesses may be subpoenaed by either party.

§ 27-18.9-14. Penalties and enforcement.

For the purposes of this chapter, in addition to the provisions of § 27-18.9-13, a health care entity and/or review agent or any person or entity conducting any activities requiring certification under this chapter shall be subject to the penalty and enforcement provisions of title 27 and chapters 14 and 14.5 of title 42 and the regulations promulgated thereunder in the same manner as a licensee or any person or entity conducting any activities requiring licensure or certification under title 27.

§ 27-18.9-15. Severability.

If any provision of this chapter or the application of any provision to any person or circumstance shall be held invalid, that invalidity shall not affect the provisions or application of this chapter which can be given effect

without the invalid provision or application, and to this end the provisions of this chapter are declared to be severable.