

Regular Session, 1999

HOUSE BILL NO. 2083 (Substitute for House Bill No. 1788 by Rep. Ansardi)

BY REPRESENTATIVES ANSARDI, MURRAY, ALEXANDER, BARTON, BAYLOR, CLARKSON, COPELIN, CRANE, CURTIS, DAMICO, DANIEL, DEVILLE, DIEZ, DONELON, FAUCHEUX, FRITH, GLOVER, HUDSON, HUNTER, ILES, KENNARD, KENNEY, LEBLANC, MARTINY, MITCHELL, MORRELL, NEVERS, ODINET, PERKINS, PIERRE, PINAC, POWELL, ROMERO, SCALISE, SCHWEGMANN, JACK SMITH, SNEED, THOMPSON, THORNHILL, TRAVIS, TRICHE, WADDELL, WARNER, WILLARD, AND WOOTON AND SENATORS BEAN, CAIN, DEAN, ELLINGTON, W. FIELDS, HINES, HOLLIS, LAMBERT, LANDRY, LANTINI, SCHEDLER, SMITH, AND ULLO

AN ACT

To amend and reenact R.S. 22:2021 and to enact Chapter 7 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:3070 through 3092, relative to health insurance; to require authorization or licensure of entities making medical necessity determinations as medical necessity review organizations; to provide for standards for such organizations; to provide for appeals from adverse determinations and for internal and external reviews; to provide for expedited appeals and reviews; to provide for standards for independent review organizations; to provide relative to the liability of organizations making medical necessity determinations; to provide for enforcement, including assessments, fines, and grounds for revocation or suspension of licensure; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:2021 is hereby amended and reenacted and Chapter 7 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:3070 through 3092, is hereby enacted, all to read as follows:

§2021. ~~Utilization~~ Medical necessity review

~~A.(1) Every health maintenance organization shall establish assure full compliance with Chapter 7 of this Title in establishing procedures for continuous review of quality of care, performance of providers, utilization of health services, facilities, and costs. Notwithstanding any other provision of law, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against any person who participates in quality of care or utilization reviews by peer review committees for any act performed during such reviews if such person acts without malice, makes a reasonable effort to obtain the facts, and believes that the action taken is warranted by the facts. The peer review committees shall not be subject to discovery, and no person in attendance at such reviews shall be required to testify as to what transpired at such reviews.~~

(2) The ~~utilization~~ medical necessity review requirements and administrative treatment guidelines of the health maintenance organization shall not fall below the appropriate standard of care and shall not impinge upon the independent medical judgment of the treating health care provider. Nothing in this Section shall be construed to prevent a health maintenance organization from conducting a ~~utilization~~ medical necessity review and quality assurance program.

~~B.(1) Every managed care entity shall either approve or disapprove within two working days of obtaining sufficient information an authorization for medical diagnostic testing or treatment requested from a health care provider that is of an urgent need.~~

(2) ~~Every managed care entity shall either approve or disapprove within five working days of obtaining sufficient information~~

~~an authorization for medical diagnostic testing or treatment requested from a health care provider that is elective.~~

~~(3) For the purposes of this Subsection, "managed care entity" means an insurance company, hospital, or medical benefit plan or program, health maintenance organization, integrated health care delivery system, an employer or employee organization, or a managed care contractor which operates a managed care plan. A managed care entity may include but it is not limited to a preferred provider organization, health maintenance organization, exclusive provider organization, independent practice association, clinic without walls, management services organization, managed care services organization, physician hospital organization, and hospital physician organization.~~

~~(4) For purposes of this Subsection, "managed care plan" or "plan" means a plan operated by a managed care entity which provides for the financing and delivery of health care and treatment services to individuals enrolled in the plan by its own employed health care providers or by contracting with selected specific providers that conform to explicit selection standards, or both. A "managed care plan" also means a formal organizational structure for continual quality assurance, a certified utilization review program, dispute resolution, or financial incentives for individual enrollees to use the participating providers and procedures of the plan.~~

~~(5) The failure to timely approve or disapprove the request by the managed care entity pursuant to Paragraphs B(1) and (2) shall constitute an authorization under the plan for the requested testing or treatment.~~

~~C. The commissioner, with the consent of the Department of Health and Hospitals and in compliance with the Louisiana Administrative Procedure Act, shall be authorized to issue such rules, regulations, and orders as shall be necessary to implement standards and criteria for the structure and operation of utilization review processes designed to facilitate ongoing assessment and management of health care services. Accreditation by a nationally recognized accrediting body or entity recognized by the commissioner shall be evidence of meeting the requirements of this Section.~~

* * *

CHAPTER 7. MEDICAL NECESSITY REVIEW ORGANIZATIONS

§3070. Legislative findings; purpose; short title

A. Without standards for entities that determine the medical necessity of health care services, Louisianians may face unreasonable delays or denials of requests for coverage from their health benefit plans.

B. Health insurance issuers are not authorized by law to engage in the practice of medicine or adopt administrative treatment guidelines that impinge upon or encumber the independent medical judgment of treating physicians or health care providers.

C. Only entities that are licensed to practice medicine or otherwise authorized by law to determine what medical services or procedures are medically necessary for an individual should be allowed to make medical necessity determinations.

D. The purpose of this Chapter is to establish the minimum standards required for any entity that determines what medical services

or procedures will be covered under a health benefit plan based on medical necessity.

E. This Chapter shall be known and may be cited as the "Medical Necessity Review Organization Act".

§3071. Definitions

As used in this Chapter, the following terms shall be defined as follows:

(1) "Adverse determination" means a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and denied, reduced, or terminated by a reviewer based on medical necessity, appropriateness, health care setting, level of care or effectiveness.

(2) "Ambulatory review" means review of health care services performed or provided in an outpatient setting.

(3) "Appropriate medical information" means all outpatient and inpatient medical records that are pertinent to the evaluation and management of the covered person and that permit the Medical Necessity Review Organization to determine compliance with the applicable clinical review criteria. In the review of coverage for particular services, these records may include but are not necessarily limited to one or more of the following portions of the covered person's medical records as they relate directly to the services under review for medical necessity: admission history and physical examination report, physician's orders, progress notes, nursing notes, operative reports, anesthesia records, hospital discharge summary, laboratory and pathology reports, radiology or other imaging reports, consultation reports, emergency room records, and medication records.

(4) "Authorized representative" means a person to whom a covered person has given written consent to represent the covered person in an internal or external review of an adverse determination of medical necessity. "Authorized representative" may include the covered person's treating provider if the covered person appoints the provider as his authorized representative and the provider waives in writing any right to payment from the covered person other than any applicable copayment or coinsurance amount. In the event that the service is determined not to be medically necessary, and the covered person or his authorized representatives thereafter requests the services, nothing shall prohibit the provider from charging usual and customary charges for all nonmedically necessary services provided.

(5) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

(6) "Certification" or "certify" means a determination by a reviewer regarding coverage of an admission, continued stay, or other health care service for the purpose of determining medical necessity, appropriateness of the setting, or level of care.

(7) "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review.

(8) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a reviewer to determine the necessity and appropriateness of covered health care services.

(9) "Commissioner" means the commissioner of insurance.

(10) "Concurrent review" means a review of medical necessity, appropriateness of care, or level of care conducted during a patient's stay or course of treatment.

(11) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(12) "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

(13) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

(14) "Disclose" means to release, transfer, or otherwise divulge protected health information to any individual, entity, or person other than the individual who is the subject of the protected health information.

(15) "Emergency medical condition" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) Placing the health of the individual in serious jeopardy.

(b) With respect to a pregnant woman, placing the health of the woman or her unborn child in serious jeopardy.

(c) Serious impairment to bodily function.

(d) Serious dysfunction of any bodily organ or part.

(16) "Entity" means an individual, person, corporation, partnership, association, joint venture, joint stock company, trust, unincorporated organization, any similar entity, agent, or contractor, or any combination of the foregoing.

(17) "External review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations and whose accreditation or certification has been reviewed and approved by the Department of Insurance.

(18) "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing facilities, inpatient hospice facilities, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

(19) "Final adverse determination" means an adverse determination that has been upheld by a reviewer at the completion of the medical necessity review organization's internal review process as set forth in this Chapter.

(20) "Health benefit plan" means group and individual health insurance coverage, coverage provided under a group health plan, or coverage provided by a nonfederal governmental plan, as those terms are defined in R.S. 22:250.1. "Health benefit plan" shall not include a plan providing coverage for excepted benefits as defined in R.S. 22:250.1(3).

(21) "Health care professional" means a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law.

(22) "Health care provider" or "provider" means a health care professional or a facility.

(23) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(24) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to any of the following:

(a) The past, present, or future physical, mental, or behavioral health or condition of a covered person or a member of the covered person's family.

(b) The provision of health care services to a covered person.

(c) Payment for the provision of health care services to a covered person.

(25) "Health insurance coverage" means benefits consisting of medical care provided or arranged for directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer.

(26) "Health insurance issuer" means an insurance company, including a health maintenance organization as defined and licensed

pursuant to Part XII of Chapter 2 of this Title, unless preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974.

(27) "Medical Necessity Review Organization" or "MNRO" means a health insurance issuer or other entity licensed or authorized pursuant to this Chapter to make medical necessity determinations for purposes other than the diagnosis and treatment of a medical condition.

(28) "Prospective review" means a review conducted prior to an admission or a course of treatment.

(29) "Protected health information" means health information that either identifies a covered person who is the subject of the information or with respect to which there is a reasonable basis to believe that the information could be used to identify a covered person.

(30) "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but shall not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

(31) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.

§3072. Authorization or licensure as an MNRO

A. No health insurance issuer shall act as an MNRO for the purpose of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or

making other similar medical determinations unless authorized as an MNRO by the commissioner as provided in this Chapter.

B. No entity acting on behalf of or as the agent of a health insurance issuer may act as an MNRO for the purpose of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar determinations unless licensed as an MNRO by the commissioner as provided in this Chapter.

C. Any other entity may apply for and be issued a license under this Chapter to act as an MNRO for the purposes of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar determinations on behalf of a health benefit plan.

D. Any entity licensed as an MNRO shall be exempt from the requirements of R.S. 40:2721 through 2736.

§3073. Procedure for application to act as an MNRO

A. Any applicant for licensure other than a health insurance issuer shall submit an application to the commissioner and pay the initial licensure fee specified in R.S. 22:3074(D). The application shall be on a form and accompanied by any supporting documentation required by the commissioner and shall be signed and verified by the applicant. The information required by the application shall include but need not be limited to the following:

(1) The name of the entity operating as an MNRO and any trade or business names used by that entity in connection with making medical necessity determinations.

(2) The names and addresses of every officer and director of the entity operating as an MNRO, as well as the name and address of the

corporate officer designated by the MNRO as the corporate representative to receive, review, and resolve all grievances addressed to the MNRO.

(3) The name and address of every person owning, directly or indirectly, five percent or more of the entity operating as an MNRO.

(4) The principal place of business of the MNRO.

(5) A general description of the operation of the MNRO which includes a statement that the MNRO does not engage in the practice of medicine or act to impinge or encumber the independent medical judgement of treating physicians or health care providers.

(6) A copy of the MNRO's procedures manual which meets the requirements of this Chapter for making medical necessity determinations and resolving disputes on an internal and external basis.

(7) A sample copy of any contract, absent fees charged, with a health insurance issuer, nonfederal government health benefit plan, or other group health plan for making determinations of medical necessity.

(8) The names, addresses, and qualifications of individuals being designated to make adverse medical necessity determinations pursuant to this Chapter.

B. A health insurance issuer holding a valid certificate of authority to operate in this state may be authorized to act as an MNRO under the requirements of this Chapter following submission to the commissioner of appropriate documentation for review and approval that shall include but need not be limited to the following:

(1) A general description of the operation of the MNRO which includes a statement that the MNRO does not engage in the practice of

medicine or act to impinge upon or encumber the independent medical judgement of treating physicians or health care providers.

(2) A copy of the MNRO's program description or procedures manual which meets the requirements of this Chapter for making medical necessity determinations and resolving disputes on an internal and external basis.

(3) A sample copy of any contract, absent fees charged, with another health insurance issuer for making determinations of medical necessity.

§3074. Expiration and renewal of license for entities other than health insurance issuers

A. Licensure pursuant to this Chapter shall expire two years from the date approved by the commissioner unless the license is renewed for a two-year term as provided in this Section.

B. Before a license expires, it may be renewed for an additional two-year term if the applicant pays a renewal fee as provided in this Section and submits to the commissioner a renewal application on the form that the commissioner requires.

C. The renewal application required by the commissioner shall include but need not be limited to the information required for an initial application.

D. The fee for initial licensure and the fee for renewal of licensure shall each be one thousand five hundred dollars.

§3075. Scope and content of medical necessity determination process

A. An MNRO shall implement a written medical necessity determination program that describes all review activities performed for

one or more health benefit plans. The program shall include the following:

(1) Methodology to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services.

(2) Data sources and clinical review of criteria used in decision-making.

(3) The process for conducting appeals of adverse determinations.

(4) Mechanisms to ensure consistent application of review criteria and compatible decisions.

(5) Data collection processes and analytical methods used in assessing utilization of health care services.

(6) Provisions for assuring confidentiality of clinical and proprietary information.

(7) The organizational structure, including any review panel or committee, quality assurance committee, or other committee that periodically accesses health care review activities and reports to the health benefit plan.

(8) The medical director's responsibilities for day-to-day program management.

(9) Any quality management program utilized by the MNRO.

B. An MNRO shall file with the commissioner an annual summary report of its review program activities that includes a description of any substantive changes that have been implemented since the last annual report.

§3076. Medical necessity review organization operational requirements

A. An MNRO shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. An MNRO may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors. An MNRO shall make available its clinical review criteria upon request to the commissioner who shall be authorized to request affirmation of such criteria from other appropriate state regulatory agencies.

B. An MNRO shall have a medical director who shall be a duly licensed physician. The medical director shall administer the program and oversee all review decisions. Adverse determinations shall be made only by a duly licensed physician or clinical peer. An adverse determination made by an MNRO in the second level review shall become final only when a clinical peer has evaluated and concurred with such determination.

C. An MNRO shall issue determination decisions in a timely manner pursuant to the requirements of this Chapter. At the time of the request for review, an MNRO shall notify the covered person or his authorized representative and the provider of all documentation required to make a medical review determination. In the event that the MNRO determines that additional information is required, it shall notify the covered person or his authorized representative and the provider, by telephone, within one work day of such determination, to request any additional appropriate medical information required. An MNRO shall obtain all information required to make a medical necessity determination, including pertinent clinical information, and

shall have a process to ensure that qualified health care professionals performing medical necessity determinations apply clinical review criteria consistently.

D. At least annually, an MNRO shall routinely assess the effectiveness and efficiency of its medical necessity determination program and report any deficiencies or changes to the commissioner.

E. An MNRO's data systems shall be sufficient to support review program activities and to generate management reports to enable the health benefit plan to monitor its activities.

F. Health insurance issuers who delegate any medical necessity determination functions to an MNRO shall be responsible for oversight, which shall include the following:

(1) A written description of the MNRO's activities and responsibilities, including reporting requirements.

(2) Evidence of formal approval of the medical necessity determination program by the health insurance issuer.

(3) A process by which the health insurance issuer monitors or evaluates the performance of the MNRO.

G. Health insurance issuers who perform medical necessity determinations shall coordinate such program with other medical management activities conducted by the health insurance issuer, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction, and risk management.

H. An MNRO shall provide health care providers with access to its review staff by a toll-free number that is operational for any

period of time that an authorization, certification, or approval of coverage is required.

I. When conducting medical necessity determinations, the MNRO shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency, and duration of services.

J. Compensation to individuals participating in a medical necessity determination program shall not contain incentives, direct or indirect, for those individuals to make inappropriate review determinations. Compensation to any such individuals shall not be based, directly or indirectly, on the quantity or type of adverse determinations rendered.

§3077. Procedures for making medical necessity determinations

A. An MNRO shall maintain written procedures for making determinations and for notifying covered persons and providers and other authorized representatives acting on behalf of covered persons of its decisions.

B.(1) In no less than eighty percent of initial determinations, an MNRO shall make the determination within two working days of obtaining any appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. In no instance shall any determination of medical necessity be made later than thirty days from receipt of the request unless the patient's physician or other authorized representative has agreed to an extension.

(2) In the case of a determination to certify a nonemergency admission, procedure, or service, the MNRO shall notify the provider

rendering the service within one work day of making the initial certification and shall provide documented confirmation of such notification to the provider within two working days of making the initial certification.

(3) In the case of an adverse determination of a nonemergency admission, the MNRO shall notify the provider rendering the service within one work day of making the adverse determination and shall provide documented confirmation of the notification to the provider within two working days of making the adverse determination.

C.(1) For concurrent review determinations of medical necessity, an MNRO shall make such determinations within one working day of obtaining the results of appropriate medical information that may be required.

(2) In the case of a determination to certify an extended stay or additional services, the MNRO shall notify the provider rendering the service within one working day of making the certification and shall provide documented confirmation to the provider within two working days of the authorization. Such documented notification shall include the number of intended days or next review date and the new total number of days or services approved.

(3) In the case of an adverse determination, the MNRO shall notify the provider rendering the service within one working day of making the adverse determination and shall provide documented notification to the provider within one work day of such notification. The service shall be authorized and payable by the health insurance issuer without liability, subject to the provisions of the policy or subscriber agreement, until the provider has been notified of the

adverse determination. The covered person shall not be liable for the cost of any services delivered following documented notification to the provider unless notified of such liability in advance.

D.(1) For retrospective review determinations, the MNRO shall make the determination within thirty working days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred eighty days from the date of service. The MNRO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon prior approval, unless the approval was based upon a material omission or misrepresentation about the covered person's health condition made by the provider or unless the coverage was duly canceled for fraud or nonpayment of premiums.

(2) In the case of an adverse determination, the MNRO shall notify in writing the provider rendering the service and the covered person within five working days of making the adverse determination.

E. A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. An MNRO shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who follows the procedures.

F. An MNRO shall have written procedures listing the information required from a covered person or health care provider in

order to make a medical necessity determination. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall also outline the process to be followed in the event that the MNRO determines the need for additional information not initially requested.

G. An MNRO shall have written procedures to address the failure or inability of a provider or a covered person to provide all necessary information for review. In cases where the provider or a covered person will not release necessary information, the MNRO may deny certification.

§3078. Informal reconsideration

A. In a case involving an initial determination or a concurrent review determination, an MNRO shall give the provider rendering the service an opportunity to request on behalf of the covered person a reconsideration of an adverse determination by the physician or clinical peer making the adverse determination.

B. The reconsideration shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the MNRO's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one working day.

C. If the reconsideration process does not resolve the differences of opinion, the adverse determination may be appealed by the covered person or the provider on behalf of the covered person. Reconsideration shall not be a prerequisite to a standard appeal or an expedited appeal of an adverse determination.

§3079. Appeals of adverse determinations; standard appeals

A. An MNRO shall establish written procedures for a standard appeal of an adverse determination, which may also be known as a first level internal appeal. Such procedures shall be available to the covered person and to the provider acting on behalf of the covered person. Such procedures shall provide for an appropriate review panel for each appeal that includes health care professionals who have appropriate expertise.

B. For standard appeals, a duly licensed physician shall be required to concur with any adverse determination made by the review panel.

C. The MNRO shall notify in writing both the covered person and the attending or ordering provider of the decision within thirty working days following the request for an appeal, unless the covered person or authorized representative and the MNRO mutually agree that a further extension of the time limit would be in the best interest of the covered person. The written decision shall contain the following:

(1) The title and qualifying credentials of the physician affirming the adverse determination.

(2) A statement of the reason for the covered person's request for an appeal.

(3) An explanation of the reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the MNRO's position.

(4) If applicable, a statement including the following:

(a) A description of the process to obtain a second level review of a decision.

(b) The written procedures governing a second level review, including any required time frame for review.

§3080. Second level review

A. An MNRO shall establish a second level review process to give covered persons who are dissatisfied with the first level review decision the option to request a review at which the covered person has the right to appear in person before authorized representatives of the MNRO. An MNRO shall provide covered persons with adequate notice of this option.

B. An MNRO shall conduct a second level review for each appeal. Appeals shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer shall not have been involved in the initial adverse determination. A majority of any review panel used shall be comprised of persons who were not previously involved in the appeal. However, a person who was previously involved with the appeal may be a member of the panel or appear before the panel to present information or answer questions. The panel shall have the legal authority to bind the MNRO and the health benefit plan to the panel's decision.

C. An MNRO shall ensure that a majority of the persons reviewing a second level appeal are health care professionals who have appropriate expertise. An MNRO shall issue a copy of the written decision to a provider who submits an appeal on behalf of a covered person. In cases where there has been a denial of service, the reviewing health care professional shall not have a financial incentive or interest in the outcome of the review.

D. The procedures for conducting a second level review shall include the following:

(1) The review panel shall schedule and hold a review meeting within forty-five working days of receiving a request from a covered person for a second level review. The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person. In cases where a face-to-face meeting is not practical for geographic reasons, an MNRO shall offer the covered person the opportunity to communicate with the review panel, at the MNRO's expense, by conference call, video conferencing, or other appropriate technology. The covered person shall be notified of the time and place of the review meeting in writing at least fifteen working days in advance of the review date; such notice shall also advise the covered person of his rights as specified in Paragraph (3) of this Subsection. The MNRO shall not unreasonably deny a request for postponement of a review meeting made by a covered person.

(2) Upon the request of a covered person, an MNRO shall provide to the covered person all relevant information that is not confidential or privileged.

(3) A covered person shall have the right to the following:

(a) Attend the second level review.

(b) Present his case to the review panel.

(c) Submit supporting material both before and at the review meeting.

(d) Ask questions of any representative of the MNRO.

(4) The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.

(5) For second level appeals, a duly licensed and appropriate clinical peer shall be required to concur with any adverse determination made by the review panel.

(6) The MNRO shall issue a written decision to the covered person within five working days of completing the review meeting. The decision shall include the following:

(a) The title and qualifying credentials of the appropriate clinical peer affirming an adverse determination.

(b) A statement of the nature of the appeal and all pertinent facts.

(c) The rationale for the decision.

(d) Reference to evidence or documentation used in making that decision.

(e) The instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination.

(f) Notice of the covered person's right to an external review.

§3081. Request for external review

A. Each health benefit plan shall provide an independent review process to examine the plan's coverage decisions based on medical necessity. A covered person, with the concurrence of the treating health care provider, may make a request for an external review of a second level appeal adverse determination.

B. Except as provided in this Subsection, an MNRO shall not be required to grant a request for an external review until the second level appeal process as set forth in this Chapter has been exhausted. A request for external review of an adverse determination may be made

before the covered person has exhausted the MNRO's appeal, if any of the following circumstances apply:

(1) The covered person has an emergency medical condition.

(2) The MNRO agrees to waive the requirements for the first level appeal, the second level appeal, or both.

C. If the requirement to exhaust the MNRO's appeal procedures is waived under Paragraph B(1) of this Section, the covered person's treating health care provider may request an expedited external review. If the requirement to exhaust the MNRO's appeal procedures is waived under Paragraph B(2) of this Section, a standard external review shall be performed.

§3082. Standard external review

A. Within sixty days after the date of receipt of a notice of a second level appeal adverse determination, the covered person whose medical care was the subject of such determination may, with the concurrence of the treating health care provider, file a request for an external review with the MNRO. Within seven days after the date of receipt of the request for an external review, the MNRO shall provide the documents and any information used in making the second level appeal adverse determination to its designated independent review organization. The independent review organization shall review all of the information and documents received and any other information submitted in writing by the covered person or the covered person's health care provider. The independent review organization may consider the following in reaching a decision or making a recommendation:

(1) The covered person's pertinent medical records.

(2) The treating health care professional's recommendation.

(3) Consulting reports from appropriate health care professionals and other documents submitted by the MNRO, covered person, or the covered person's treating provider.

(4) Any applicable generally accepted practice guidelines, including but not limited to those developed by the federal government or national or professional medical societies, boards, and associations.

(5) Any applicable clinical review criteria developed exclusively and used by MNRO that are within the appropriate standard for care, provided such criteria were not the sole basis for the decision or recommendation unless the criteria had been reviewed and certified by the appropriate licensing board of this state.

B. The independent review organization shall provide notice of its recommendation to the MNRO, the covered person or his authorized representative and the covered person's health care provider within thirty days after the date of receipt of the second level determination information subject to an external review, unless a longer period is agreed to by all parties.

§3083. Expedited appeals

A. An MNRO shall establish written procedures for the expedited appeal of an adverse determination involving a situation where the time frame of the standard appeal would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. An expedited appeal shall be available to and may be initiated by the covered person, with the consent of the treating health care professional, or the provider acting on behalf of the covered person.

B. Expedited appeals shall be evaluated by an appropriate clinical peer or peers in the same or a similar specialty as would typically manage the case under review. The clinical peer or peers shall not have been involved in the initial adverse determination.

C. An MNRO shall provide an expedited appeal to any request concerning an admission, availability of care, continued stay, or health care service for a covered person or his authorized representative who has received emergency services but has not been discharged from a facility.

D. In an expedited appeal, all necessary information, including the MNRO's decision, shall be transmitted between the MNRO and the covered person, or his authorized representative, or the provider acting on behalf of the covered person by telephone, telefacsimile, or any other available expeditious method.

E. In an expedited appeal, an MNRO shall make a decision and notify the covered person or the provider acting on behalf of the covered person as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two hours after the appeal is commenced. If the expedited appeal is a concurrent review determination, the service shall be authorized and payable, subject to the provisions of the policy or subscriber agreement, until the provider has been notified of the determination. The covered person shall not be liable for the cost of any services delivered following documented notification to the provider until documented notification of such liability is provided to the covered person.

F. An MNRO shall provide written confirmation of its decision concerning an expedited appeal within two working days of providing

notification of that decision if the initial notification was not in writing.
The written decision shall contain the information specified in R.S.
22:3079(C)(1) through (3).

G. An MNRO shall provide reasonable access, within a period
of time not to exceed one work day, to a clinical peer who can perform
the expedited appeal.

H. In any case where the expedited appeal process does not
resolve a difference of opinion between the MNRO and the covered
person or the provider acting on behalf of the covered person, such
provider may request a second level appeal of the adverse
determination.

I. An MNRO shall not provide an expedited appeal for
retrospective adverse determinations.

§3084. Expedited external review

A. At the time that a covered person receives an adverse
determination involving an emergency medical condition of the covered
person, the covered person's health care provider may request an
expedited external review.

B. For emergency medical conditions, the MNRO shall provide
or transmit all necessary documents and information used in making the
adverse determination to the independent review organization by
telephone, telefacsimile, or any other available expeditious method.

C. In addition to the documents and information provided or
transmitted, the independent review organization may consider the
following in reaching a decision or making a recommendation:

- (1) The covered person's pertinent medical records.
- (2) The treating health care professional's recommendation.

(3) Consulting reports from appropriate health care professionals and other documents submitted by the MNRO, the covered person, or the covered person's treating provider.

(4) Any applicable generally accepted practice guidelines, including but not limited to those developed by the federal government or national or professional medical societies, boards, and associations.

(5) Any applicable clinical review criteria developed exclusively and used by the MNRO that are within the appropriate standard for care, provided such criteria were not the sole basis for the decision or recommendation, unless the criteria had been reviewed and certified by the appropriate state licensing board of this state.

D. Within seventy-two hours after receiving appropriate medical information for an expedited external review, the independent review organization shall do the following:

(1) Make a decision to uphold or reverse the adverse determination.

(2) Notify the covered person, the MNRO, and the covered person's health care provider of the decision. Such notice shall include the principal reason or reasons for the decision and references to the evidence or documentation considered in making the decision.

§3085. Binding nature of external review decisions

A. Coverage for the services required under this Chapter shall be provided subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the plan. Nothing in this Chapter shall be construed to require the plan to pay for services that are not otherwise covered pursuant to the evidence of coverage under the plan or otherwise required under any applicable state or federal law.

B. An external review decision made pursuant to this Chapter shall be binding on the MNRO and on any health insurance issuer or health benefit plan that utilizes the MNRO for making medical necessity determinations.

C. An external review decision shall be binding on the covered person for purposes of determining coverage under a health benefit plan that requires a determination of medical necessity for a medical service to be covered.

D. A covered person or his representatives, heirs, assigns, or health care providers shall have a cause of action for benefits or damages against an MNRO, health insurance issuer, health benefit plan, or independent review organization for any action involving or resulting from a decision made pursuant to this Chapter if the determination or opinion was rendered in bad faith or involved negligence, gross negligence, or intentional misrepresentation of factual information about the covered person's medical condition.

§3086. Minimum qualifications for independent review organizations

A. To qualify to conduct external reviews for an MNRO, an independent review organization shall meet the following minimum qualifications:

(1) Develop written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process that include, at a minimum, the following:

(a) Procedures to ensure that external reviews are conducted within the specified time frames and that required notices are provided in a timely manner.

(b) Procedures to ensure the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases.

(c) Procedures to ensure the confidentiality of medical and treatment records and clinical review criteria.

(d) Procedures to ensure that any individual employed by or under contract with the independent review organization adheres to the requirements of this Chapter.

(2) Establish a quality assurance program.

(3) Establish a toll-free telephone service to receive information related to external reviews on a twenty-four-hour-day, seven-day-a-week basis that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.

B. Any clinical peer reviewer assigned by an independent review organization to conduct external reviews shall be a physician or other appropriate health care provider who meets the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review.

(2) Be knowledgeable about the recommended health care service or treatment through actual clinical experience that may be based on either of the following:

(a) The period of time spent actually treating patients with the same or similar medical condition of the covered person.

(b) The period of time that has elapsed between the clinical experience and the present.

(3) Hold a nonrestricted license in a state of the United States and, in the case of a physician, hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

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

C. In addition to the requirements of Subsection A of this Section, an independent review organization shall not own or control, be a subsidiary of, in any way be owned or controlled by, or exercise control with a health insurance issuer, health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.

D. In addition to the other requirements of this Section, in order to qualify to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor the clinical peer reviewer assigned by the independent organization to conduct the external review shall have a material professional, familial, or financial interest with any of the following:

(1) The MNRO that is the subject of the external review.

(2) Any officer, director, or management employee of the MNRO that is the subject of the external review.

(3) The health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review.

(4) The facility at which the recommended health care service or treatment would be provided.

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

§3087. External review register

A. An MNRO shall maintain written records in the aggregate and by health insurance issuer and health benefit plan on all requests for external review for which an external review was conducted during a calendar year, hereinafter referred to as the "register". For each request for external review, the register shall contain, at a minimum, the following information:

(1) A general description of the reason for the request for external review.

(2) The date received.

(3) The date of each review.

(4) The resolution.

(5) The date of resolution.

(6) The name of the covered person for whom the request for external review was filed.

B. The register shall be maintained in a manner that is reasonably clear and accessible to the commissioner.

C. The register compiled for a calendar year shall be retained for the longer of three years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.

D. The MNRO shall submit to the commissioner, at least annually, a report in the format specified by the commissioner. The report shall include the following for each health insurance issuer and health benefit plan:

(1) The total number of requests for external review.

(2) The number of requests for external review resolved and their resolution.

(3) A synopsis of actions being taken to correct problems identified.

§3088. Emergency services

A. When conducting medical necessity determinations for emergency services, an MNRO shall not disapprove emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of such services if a prudent lay person acting reasonably would have believed that an emergency medical condition existed. With respect to care obtained from a noncontracting provider within the service area of a managed care plan, an MNRO shall not disapprove emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of the services if a prudent lay person would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency or if a provision of federal, state, or local law requires the use of a specific provider.

B. If a participating provider or other authorized representative of a health insurance issuer or health benefit plan authorizes emergency services, the MNRO shall not subsequently retract its authorization after the emergency services have been provided or reduce payment for an item, treatment, or service furnished in reliance upon approval, unless the approval was based upon a material omission or misrepresentation about the covered person's health condition made by the provider of emergency services.

C. Coverage of emergency services shall be subject to state and federal laws as well as contract or policy provisions, including copayments or coinsurance and deductibles.

D. For immediately required post-evaluation or post-stabilization services, an MNRO shall provide access to an authorized representative twenty-four hours a day, seven days a week, to facilitate review.

§3089. Confidentiality requirements

An MNRO shall annually provide written certification to the commissioner that its program for determining medical necessity complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

§3090. Regulations

The commissioner may, after notice and hearing, promulgate such rules and regulations as may be necessary or proper to carry out the provisions of this Chapter. Such rules and regulations shall be promulgated and adopted in accordance with the Administrative Procedure Act.

§3091. Examination of MNRO and other parties

A. The commissioner or a member of his staff may make an examination of the affairs of any MNRO or any health insurance issuer authorized to act as an MNRO as often as it is reasonably necessary for the protection of the interest of the people of this state, but not less frequently than once every three years, to determine whether the MNRO is adhering to the requirements of this Chapter.

B. The commissioner shall be authorized to assess health insurance issuers and licensed MNROs for the cost of performing examinations to determine compliance with this Chapter.

§3092. Fines; cease and desist orders; grounds for suspension or revocation of licensure or certificate of authority

A. Whenever the commissioner has reason to believe that any health insurance issuer or licensed MNRO is not in full compliance with the provisions of this Chapter, he shall notify such person and, after notice and opportunity for hearing pursuant to Part XXIX of this Chapter, subject to Chapter 13-B of Title 49 of the Louisiana Revised Statutes of 1950, the commissioner shall issue and cause to be served an order requiring the health insurance issuer or MNRO to cease and desist from any violation and order any one or more of the following:

(1) Payment of a monetary penalty of not more than twenty-five dollars for each day that a determination was not made within the time frames established by this Chapter.

(2) Payment of a monetary penalty of not more than one thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of one hundred thousand dollars. However, if the health insurance issuer or MNRO knew or reasonably should have

known it was in violation of this Chapter, the penalty shall be not more than twenty-five thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of two hundred fifty thousand dollars in any six-month period.

(3) Suspension or revocation of the license of the health insurance issuer's certificate of authority to operate in this state or the license of an MNRO if the health insurance issuer or MNRO knew or reasonably should have known it was in violation of this Chapter.

B. Any health insurance issuer or licensed MNRO who violates a cease and desist order issued by the commissioner pursuant to this Chapter while such order is in effect shall, after notice and opportunity for hearing, be subject at the discretion of the commissioner to any one or more of the following:

(1) A monetary penalty of not more than twenty-five thousand dollars for each and every act or violation, not to exceed an aggregate of two hundred fifty thousand dollars.

(2) Suspension or revocation of the health insurance issuer's certificate of authority to operate in this state or the license of the MNRO to operate in this state.

C. The license of an MNRO or authorization of a health insurance issuer to act as an MNRO shall be suspended or revoked, or, in lieu of such revocation, a fine may be imposed for each separate violation, not to exceed five thousand dollars per violation, or twenty-five thousand dollars in the aggregate, if the commissioner finds that the MNRO has engaged in any of the following:

(1) Using such methods or practices in the conduct of its business so as to render its further determinations of medical necessity in this state hazardous or injurious to covered persons or the public.

(2) Failing to comply with any independent review organization determination within sixty days after the determination has become final.

Section 2. The provisions of this Act shall not apply to health insurance issuers until January 1, 2001; however, each health insurance issuer making medical necessity determinations shall file all documentation required by R.S. 22:3073(B) for authorization as an MNRO with the commissioner of insurance no later than June 30, 2000.

Section 3. This Act shall become effective on January 1, 2000.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____