SENATE FILE NO. SF0095

Medical necessity review procedures.

Sponsored by: Senator(s) Ross, Hastert, Massie, Schiffer and Sessions and Representative(s) Millin and Stubson

A BILL

for

AN ACT relating to insurance; defining medical necessity; setting requirements for analyzing insurance coverage and benefit payments under a medical necessity standard; setting requirements for denying payment or coverage; establishing review procedures; modifying unfair claims settlement practices accordingly; allocating costs; and providing for effective dates.

Be It Enacted by the Legislature of the State of Wyoming:

Section 1. W.S. 26-40-201 is created to read:

ARTICLE 2

MEDICAL NECESSITY STANDARD

26-40-201. Payment of claims under medical necessity standard; review.

(a) As used in this section, "medical necessity or other similar basis" includes, but is not limited to, "medically necessary," "medically necessary care" and "medically necessary and appropriate," as defined in W.S. 26-40-102(a)(iii).

(b) If any disability insurance policy, as defined by W.S. 26-5-103, provides for settlement of a claim for payment of medical services, procedures or supplies provided by a health care provider using a medical necessity or other similar basis the insurer shall:

(i) Define medical necessity or other similar basis as "medical necessity" is defined in this chapter and W.S. 26-40-102(a)(iii);

(ii) Make all determinations whether a medical service, procedure or supply is medically necessary based only upon the factors stated in the definition of medical necessity contained in W.S. 26-40-102(a)(iii);

(iii) Provide internal review and external review procedures for all denied claims as required in this section and disclose all procedures, time lines and requirements for such review procedures in every disability insurance policy and as otherwise required in this section. An insurer applying the notification and appeal procedures consistent with the Employee Retirement Income Security Act shall be deemed in compliance with this section.

(c) When any claim for payment of medical services, procedures or supplies is first denied as not being a medical necessity, or on another similar basis, the insurer shall provide to the claimant, in writing, a complete explanation of the basis for the settlement and shall specify why the services, procedures or supplies requested are not medically necessary. Such explanation shall also include:

(i) A statement in the following, or substantially equivalent, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You have the right to have our decision reviewed by following the procedures outlined in this notice. You also may have the right to an

1 expedited review under circumstances where a delayed review
2 would adversely affect you."; and
3
4 (ii) A statement describing a procedure for
5 having the claim denial reviewed by the insurer, including
6 all applicable time limits, requirements and a process for
7 having a expedited review initiated as expeditiously as the
8 claimant's medical condition or circumstances require, and
9 in any event within three (3) working days, where:
10
11 (A) The timeframe for the completion of a
12 normal review would seriously jeopardize the life or health
13 of the claimant or would jeopardize the claimant's ability
14 to regain maximum function; or
15
16 (B) The claimant's claim concerns a request
17 for an admission, availability of care, continued stay or
18 health care service for which the claimant received
19 emergency services, but has not been discharged from a
20 health care facility.
21
22 (d) A claimant shall have not less than thirty (30)
23 days in which to file a request for the review provided in
24 subsection (c) of this section and such review shall be

completed by the insurer, and a decision delivered to the claimant, no later than forty-five (45) days after receipt of a request for review. In the event the insurer applies the provisions of the Employee Retirement Income Security Act related to notification and appeal rights, the insurer will be deemed to have met the provisions of this section.

(e) If a claim for medical services, procedures or supplies is denied on the basis that it is not a medical necessity, or on other similar basis, after having been reviewed by the insurer pursuant to subsection (c) of this section, the insurer shall provide to the claimant, in writing, a complete explanation of the basis for the decision and shall specify why the services, procedures or supplies requested are not medically necessary. Such explanation shall also include:

(A) The signed opinion of at least one (1) credited medical consultant who agrees with the denial and who is not an employee of the insurer if requested by the claimant;

(B) A statement in the following, or substantially equivalent, language: "We have denied your

1 request for the provision of or payment for a health care
2 service or course of treatment. You may have the right to
3 have our decision reviewed by health care professionals who
4 have no association with us and is not the attending
5 physician or the physician's partner by following the
6 procedures outlined in this notice. You also may have the
7 right to an expedited review under circumstances where a
8 delayed review would adversely affect you."; and
9
10 (C) A statement describing the procedure
11 for having the denied claim reviewed by an external review
12 organization pursuant to regulations adopted by the
13 commissioner. The statement shall include a description of
14 all procedures, time limits and requirements, including
15 those related to expedited reviews, which the claimant must
16 follow to obtain an external review and include a request
17 for external review form and release of records form
18 approved by the commissioner. In the event the insurer
19 applies the provisions of the Employee Retirement Income
20 Security Act related to notification and appeal rights, the
21 insurer will be deemed to have met the provisions of this
22 section.
23

1 (f) Within sixty (60) days of receiving the written
2 explanation required by subsection (e) of this section, a
3 claimant may request an external review of the decision
4 which is the subject of the explanation by filing a written
5 request for such review. The request shall be submitted to
6 the insurer on a form approved by the commissioner, unless
7 such form was not provided to the claimant as required by
8 subsection (e) of this section, in which event any written
9 request for an external review shall be sufficient. In the
10 event the insurer applies the provisions of the Employee
11 Retirement Income Security Act related to notification and
12 appeal rights, the insurer will be deemed to have met the
13 provisions of this section.
14
15 (g) Upon receiving a request for external review, the
16 insurer shall:
17
18 (i) Immediately send a copy of the request to
19 the commissioner;
20
21 (ii) Assign the request to an independent review
22 organization that has been approved by the commissioner for
23 a preliminary review to determine whether:
24

1 (A) The claimant is or was a covered person
2 in the disability insurance policy at the time the medical
3 services, procedures or supplies were requested or
4 provided;
5
6 (B) The medical services, procedures or
7 supplies requested by the claimant reasonably appear to be
8 a covered service under the disability insurance policy,
9 but for the determination by the insurer that the services,
10 procedures or supplies are not a medical necessity;
11
12 (C) The insurer has denied the claimant's
13 request for medical services, procedures or supplies after
14 having been given the opportunity to review the insurer's
15 first denial one (1) or more times;
16
17 (D) The claimant has provided to the
18 insurer all the information and forms required to process
19 an external review, including a release form, approved by
20 the commissioner, by which the claimant authorizes the
21 release of protected health information pertinent to the
22 external review.
23

1 (h) The independent review organization shall
2 complete the review in a timely manner and immediately
3 notify the claimant and the insurer in writing whether the
4 documentation is complete. The claimant or insurer may
5 submit in writing to the independent review organization
6 any additional supporting documentation that the
7 independent review organization should consider or may
8 require when conducting its external review. If the
9 request for review is not complete, the independent review
10 organization shall require from the insurer or the insured
11 the information or materials needed to make the request
12 complete.
13
14 (j) The insurer or insured shall provide to the
15 independent review organization the documents and any
16 information considered in settling the claim which is the
17 subject of the review. Failure to provide the documents
18 and other information shall not delay the conduct of the
19 external review.
20
21 (k) All documentation or other information provided
22 to the independent review organization by the claimant
23 shall be immediately provided to the insurer, which insurer
24 may use the information to reconsider its settlement of the

claimant's claim. If the insurer chooses to reverse its prior decision, it shall immediately provide written notice to the claimant, the independent review organization and the commissioner, at which time the review shall be terminated.

(m) In addition to the documents and information provided pursuant to this section, the independent review organization, to the extent the information is available and the independent review organization considers them appropriate, shall consider the following in reaching its decision:

(i) The claimant's medical records;

(ii) The attending health care professional's recommendation;

(iii) Consulting reports from appropriate health care professionals and other documents submitted by the insurer, claimant or the claimant's treating provider;

(iv) The terms of coverage under the claimant's disability insurance policy;

1

2 (v) The standards identified in W.S.
3 26-40-102(a)(iii);
4
5 (vi) All evidence based research used in the
6 insurer's denial of the claim.
7
8 (n) Within forty-five (45) days after the date of
9 receipt of the request for external review, the assigned
10 independent review organization shall provide written
11 notice to the claimant, the insurer and the commissioner of
12 its decision to uphold or reverse the decision of the
13 insurer that the medical service, procedure or supply
14 requested by the claimant is not medically necessary. Such
15 written notice shall include:
16
17 (i) A general description of the reason for the
18 request for external review;
19
20 (ii) The date the independent review
21 organization received the assignment from the insurer to
22 conduct the review;
23

1 (iii) The date the external review was
2 conducted;
3
4 (iv) The date of its decision;
5
6 (v) The principal reasons for its decision;
7
8 (vi) The rationale for its decision; and
9
10 (vii) References to the evidence or
11 documentation considered in reaching its decision.
12
13 (o) In the event the external review organization
14 determines the claim should be allowed, the insurer shall
15 approve the request for medical services, procedures or
16 supplies that was the subject of the review and notify the
17 claimant of such approval.
18
19 (p) The engagement by an insurer of an independent
20 review organization to conduct an external review in
21 accordance with this section shall be fair and impartial.
22 The insurer, insured and the independent review
23 organization shall comply with regulations promulgated by
24 the commissioner to ensure fairness and impartiality in the

1 engagement of approved independent review organizations, in
2 the terms, termination and payment of independent review
3 organizations and in the review process.
4
5 (q) The commissioner shall adopt regulations
6 establishing an expedited review by an external review
7 organization as expeditiously as the claimant's medical
8 condition or circumstances require, but in no event more
9 than seventy-two (72) hours after the date of receipt of
10 the request for an expedited external review, and which
11 allows an expedited external review where:
12
13 (i) The timeframe for the completion of a normal
14 external review would seriously jeopardize the life or
15 health of the claimant or would jeopardize the claimant's
16 ability to regain maximum function; or
17
18 (ii) The claimant's claim concerns a request for
19 an admission, availability of care, continued stay or
20 health care service for which the claimant received
21 emergency services, but has not been discharged from a
22 health care facility.
23

1 (r) The insurer against whom a request for external
2 review is filed shall pay the costs of the independent
3 review organization's external review.
4
5 (s) The commissioner shall adopt such regulations as
6 are necessary to promote the purposes of this section,
7 which regulations shall include:
8
9 (i) Fees, including the waiver of fees for
10 indigent persons;
11
12 (ii) Standards and procedures for the approval
13 of independent review organizations;
14
15 (iii) External review organization reporting and
16 record retention requirements.
17
18 (t) An insurer applying the notification and appeal
19 procedures consistent with the Employee Retirement Income
20 Security Act shall be deemed in compliance with this
21 section.
22

Section 2. W.S. 26-13-124(a)(xiii) and by creating new paragraphs (xv) through (xvii) and 26-40-102(a) by creating a new paragraph (iii) are amended to read:

26-13-124. Unfair claims settlement practices.

(a) A person is considered to be engaging in an unfair method of competition and unfair and deceptive act or practice in the business of insurance if that person commits or performs with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(xiii) Failing to promptly settle claims, where liability has become reasonably clear, under one (1) portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; ~~or~~

(xv) Denying or failing to timely pay disability insurance claims for medically necessary services, procedures or supplies as required by W.S. 26-40-201;

1 (xvi) Failing to comply with the external review
2 procedures required by W.S. 26-40-201; or
3
4 (xvii) Failing to pay a claim after an external
5 review organization has declared such claim to be a benefit
6 covered under the terms of the insurance policy.
7
8 **26-40-102. Definitions.**
9
10 (a) As used in this chapter:
11
12 (iii) "Medical necessity," means:
13
14 (A) A medical service, procedure or supply
15 provided for the purpose of preventing, diagnosing or
16 treating an illness, injury, disease or symptom and is a
17 service, procedure or supply that:
18
19 (I) Is medically appropriate for the
20 symptoms, diagnosis or treatment of the condition, illness,
21 disease or injury;
22

1 (II) Provides for the diagnosis,
2 direct care and treatment of the patient's condition,
3 illness, disease or injury;
4
5 (III) Is in accordance with
6 professional, evidence based medicine and recognized
7 standards of good medical practice and care; and
8
9 (IV) Is not primarily for the
10 convenience of the patient, physician or other health care
11 provider.
12
13 (B) A medical service, procedure or supply
14 shall not be excluded from being a medical necessity under
15 this section solely because the service, procedure or
16 supply is not in common use if the safety and effectiveness
17 of the service, procedure or supply is supported by:
18
19 (I) Peer reviewed medical literature,
20 including literature relating to therapies reviewed and
21 approved by a qualified institutional review board,
22 biomedical compendia and other medical literature that meet
23 the criteria of the National Institutes of Health's Library
24 of Medicine for indexing in Index Medicus (Medline) and

1 Elsevier Science Ltd. for indexing in Excerpta Medicus
2 (EMBASE); or
3
4 (II) Medical journals recognized by
5 the Secretary of Health and Human Services under Section
6 1861(t)(2) of the federal Social Security Act.
7
8 **Section 3.** This act applies to disability insurance
9 policies and certificates of coverage issued, renewed,
10 delivered or issued for delivery in this state on or after
11 July 1, 2010.
12
13 **Section 4.** The insurance commissioner may adopt rules
14 and regulations implementing the provisions of this act
15 upon the effective date of this section.
16
17 **Section 5.**
18
19 (a) Section 4 of this act is effective immediately
20 upon completion of all acts necessary for a bill to become
21 law as provided by Article 4, section 8 of the Wyoming
22 Constitution.
23

1 (b) Except as provided in subsection (a) of this
2 section, this act is effective July 1, 2010.
3
4 (END)