SENATE BILL 3806

By Johnson

AN ACT to amend Tennessee Code Annotated, Title 56, relative to review of health claims.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated Title 56, is amended by adding SECTION 2 through SECTION 25 as a newly designated chapter thereto.

SECTION 2. This chapter shall be known and may be cited as the "Tennessee Health Carrier Grievance and External Review Procedure Act." This purpose of this chapter is to provide standards for the establishment and maintenance of precedures by health carriers to assure that covered persons and health care providers have the opportunity for the appropriate resolution of grievances, as defined in this Chapter.

SECTION 3. For purposes of this chapter, unless the context otherwise requires:

(1) "Adverse determination" means:

(A) A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;

(B) The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier of a covered person's eligibility to participate in the health carrier's health benefit plan; or

(C) Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment for, in whole or in part, a benefit;

(2) "Authorized representative" means:

(A) A person to whom a covered person has given express written consent to represent the covered person for purposes of this act;

(B) A person authorized by law to provide substituted consent for a covered person;

(C) A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;

(D) A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or

(E) In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition;

(3) "Clinical peer" means a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty that would typically manage the medical condition, procedure or treatment under review;

(4) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services;

(5) “Closed plan” means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan or the plan will not provide covered benefits to the covered person;

(6) “Commissioner” means the commissioner of insurance;

(7) “Covered benefits” or “benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan;

(8) “Covered person” means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan;

(9) “Emergency medical condition” means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy;

(10) “Emergency services” means health care items and services furnished or required to evaluate and treat an emergency medical condition;

(11) “External review organization” means an entity that conducts independent external reviews of adverse determinations and final adverse determinations;

(12) “Facility” means an institution licensed under title 68 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 centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation;

(13) “Final adverse determination” means an adverse determination involving a covered benefit that has been upheld by a health carrier at the

completion of the health carrier's internal grievance process procedures as set forth in the Tennessee Health Carrier Grievance Procedure Act.

(14) "Grievance" means a written appeal of an adverse determination or final adverse determination, if the appeal involves an urgent care request submitted by or on behalf of a covered person regarding:

(A) Availability, delivery or quality of health care services regarding an adverse determination;

(B) Claims payment, handling or reimbursement for health care services;

(C) Matters pertaining to the contractual relationship between a covered person and a health carrier; or

(D) Matters pertaining to the contractual relationship between a health care provider and a health carrier;

(15) "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services;

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

(17) "Health care provider" or "provider" means a health care professional or a facility;

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

(19) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that

contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident, insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services;

(20) "Health indemnity plan" means a health benefit plan that is not a managed care plan;

(21) "Managed care plan" means a health benefit plan that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier. "Managed care plan" includes:

(A) A closed plan, as defined in subdivision (5); and

(B) An open plan, as defined in subdivision (26);

(22) "Medical or scientific evidence" means evidence found in the following sources:

(A) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(B) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for

indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

(C) Medical journals recognized by the secretary of health and human services under § 1861(t)(2) of the federal Social Security Act, codified in 42 USC § 1395

(D) The following standard reference compendia:

(i) The American Hospital Formulary Service–Drug Information;

(ii) Drug Facts and Comparisons;

(iii) The American Dental Association Accepted Dental Therapeutics;

(iv) The United States Pharmacopoeia–Drug Information; or

(v) Any other medical or scientific evidence that is comparable to the sources listed in subdivisions (22)(D) (i) through (iv);

(23) "Medically necessary" or "medical necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

(A) In accordance with generally accepted standards of medical practice;

(B) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

(C) Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease;

(24) "NAIC" means the National Association of Insurance Commissioners;

(25) "Network" means the group of participating providers providing services to a managed care plan;

(26) "Open plan" means a managed care plan, other than a closed plan, that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan;

(27) "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier;

(28) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the listed entitles;

(29) "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision;

(30) “Register” means the written records kept by a health carrier to document all grievances received during a calendar year;

(31) “Retrospective review” means any review of a request for a benefit that is not a prospective review request. Retrospective review does not include the review of a claim that is limited to veracity of documentation or accuracy of coding; and

(32)

(A) “Urgent care request” means a request for a health care service or course of treatment with respect to which the time periods for making non-urgent care request determination:

(i) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(ii) In the opinion of a physician with knowledge of the covered person’s medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request;

(B)

(i) In determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine;

(ii) Any request that a physician with knowledge of the covered person’s medical condition determines is an urgent care

request within the meaning of subdivision(32)(A) shall be treated as an urgent care request.

SECTION 4. Except as otherwise specified, this chapter shall apply to all health carriers.

SECTION 5. Nothing in this Chapter shall limit or restrict the health carrier from denying coverage on the grounds that the services are determined not to be medically necessary.

SECTION 6.

(a) A health carrier shall maintain written records to document all grievances received during a calendar year. The register shall be maintained in a manner that is reasonably clear and accessible to the commissioner.

(b) A request for a first level review of a grievance involving an adverse determination shall be processed in compliance with SECTION 8 but is not required to be included in the health carrier's register.

(c) A request for second level review of a grievance involving an adverse determination that may be conducted pursuant to SECTION 9 shall be included in the health carrier's register.

(d) For each grievance the register shall contain, at a minimum, the following information:

(1) A general description of the reason for the grievance;

(2) The date the grievance was received;

(3) The date of each review or, if applicable, review meeting;

(4) Resolution at each level of the grievance, if applicable;

(5) Date of resolution at each level, if applicable; and

(6) Name of the covered person or health provider for whom the grievance was filed.

(e)

(1) A health carrier shall retain the register compiled for a calendar year for the longer of five (5) years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.

(2)

(A) A health carrier shall submit to the commissioner, at least annually, a report in the format specified by the commissioner.

(B) The report shall include for each type of health benefit plan offered by the health carrier:

(i) The number of covered lives that fall under the chapter's protections;

(ii) The total number of grievances;

(iii) The number of grievances for which a covered person requested a second level voluntary grievance review pursuant to SECTION 9;

(iv) The number of grievances resolved at each level, if applicable, and their resolution; and

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

SECTION 7.

(a) Except as specified in SECTION 10, a health carrier shall use written procedures for receiving and resolving grievances from covered persons and health care providers, as provided in SECTIONS 8 and 9.

(b) A description of the grievance procedures required under this section shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons.

SECTION 8.

(a) Within one-hundred and eighty (180) days after the date of receipt of a notice of an adverse determination, a covered person or the covered person's authorized representative may file a grievance with the health carrier requesting a first level review of the adverse determination.

(b) The health carrier shall provide the covered person or the authorized representative with the name, address and telephone number of a person or organizational unit designated to coordinate the first level review on behalf of the health carrier.

(c)

(1)

(A) A covered person does not have the right to attend, or to have a representative in attendance at the first level review; provided that, the covered person or, if applicable, the covered person's authorized representative is entitled to:

(i) Submit written comments, documents, records and other material relating to the request for benefits for the reviewer or reviewers to consider when conducting the review; and

(ii) Receive from the health carrier, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the covered person's request for benefits.

(B) For purposes of subdivision (c)(1)(A)(ii), a document, record or other information shall be considered "relevant" to a covered person's request for benefits if the document, record or other information:

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered or generated in the course of making the adverse determination, without regard to whether the document, record or other information was relied upon in making the benefit determination;

(iii) Demonstrates that, in making the benefit determination, the health carrier or its designated representatives applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or

(iv) Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied health care service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

(2) The health carrier shall make the provisions of subdivision (c)(1) known to the covered person or, if applicable, the covered person's authorized representative within five (5) working days after the date of receipt of the grievance within the appropriate department of the health carrier.

(d) For purposes of calculating the time periods within which a determination is required to be made and notice provided under subsection (e), the time period shall begin on the date the grievance requesting the review is filed with the health carrier in

accordance with the health carrier's procedures established pursuant to SECTION 8; unless the health carrier finds the information received materially incomplete such that no reasonable review may begin.

(e)

(1) A health carrier shall notify and issue a decision in writing or electronically to the covered person or, if applicable, the covered person's authorized representative within the time frames provided in subdivisions((f)(2) and (3).

(2) With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty (30) days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to subsection (a).

(3) With respect to a grievance requesting a first level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision within a reasonable period of time, but no later than sixty (60) days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to subsection (a).

(f) The decision issued pursuant to subsection (e) shall set forth in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative:

(1) A statement of the reviewer's understanding of the covered person's grievance;

(2) The reviewer's decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

(3) A reference to the evidence or documentation used as the basis for the decision;

(4) For a first level review decision issued pursuant to subsection (e) involving an adverse determination:

(A) The specific reason or reasons for the adverse determination;

(B) The reference to the specific plan provisions on which the determination is based;

(C) A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in subdivision (c)(1)(B), to the covered person's benefit request;

(D) If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request and the date such policy was effective;

(E) If the adverse determination is based on medical necessity, either an explanation of the criteria for making the determination, applying the terms of the health benefit plan to the covered person's

medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request; and

(F) If applicable, instructions for requesting:

(i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in subdivision (f)(4)(D); and

(ii) The written statement of the criteria for the determination, as provided in subdivision (f)(4)(E);

(5) If applicable, a statement indicating:

(A) A description of the process to obtain an additional second level review of the first level review decision involving an adverse determination, if the covered person wishes to request a second level review pursuant to SECTION 9;

(B) The written procedures governing the second level review, including any required time frame for the review; and

(C) A description of the procedures for obtaining an independent external review of the adverse determination pursuant to this chapter if the covered person decides not to file for a second review of the first level review decision involving an adverse determination.

SECTION 9.

(a)

(1) A health carrier 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 second level review, at which the covered person or the

covered person's authorized representative has the right to appear in person at the review meeting before designated representatives of the health carrier.

(2) This section shall not apply to health indemnity plans.

(b)

(1) Health carriers required by this section to establish a second level review process shall provide covered persons or their authorized representatives with notice pursuant to SECTION 8, as appropriate, of the option to file a request with the health carrier for an additional review of the first level review decision received under SECTION 8.

(2) Upon receipt of a request for a second level review, the health carrier shall send notice to the covered person or, if applicable, the covered person's authorized representative of the covered person's right to:

(A) Request, within the time frame specified in subdivision (b)(3)(A), the opportunity to appear in person before a review panel of the health carrier's designated representatives;

(B) Receive from the health carrier, upon request, copies of all documents, records and other information that is not confidential or privileged relevant to the covered person's request for benefits;

(C) Present the covered person's case to the review panel;

(D) Submit written comments, documents, records and other material relating to the request for benefits for the review panel to consider when conducting the review both before and, if applicable, at the review meeting;

(E) If applicable, ask questions of any representative of the health carrier on the review panel, provided such questions are governed and relevant to the subject matter of the review; and

(F) Be assisted or represented by an individual of the covered person's choice, at the expense of such covered person.

(3)

(A) A covered person or the authorized representative of the covered person wishing to request to appear in person before the review panel of the health carrier's designated representatives shall make the request to the health carrier within ten (10) working days after the date of receipt of the notice sent in accordance with subdivision (b)(2).

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

(c)

(1)

(A) With respect to a second level review of a first level review decision made pursuant to SECTION 8, a health carrier shall appoint a review panel to review the request.

(B) In conducting the review, the review panel shall take into consideration all comments, documents, records and other information regarding the request for benefits submitted by the covered person or the covered person's authorized representative pursuant to subdivision (b)(2), without regard to whether the information was submitted or considered in reaching the first level review decision.

(C) The panel shall have the legal authority to bind the health carrier to the panel's decision.

(2)

(A) Except as provided in subdivision (c)(2)(B), a majority of the panel shall be comprised of individuals who were not involved in the in the first level review decision made pursuant to SECTION 8.

(B) An individual who was involved with the first level review decision may be a member of the panel or appear before the panel to present information or answer questions.

(C) The health carrier shall ensure that the individuals conducting the second level review of the first level review decision have appropriate expertise or have access to appropriate expertise.

(D) No member of the review panel shall have a direct financial interest in the outcome of the review.

(d) The procedures for conducting the review shall:

(1) Be held during regular business hours at a location reasonably accessible to the covered person or, if applicable, the covered person's authorized representative;

(2) In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier, may offer the covered person or, if applicable, the covered person's authorized representative, the opportunity to communicate with the review panel by conference call;

(3) Provide the covered person, or if applicable, the covered person's authorized representative the right to have an attorney present; and

(4) Require the review panel to issue a written or electronic decision, as provided in subsection (e), to the covered person or, if applicable, the covered person's authorized representative within five (5) working days of completing the review meeting.

(e) A decision issued pursuant to this section shall include the:

(A) Titles and qualifying credentials of the members of the review panel;

(B) Statement of the review panel's understanding of the nature of the grievance and all pertinent facts;

(C) Rationale for the review panel's decision;

(D) Reference to evidence or documentation considered by the review panel in making that decision;

(E) In cases concerning a grievance involving an adverse determination:

(i) Instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and

(ii) If applicable, a statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to this chapter.

SECTION 10.

(a) A health carrier shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination.

(b) In addition to subsection (a), a health carrier shall provide expedited review of a grievance involving an adverse determination with respect to concurrent review

urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services, but has not been discharged from a facility.

(c) The procedures shall allow a covered person or the covered person's authorized representative to request an expedited review under this section orally or in writing.

(d) A health carrier shall appoint an appropriate clinical peer, or peers as would typically manage the case being reviewed, to review the adverse determination. The clinical peer or peers shall not have been involved in making the initial adverse determination.

(e) In an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or, if applicable, the covered person's authorized representative by telephone, facsimile or the most expeditious method available.

(f)

(1) An expedited review decision shall be made and the covered person or, if applicable, the covered person's authorized representative, shall be notified of the decision in accordance with subsection (h) as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two (72) hours after the receipt of the request for the expedited review.

(2) If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.

(g) For purposes of calculating the time periods within which a decision is required to be made under subsection (f), the time period within which the decision is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to SECTION 8; unless the health carrier finds the information received materially incomplete, such that no reasonable review may begin.

(h)

(1) A notification of a decision under this section shall, in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative, set forth:

(A) The titles and qualifying credentials of the person or persons participating in the expedited review process;

(B) A statement of the reviewers' understanding of the covered person's grievance;

(C) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

(D) A reference to the evidence or documentation used as the basis for the decision; and

(E) If the decision involves an adverse determination, the notice shall provide:

(i) The specific reasons or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(iv) If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and a copy of the rule, guideline, protocol or other similar criterion;

(v) If the adverse determination is based on medical necessity, an explanation of the criteria for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(vi) If applicable, instructions for requesting:

(*a*) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination in accordance with subdivision (h)(1)(E)(iv); or

(*b*) The written statement of the criteria for the adverse determination in accordance with subdivision (h)(1)(E)(v);

(vii) A statement describing the procedures for obtaining an independent external review of the adverse determination pursuant this chapter.

(2)

(A) A health carrier may provide the notice required under this section orally, in writing or electronically.

(B) If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three (3) days following such oral notification.

SECTION 11. The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this chapter. Such regulations shall be subject to review in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 12. A person that violates this chapter shall be subject to the penalties set forth in § 56-2-305.

SECTION 13. Applicability and Scope.

(a) Except as provided in subsection (b), this chapter shall apply to all health carriers. However, health carriers that have received accreditation from the National Committee for Quality Assurance or URAC may elect to follow the external review guidelines set forth by the accrediting bodies in lieu of following the guidelines set forth in this chapter.

(b) This chapter shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by § 56-42-103, vision care or any other limited supplemental benefit or to a Medicare supplement

policy of insurance, as defined by the commissioner, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under 10 U.S.C. § 1071 et seq. and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable without regard to fault, whether written on a group blanket or individual basis.

SECTION 14.

(a) A health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to SECTIONS 17 and 18 and include the appropriate statements and information set forth in subsection (b) at the same time the health carrier sends written notice of a final adverse determination and as part of the written notice required under this subsection (a), a health carrier shall include 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 health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a written request for external review to us.

(b) The health carrier shall include the following in the notice required under subsection (a):

(1) For a notice related to an adverse determination, a statement informing the covered person that:

(A) If the covered person has a medical condition where the timeframe for completion of an expedited review of a grievance involving an adverse determination set forth in SECTION 10 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to SECTION 18.

(B) The covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process as set forth in SECTION 8, but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within sixty (60) days following the date the covered person or the covered person's authorized representative files the grievance, with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review pursuant to SECTION 17 and shall be considered to have exhausted the health carrier's internal grievance process for purposes of SECTION 16; and

(2) For a notice related to a final adverse determination, a statement informing the covered person that:

(A) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to SECTION 17 would seriously jeopardize the life or health of the covered

person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to SECTION 18.

(B) If the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person or the covered person's authorized representative may request an expedited external review pursuant to SECTION 18; or

(c) In addition to the information to be provided pursuant to subdivision (b)(1), the health carrier shall include a copy of the description of both the standard and expedited external review procedures highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

(d) As part of any forms provided under subdivision (b)(2), the health carrier shall include an authorization form that complies with the requirements of 45 CFR § 164.508, by which the covered person, for purposes of conducting an external review under this chapter, authorizes the health carrier and the covered person's treating health care provider to disclose protected health information, including but not limited to, medical records, concerning the covered person that are pertinent to the external review.

SECTION 15.

(a) Except for a request for an expedited external review as set forth in SECTION 18, all requests for external review shall be made in writing to the health carrier.

(b) Unless otherwise set forth, a covered person may make a request for external review after the receipt of a final adverse determination.

SECTION 16.

(a) Except as provided in subsection (b), a request for an external review pursuant to SECTION 17 shall not be made until the covered person has exhausted the health carrier's internal grievance process as set forth in the this chapter.

(1) A covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section, if the covered person or the covered person's authorized representative:

(A) Has filed a grievance involving an adverse determination pursuant to SECTION 8; and

(B) Except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within sixty (60) days following the date the covered person or the covered person's authorized representative filed the grievance with the health carrier.

(2) Notwithstanding subdivision (a)(1)(B), a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination until the covered person has exhausted the health carrier's internal grievance process.

(b) A request for an external review of an adverse determination may be made before the covered person has exhausted the heath carrier's heath carrier's internal grievance procedures as set forth in SECTION 8 whenever the health carrier agrees to waive the exhaustion requirement.

(c) If the requirement to exhaust the health carrier's internal grievance procedures is waived under subsection (b), the covered person or the covered person's authorized representative may file a request in writing for a standard external review as set forth in SECTION 17.

SECTION 17.

(a) Within six (6) months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to SECTION 14, a covered person or the covered person's authorized representative may file a request for an external review with the health carrier.

(b) Within ten (10) business days following the date of receipt of the copy of the external review request, the health carrier shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;

(2) The health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan;

(3) The covered person has exhausted the health carrier's internal grievance process as set forth in this chapter unless the covered person is not

required to exhaust the health carrier's internal grievance process pursuant to SECTION 16; and

(4) The covered person has provided all the information and forms required to process an external review, including the release form provided under SECTION 14.

(c) Within six (6) business days after completion of the preliminary review, the health carrier shall notify the covered person and, if applicable, the covered person's authorized representative in writing whether:

(1) The request is complete; and

(2) The request is eligible for external review.

(d) If the request set out in subsection (a):

(1) Is not complete, the health carrier shall inform the covered person and, if applicable, the covered person's authorized representative in writing and include in the notice what information or materials are needed to make the request complete; or

(2) Is not eligible for external review, the health carrier shall inform the covered person, and if applicable, the covered person's authorized representative in writing and include in the notice the reasons for its ineligibility.

(e) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative, that a health carrier's initial determination that the external review request is ineligible for review may file a complaint with the commissioner.

(f) Whenever the health carrier determines that a request is eligible for external review following the preliminary review conducted pursuant to subdivision (c)(2), within six (6) business days after the date of receipt of the determination, the health carrier

shall notify in writing the covered person and, if applicable, the covered person's authorized representative, of the request's eligibility and acceptance for external review.

(g) In reaching a decision, the external review organization is not bound by any decisions or conclusions reached during the health carrier's internal grievance process as set forth in this chapter. However, the external review organization shall be bound by the terms and conditions of the covered person's health benefit plan.

(h) The health carrier shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative, a statement that the covered person or the covered person's authorized representative may submit in writing to the health carrier within six (6) business days following the date of receipt of the notice provided pursuant to subsection (f) additional information that the external review organization shall consider when conducting the external review. The external review organization is not required to, but may, accept and consider additional information submitted by the covered person after six (6) business days.

(i) Within six (6) business days after the date of receipt of the notice provided pursuant to subsection (f), the health carrier shall provide to the external review organization the documents and any information considered in making the adverse determination or final adverse determination.

(1) Failure by the health carrier to provide the documents and information within the time specified in subsection (i) shall not delay the conduct of the external review.

(2) If the health carrier fails to provide the documents and information within the time specified in subsection (i), the external review organization may terminate the external review.

(j) Within three (3) business day after making the decision under subsection (a), the external review organization shall notify the health carrier. Within five (5) business days after receiving the decision from the external review organization, the health carrier shall notify the covered person, and if applicable, the covered person's authorized representative, of the external review organization's decision.

(k) The external review organization shall review all of the information and documents received pursuant to subsection (i) and any other information submitted in writing to the external review organization by the covered person or the covered person's authorized representative pursuant to subsections (h) and (i).

(l) Upon receipt of the information, if any, is required to be forwarded pursuant to subsection (h), the health carrier may reconsider its final adverse determination that is the subject of the external review.

(1) Reconsideration by the health carrier of its final adverse determination shall not delay or terminate the external review.

(2) The external review may only be terminated by the health carrier if the health carrier decides, upon completion of its reconsideration, to reverse its final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination. If the health carrier reverses its previous determinations pursuant to this subsection (l), the health carrier shall not at a later date reverse its reversal unless it can introduce and produce new documents or supporting evidence to the record generated during the internal grievance process.

(3) Within five (5) business days after making the decision to reverse its adverse determination or final adverse determination, the health carrier shall notify the covered person, if applicable, the covered person's authorized

representative, and the external review organization in writing of its decision. The external review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subdivision (l)(3) of this subsection (l). In addition to the documents and information provided pursuant to subsections (h) and (i), the external review organization, to the extent the information or documents are available and the external review organization considers them appropriate, shall consider the following in reaching a decision:

(A) The covered person's medical records;

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

(C) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(D) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

(E) Applicable clinical review criteria developed and used by the health carrier; and

(F) The opinion of the external review organization's clinical reviewer or reviewers after considering subdivisions (A) – (E) to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(m) Within forty-five (45) days after the date of receipt of the request for an external review, the external review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the health carrier. The health carrier shall immediately notify the covered person, or if applicable, the covered person's authorized representative of the external review organization's decision to uphold or reverse the adverse determination or final adverse determination.

(n) The external review organization shall include in the notice sent pursuant to subsection (m):

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

(2) The date the external review organization received the assignment from the health carrier to conduct the external review;

(3) The date the external review was conducted;

(4) The date of its decision;

(5) The principal reason or reasons for its decision, including applicable, if any, evidence-based standards used as a basis for its decision;

(6) The rationale for its decision; and

(7) References to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

(o) Upon receipt of a notice of a decision pursuant to subsection (m) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

SECTION 18.

(a) Except as provided in subsection (f), a covered person, or the covered person's authorized representative, may make a request for an expedited external review with the health carrier at the time the covered person receives:

(1) An adverse determination if:

(A) The adverse determination involves a medical condition of the covered person for which the time-frame for completion of an expedited internal review of a grievance involving an adverse determination set forth in SECTION 10 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(B) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in SECTION 10; or

(2) A final adverse determination:

(A) If the covered person has a medical condition where the time-frame for completion of a standard external review pursuant to SECTION 17 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(B) If the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility.

(b)

(1) Immediately upon receipt of the request, the health carrier shall determine whether the request meets the reviewability requirements set forth in SECTION 17. The health carrier shall immediately notify the covered person and, if applicable, the covered person's authorized representative, of its eligibility determination regarding the availability of external review.

(2) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that an external review request is ineligible for review and that the covered person, and if applicable, the covered person's authorized representative, may file a complaint with the commissioner.

(c) Upon determining that the request meets the reviewability requirements to conduct the expedited external review, the health carrier shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the external review organization electronically or by telephone or facsimile or any other available expeditious method.

(d) In addition to the documents and information provided or transmitted pursuant to subsection (c), the external review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

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

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

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

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the external review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

(5) Applicable criteria developed and used by the health carrier in making adverse determinations; and

(6) The opinion of the external review organization's clinical reviewer or reviewers after considering subdivisions (d)(1) - (5) to the extent the information and documents are available and the clinical reviewer or reviewers consider appropriate.

(e) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements the external review organization shall make a decision to uphold or reverse the adverse determination or final adverse determination; and

(1) Notify the health carrier of the decision. The health carrier must immediately notify the covered person, and if applicable, the covered person's authorized representative. The covered person, and if applicable, the covered person's authorized representative, must receive the decision of the expedited review within seventy-two (72) hours after the date of receipt of the request for expedited external review.

(2) If the notice provided pursuant to subsection (e) was not in writing, within forty-eight (48) hours after the date of providing that notice, the external review organization shall:

(A) Provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner; and

(B) Include the information set forth in SECTION 18.

(3) Upon receipt of the notice a decision pursuant to subdivision (e)(1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the final adverse determination.

(f) An expedited external review may not be provided for retrospective adverse or final adverse determinations.

SECTION 19.

(a) An external review decision is binding on the health carrier except to the extent the health carrier has other remedies available under other provisions of Tennessee law.

(b) An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

(c) A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to this chapter.

SECTION 20.

(a) The commissioner shall approve independent review organizations eligible to conduct external reviews under this chapter.

(b) In order to be eligible for approval by the commissioner under this section to conduct external reviews under this chapter an external review organization:

(1) Except as otherwise provided in this section, shall be accredited by a nationally recognized private accrediting entity that the commissioner has determined has external review organization accreditation standards that are equivalent to or exceed the minimum qualifications for external review organizations established under SECTION 21; and

(2) Shall submit an application for approval in accordance with subsection (d).

(c) The commissioner shall develop an application form for initially approving and for reapproving external review organizations to conduct external reviews.

(d) Any external review organization wishing to be approved to conduct external reviews under this Act shall submit the application form and include with the form all documentation and information necessary for the commissioner to determine if the external review organization satisfies the minimum qualifications established under SECTION 21.

(1) Subject to subdivision (d)(2), an external review organization is eligible for approval under this section only if it is accredited by a nationally recognized private accrediting entity that the commissioner has determined has external review organization accreditation standards that are equivalent to or exceed the minimum qualifications for external review organizations under SECTION 21.

(2) The commissioner may approve external review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing external review organization accreditation.

(3) The commissioner may charge an application fee that external review organizations shall submit to the commissioner with an application for approval and reapproval.

(e) An approval is effective for two (2) years, unless the commissioner determines before its expiration that the external review organization is not satisfying the minimum qualifications established under SECTION 21. Whenever the commissioner determines that an external review organization has lost its accreditation or no longer satisfies the minimum requirements established under SECTION 21, the commissioner shall terminate the approval of the external review organization and remove the external review organization from the list of external review organizations approved to conduct external reviews under this Act that is maintained by the commissioner pursuant to subsection (f).

(f) The commissioner shall maintain and periodically update a list of approved external review organizations.

(g) The commissioner may promulgate regulations to carry out the provisions of this section.

SECTION 21.

(a) To be approved under SECTION 20 to conduct external reviews, an external review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this chapter that include, at a minimum:

(1) A quality assurance mechanism in place that:

(A) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(B) Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;

(C) Ensures the confidentiality of medical and treatment records and clinical review criteria; and

(D) Ensures that any person employed by or under contract with the external review organization adheres to the requirements of this act;

(2) A toll-free telephone service to receive information on a twenty-four (24) hour a day, seven (7) day a week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

(3) Agree to maintain and provide to the commissioner the information set out in SECTION 25.

(b) All clinical reviewers assigned by an external review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet 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 recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

(3) Hold a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

(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 reviewer's physical, mental or professional competence or moral character.

(c) In addition to the requirements set forth in subsection (a), an external review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a 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 requirements set forth in subsections (a), (b) and (c), to be approved pursuant to SECTION 22 to conduct an external review of a specified case, neither the external review organization selected to conduct the external review nor any clinical reviewer assigned by the external organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

(1) The health carrier that is the subject of the external review;

(2) The covered person whose treatment is the subject of the external review or the covered person's authorized representative;

(3) Any officer, director or management employee of the health carrier that is the subject of the external review;

(4) The health care provider, 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;

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

(6) 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.

(e) In determining whether an external review organization or a clinical reviewer of the external review organization has a material professional, familial or financial conflict of interest for purposes of subsection (d), the commissioner shall take into consideration situations where the external review organization conducting an external review of a specified case or a clinical reviewer to be assigned by the external review organization to conduct an external review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in subsection (d), but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

(f) An external review organization that is accredited by a nationally recognized private accrediting entity that has external review accreditation standards that the commissioner has determined are equivalent to or exceed the minimum qualifications of

this section shall be presumed in compliance with this section to be eligible for approval under SECTION 22.

(g) The commissioner shall initially review and periodically review the external review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section. The commissioner may accept a review conducted by the NAIC for the purpose of the determination under this subsection (g).

(h) Upon request, a nationally recognized private accrediting entity shall make its current external review organization accreditation standards available to the commissioner or the NAIC in order for the commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The commissioner may exclude any private accrediting entity that is not reviewed by the NAIC.

(i) An external review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.

SECTION 22. No external review organization or clinical reviewer working on behalf of an external review organization or an employee, agent or contractor of an external review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organizations or person's duties under the law during or upon completion of an external review conducted pursuant to this chapter, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

SECTION 23.

(a) An external review organization conducting an external review pursuant to this chapter shall maintain written records in the aggregate by state and by health carrier on all requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the commissioner, as required under subdivision (a)(2).

(1) Each external review organization required to maintain written records on all requests for external review for which it conducted an external review shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(2) The report shall include in the aggregate by state, and for each health carrier:

(A) The total number of requests for external review;

(B) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(C) The average length of time for resolution;

(D) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the commissioner;

(E) The number of external reviews pursuant to SECTION 17 that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

(F) Any other information the commissioner may request or require.

(3) The external review organization shall retain the written records required pursuant to this subsection (a) for at least three (3) years.

(b) Each health carrier shall maintain written records in the aggregate, by state and for each type of health benefit plan offered by the health carrier on all requests for external review that the health carrier receives notice of from the commissioner pursuant to this chapter.

(1) Each health carrier required to maintain written records on all requests for external review pursuant to this subsection (b) shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(2) The report shall include in the aggregate, by state, and by type of health benefit plan:

(A) The total number of requests for external review;

(B) From the total number of requests for external review reported under subdivision (b)(2)(A), the number of requests determined eligible for a full external review; and

(C) Any other information the commissioner may request or require.

(3) The health carrier shall retain the written records required pursuant to this subsection (b) for at least three (3) years.

SECTION 24. The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the external review organization for conducting the external review.

SECTION 25.

(a) Each health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons.

(b) The disclosure required by subsection (a) shall be in a format prescribed by the commissioner.

(c) The description required under subsection (a) shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the commissioner. The statement may explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness. The statement shall include the telephone number and address of the commissioner.

(d) In addition to subsection (b), the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

SECTION 26. Tennessee Code Annotated Sections 56-7-2352 and 56-7-2355, are amended by deleting the Sections in their entirety.

SECTION 27. Tennessee Code Annotated Section 56-7-120, is amended by adding the following as a new subsection (c):

This section shall not apply to health care providers who have not entered into a valid written contract with a health carrier, or who have not agreed pursuant to an arrangement with another entity which has a valid written contract with a health carrier, to provide covered services to a health carrier's members during the effective period of

such a contract. The fact that a health care provider has entered into an agreement with a rental network does not make that health care provider meet the requirements set forth in this subsection (c).

SECTION 28. If any provision of this act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

SECTION 29. For purposes of promulgating rules and regulations, this act shall take effect upon becoming a law, the public welfare requiring it, for all other purposes, this act shall take effect May 1, 2011.